To: Jim Mehl, ERU Supervisor

From: Zack Clayton, Rad Coord

Subject: August Monthly Report

Date: September 14, 2007

Beans:

Training:	0
Drills	0
Meetings:	3
Technical Assistance:	2
Public Assistance:	1
SAIC	3

Web Page Hits: There were 73 RAD hits in August.

Coming Attractions:

Working Group	9/5 10/1
After Action	9/5
Perry Seurity Drill	9/12
REP revisions	9/28
SAIC	9/10 9/17 9/24
URSB	10/9
NEPAC	10/11

Facility Updates:

Davis Besse Nuclear Power Station

Davis Besse operated for the month at full power.

Perry Nuclear Power Plant

Perry operated at full power for the month. The plant discovered that a section of grating in the containment pool swell region was not properly restrained. During a postulated large break Loss of Coolant Accident, the grating could become dislodged and subsequently impact the ECCS suction strainer located in the suppression pool below the grating. This has been fixed.

Beaver Valley Unit I

Beaver Valley Unit I operated for the month at full power. A contract employee had access suspended for failing a fitness for duty test for alcohol.

Beaver Valley Unit II

Beaver Valley Unit II operated at full power for the month.

Fermi II

Fermi operated for the month at full power. The plant did work on the HVAC system to the Technical Support Center which placed it out of service for one day. This work is complete.

Portsmouth Gaseous Diffusion Plant reported an overpressure alarm in an autoclave. No UF6 was released and the autoclave has been tagged out for repairs. Ports later retracted the notification report for technical reasons. This autoclave was later determined to have a failed O-ring in the valving system.

Meetings:

8/8 Working Group covered plant activities, RAT training, and KI distribution/replacement.

8/8 After Action Meeting discussed several issues from the Davis Besse Exercise and assigned agency leads. About 12 items were resolved and removed from the active matrix.

8/15 Davis Besse groundwater briefing. There is a legacy plume of tritium in the surface layer from an old spill at the facility. This is being removed and monitored to benchmark the new monitoring well system.

8/6 8/20 8/27 SAIC

Office Issues:

No outstanding office issues.

NRC Reports and Statistics:

August operating power levels

Date	BV1	BV2	DB	Fermi	Perry	
1	100	100	100	100	100	Down to replace recirculation pump motor winding
6	100	100	100	100	100	
13	100	100	100	100	100	
20	100	100	100	100	100	
27	100	100	100	100	100	

31 100 100 100 100 100

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General Information or Other	Event Number: 43532
Rep Org: OHIO BUREAU OF RADIATION PROTECTION Licensee: VARIAN MEDICAL SYSTEMS Region: 1 City: CHARLOTTSVILLE State: VA County: License #: 45-30951-01 Agreement: N Docket: NRC Notified By: STEPHEN JAMES HQ OPS Officer: JASON KOZAL	Notification Date: 07/27/2007 Notification Time: 17:02 [ET] Event Date: 07/27/2007 Event Time: 14:15 [EDT] Last Update Date: 07/27/2007
Emergency Class: NON EMERGENCY 10 CFR Section: AGREEMENT STATE	Person (Organization): JOHN WHITE (R1) ERIC DUNCAN (R3) DENNIS RATHBUN (FSME)

Event Text

AGREEMENT STATE REPORT - FAILURE OF SOURCE TO RETRACT

The State provided the following information via email:

"ODH Bureau of Radiation Protection received a phone call from Varian Medical Systems at approximately 3:15 PM EDT regarding a situation which had occurred at a customer's location (St. Elizabeth Hospital in Youngstown, Ohio). The incident occurred at approximately 2:15 PM EDT. A Varian technician was performing maintenance on a Gamma Med Model 12i HDR unit, with the source extended into a shielded safe. During the maintenance action the technician disconnected a nylon tube that was part of the source wire travel path. This action caused the retract mechanism in the unit to energize, retracting the source wire from the safe, exposing approximately 8 inches of the source wire and the source end. The source is approximately 9.5 Curies of Iridium-192.

"Varian personnel believe that the disconnection of the nylon tube reduced the tension on the source wire, causing the park switch to no longer sense the presence of the wire, and energizing the retraction mechanism, which then pulled the source from the safe. The technician realized that something was not right when he heard the drive mechanism energize, and exited the treatment room immediately. Varian estimates the exposure to the technician as approximately 15 mrem, based on the activity of the source and time required to exit the room. The technician was not wearing his dosimetry at the time the incident occurred.

"Varian is sending an additional engineer to the customer location to assist with source recovery, with an estimated arrival time between 7:00 PM and 8:00 PM EDT. Varian has set-up a mock scenario at their office with the same model unit in the same configuration as what is present at the customer site. They have performed run throughs of source recovery, and have determined that the most effective method of retrieval will be to grasp the source wire with 18" forceps and then guide the source wire back into the shielded safe. They expect the evolution to take 5 - 8 seconds with an estimated whole body exposure of 25 mrem or less."

Ohio report # 2007-046

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Fuel Cycle Facility	Event Number: 43549
Facility: PORTSMOUTH GASEOUS DIFFUSION PLANT RX Type: URANIUM ENRICHMENT FACILITY Comments: 2 DEMOCRACY CENTER 6903 ROCKLEDGE DRIVE BETHESDA, MD 20817 (301)564-3200 Region: 2 City: PIKETON State: OH County: PIKE License #: GDP-2 Agreement: Y Docket: 0707002 NRC Notified By: RON CRABTREE HQ OPS Officer: PETE SNYDER	Notification Date: 08/05/2007 Notification Time: 09:33 [ET] Event Date: 08/04/2007 Event Time: 10:25 [EDT] Last Update Date: 08/05/2007
Emergency Class: NON EMERGENCY 10 CFR Section: OTHER UNSPEC REQMNT	Person (Organization): JAMES MOORMAN (R2) JACK DAVIS (FSME)

Event Text

X-342 FACILITY CONTAINMENT SHUTDOWN

"On Saturday August 4th 2007 at 1025 hours, Autoclave # 1 in the X-342 Facility experienced a Containment Shutdown due to the actuation of both 'A' and 'B' EXTREME PRESSURE AUTOCLAVE alarms. The autoclave was in (applicable) TSR MODE II 'Heating' for 55 minutes when these actuations occurred. After reviewing the other autoclave operating parameters and the results of the as-found pressure loop values, it is evident that there was no release of UF6 inside this autoclave. Operations and Engineering Personnel are continuing their investigation into the circumstances surrounding this event in an attempt to identify the cause of the alarm actuations. With no evidence to suggest these alarms were caused by an invalid signal, the Plant Shift Superintendent's (PSS) Office is reporting this event as a valid actuation of a 'Q' Safety System.

"The autoclave was placed in MODE VII 'Shutdown' and declared inoperable by the Plant Shift Superintendent (PSS). No release of radioactive material occurred as a result of the incident. This event is being reported in accordance with UE2-RA-RE1030 Appendix D. J. 2. Safety Equipment Actuations."

The licensee notified the Department of Energy and the NRC Resident Inspector.

* * * RETRACTION PROVIDED BY RON CRABTREE TO JEFF ROTTON AT 1232 EDT ON 08/14/07 * * *

" Following a comprehensive review of the circumstances surrounding this incident by the PORTS Nuclear Regulatory Affairs (NRA) Group, a recommendation was made to the PSS Office that this event be retracted. This recommendation was based upon the determination that the 'Q' Safety function of the 'A' and 'B' EXTREME PRESSURE AUTOCLAVE alarms is to actuate when the internal autoclave shell pressure rises above the operating steam pressure (thereby indicating a UF6 release within the autoclave and placing the autoclave in containment. Since there was no UF6 release and the autoclave internal pressure was only due to steam, there was no valid signal to the 'Q' Autoclave Shell High Pressure Containment Shutdown System. Per the reporting criteria stated in PORTS SAR section 6.9, Table 1, criteria J.2, this is not a reportable event due to the 'Q' system actuation being caused by an invalid signal. Based upon the information provided, the PORTS PSS Office is retracting this event."

The licensee notified the NRC Resident Inspector. The licensee will be notifying the Department of Energy.

Notified R2DO (Ogle) and FSME EO (Flannery).

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Power Reactor	Event Number: 43565
Facility: FERMI Region: 3 State: MI Unit: [2] [ ] [ ] RX Type: [2] GE-4 NRC Notified By: DAVID DUNCAN HQ OPS Officer: JOHN KNOKE	Notification Date: 08/14/2007 Notification Time: 13:22 [ET] Event Date: 08/14/2007 Event Time: 12:51 [EDT] Last Update Date: 08/14/2007
Emergency Class: NON EMERGENCY 10 CFR Section: 50.72(b)(3)(xiii) - LOSS COMM/ASMT/RESPONSE	Person (Organization): JAMNES CAMERON (R3)

Unit	SCRAM Code	RX CRIT	Initial PWR	Initial RX Mode	Current PWR	Current RX Mode
2	N	Y	100	Power Operation	100	Power Operation

Event Text

TECHNICAL SUPPORT CENTER UNAVAILABLE FOR EMERGENCY USE

"Fermi 2 removed the Technical Support Center (TSC) heating ventilation and air conditioning system from operation to facilitate preventive maintenance activities on August 14, 2007. During this work, the facility will not be available for emergency use. Fermi is making this notification in accordance with 10 CFR 50.72(b)(3)(xiii). In the event TSC activation is necessary, the EOF will be utilized. Activation and use of the EOF as a backup for the TSC is included in Fermi's Radiological Emergency Response Preparedness Plan, and drills have been held performing both the TSC and EOF functions from the EOF. Fermi will notify the NRC upon completion of this work, which is scheduled for Wednesday August 15, 2007."

The licensee will notify the NRC Resident Inspector.

* * * UPDATE PROVIDED BY JEFF GROFF TO JEFF ROTTON AT 2342 EDT ON 08/14/07 * * *

"Preventive Maintenance activities on the TSC HVAC system have been complete. The TSC is now available for use."

The licensee notified the NRC Resident Inspector. Notified R3DO (J. Cameron)

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Fuel Cycle Facility	Event Number: 43578
Facility: PORTSMOUTH GASEOUS DIFFUSION PLANT RX Type: URANIUM ENRICHMENT FACILITY Comments: 2 DEMOCRACY CENTER 6903 ROCKLEDGE DRIVE BETHESDA, MD 20817 (301)564-3200 Region: 2 City: PIKETON State: OH County: PIKE License #: GDP-2	Notification Date: 08/18/2007 Notification Time: 20:18 [ET] Event Date: 08/18/2007 Event Time: 02:10 [EDT] Last Update Date: 08/18/2007

Agreement: Y Docket: 0707002 NRC Notified By: JIM MCCLEERY HQ OPS Officer: MARK ABRAMOVITZ	
Emergency Class: NON EMERGENCY 10 CFR Section: OTHER UNSPEC REQMNT	Person (Organization): CHARLES R. OGLE (R2) JOSEPH HOLONICH (FSME)

Event Text

FEED FACILITY AUTOCLAVE O-RING FAILURE

"08-18-07 at 0210 in the X-342 , Feed Facility, Autoclave #1, 10 minutes into the heating cycle (mode II) experienced an air leak past the Viton O-ring. The steam was secured and autoclave shell opened 30 minutes later. Inspection of the Viton O-ring resulted in the discovery of a 3/8" separation of splice joint. A pressure decay was performed to determine if the O-ring would have performed its 'Q' function. The test failed resulting in a 24 hr. event."

This was reported under 10CFR76.120(c)(2)(i).

The licensee will notify the NRC Resident Inspector.

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Power Reactor	Event Number: 43588
Facility: BEAVER VALLEY Region: 1 State: PA Unit: [1] [ ] [ ] RX Type: [1] W-3-LP,[2] W-3-LP NRC Notified By: GREG LOOSE HQ OPS Officer: STEVE SANDIN	Notification Date: 08/23/2007 Notification Time: 15:42 [ET] Event Date: 08/22/2007 Event Time: 18:12 [EDT] Last Update Date: 08/23/2007
Emergency Class: NON EMERGENCY 10 CFR Section: 26.73 - FITNESS FOR DUTY	Person (Organization): JAMES DWYER (R1)

Unit	SCRAM Code	RX CRIT	Initial PWR	Initial RX Mode	Current PWR	Current RX Mode
1	N	Y	100	Power Operation	100	Power Operation

Event Text

FITNESS-FOR-DUTY REPORT INVOLVING A CONTRACT EMPLOYEE SUPERVISOR

A contract employee supervisor was determined unfit for duty based on site policy regarding alcohol use during a for cause fitness-for-duty test. The employee's unescorted access to the plant has been placed on administrative hold. Contact the Headquarters Operations Officer for additional details.

The licensee informed the NRC Resident Inspector.

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Power Reactor	Event Number: 43603
Facility: PERRY Region: 3 State: OH	Notification Date: 08/27/2007 Notification Time: 20:45 [ET]

Unit: [1] [ ] [ ] RX Type: [1] GE-6 NRC Notified By: AL RABENOLD HQ OPS Officer: MARK ABRAMOVITZ	Event Date: 08/27/2007 Event Time: 16:45 [EDT] Last Update Date: 08/27/2007
Emergency Class: NON EMERGENCY 10 CFR Section: 50.72(b)(3)(v)(D) - ACCIDENT MITIGATION 50.72(b)(3)(ii)(B) - UNANALYZED CONDITION	Person (Organization): CHRISTINE LIPA (R3)

Unit	SCRAM Code	RX CRIT	Initial PWR	Initial RX Mode	Current PWR	Current RX Mode
1	N	Y	100	Power Operation	100	Power Operation

Event Text

GRATING INSIDE CONTAINMENT FOUND UNSECURED

"At 1645 hours on 8/27/07 it was determined that a section of grating in the containment pool swell region was not properly restrained. During a postulated large break Loss of Coolant Accident, the grating could become dislodged and subsequently impact the ECCS suction strainer located in the suppression pool below the grating. An engineering review determined that the force of the impact could be larger than the impingement forces that had been previously evaluated. The forces were postulated to impact one of two concentric suction strainers. The resulting damage could cause either Residual Heat Removal B and C loops or High Pressure Core Spray (not both) to be inoperable. This condition was determined to meet the reporting requirements for 10 CFR 50.72(b)(3)(ii)(B), 'Any event or condition that results in: (B) The nuclear power plant being in an unanalyzed condition that significantly degrades plant safety.' Since one of the strainers was for High Pressure Core Spray, a single train safety system, this event was also determined to meet the reporting criteria for 10 CFR 50.72(b)(3)(v)(D), 'Any event or condition that at the time of discovery could have prevented the fulfillment of the safety function of systems needed to (D) mitigate the consequences of an accident.'

"Technical Specification 3.5.1, ECCS - Operating, was entered and Required Actions taken within the specified completion time. The grating was subsequently restored to design configuration and the Technical Specification LCO was exited."

"Time of restoring grating to design was 1838 8/27/07, exited Tech Spec 3.5.1. Location of grating is in the Containment Building on the 599' elevation near the lower air lock. The section is a 3 X 7 foot piece of grating that is located on the level just above the suppression pool. We still are investigating when the grating hold down plates were removed, potentially removed during our recent recirc motor replacement in July 07. The grating hold down plates were discovered by an Operations Roving Operator during his tour on rounds."

The licensee notified the NRC Resident Inspector.