Beaver Valley 2
4Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT AN ADEQUATE TDAFW PUMP SEAL PACKING PROCEDURE
The inspectors identified a self-revealing, non-cited violation of Technical Specification (TS) 6.8.1, when the Unit 2 Turbine Driven Auxiliary Feedwater (TDAFW) pump failed a quarterly test due to improper seal packing adjustment. During the test, the operators secured the pump when the outboard gland temperature exhibited excessive temperatures due to lack of seal leak-off. The outboard packing was adjusted during the previous successful test of the TDAFW pump, however, the licensee did not use an adequate packing adjustment procedure.

The finding is greater than minor because it adversely affected the reliability of a safety-related AFW pump as well as the mitigating systems cornerstone objective. The finding is of very low safety significance since an engineering analysis determined that the pump would have remained operable, and was therefore capable of performing its design basis function.
Inspection Report# : 2004006*(pdf)*

Significance: G Sep 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE PROCEDURAL ADHERENCE DURING THE INSTALLATION OF SCAFFOLDING
The inspectors identified a non-cited violation of Technical Specification 6.8.1, because an improperly built scaffold adversely impacted the Unit 2 ‘C' service water pump. Specifically, a scaffold bar was attached to the motor lifting lug of the service water pump, contrary to the scaffold erection procedure.

The finding is more than minor because it adversely affected the reliability of a safety-related service water pump as well as the mitigating systems cornerstone objective. The finding is of very low safety significance since further engineering analysis determined that the pump would have remained operable, and therefore capable of performing its design basis function. [This finding involved the cross-cutting area of human performance, due to the failure to properly implement a scaffold procedure that prohibited the attachment of scaffold to safety related components.]
Inspection Report# : 2004005*(pdf)*

Significance: G Jul 23, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CORRECTIVE ACTION ASSOCIATED WITH EMERGENCY DIESEL GENERATOR VENTILATION SYSTEM FAILURES
The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because inadequate corrective action associated with emergency diesel generator (EDG) ventilation temperature switch failures caused the affected EDG to be rendered inoperable. These temperature switches were subsequently bypassed by a temporary modification to restore EDG operability.

This finding is greater than minor because it affected the availability and reliability of a mitigating systems component. The finding is of very low safety significance since operator action is considered highly probable to ensure the EDG would continue to perform its design basis accident mitigation function. [This finding was related to the Problem Identification and Resolution Cross-Cutting area, in that inadequate problem resolution led to the tripping of the EDG supply fan which rendered the 2-2 EDG out of service.]
Inspection Report# : 2004004*(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: G May 13, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
PAR DEVELOPMENT DEFICIENCY NOT IDENTIFIED BY THE LICENSEE IN ITS CRITIQUE
The inspectors identified a non-cited violation against 10 CFR 50 Appendix E, Section IV.F.2.g, when the licensee's critique did not identify an invalid radiological release duration time used in dose projections during the May 11, 2004, exercise.

This finding is more than minor because it affects the emergency response organization performance attribute of the emergency preparedness cornerstone. Failing to identify and correct an invalid radiological release duration time could impact the EP cornerstone objective of ensuring that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Because the performance problem occurred with a protective action recommendation developed in association with a successful Drill and Exercise Performance (DEP) Performance Indicator (PI) opportunity, it is not considered to be a loss of planning standard function of 10 CFR 50.47(b)(14) and therefore is of very low safety significance.
Inspection Report# : 2004008*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: G Sep 30, 2004
Identified By: NRC
Item Type: FIN Finding
ACCEPTABILITY OF LICENSEE'S SIMULATOR TESTING METHODOLOGY
The inspectors identified a finding because the licensee's methodology for simulator testing deviated from the accepted guidance. Inspectors noted the potential existed for deviations to be introduced between the plant's control room and the plant reference simulators. Deviations could cause negative training, which in turn could have an adverse effect on operator actions during plant operations.

The finding is more than minor because it affects the Human Performance attribute of the Mitigating Systems Cornerstone, in that simulator deviations could lead to pre- and post-event human error. The finding is of very low safety significance since the finding is related to simulator fidelity, and deviations between the actual plant and the simulator could impact operator actions.
Inspection Report# : 2004005*(pdf)*

Last modified : March 09, 2005