

Vogtle 2

2Q/2004 Plant Inspection Findings

Initiating Events

Significance:  Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Unit Operating Procedure

A self-revealing NCV of Technical Specification (TS) 5.4.1.a was identified for failure to follow the Unit 2 operating procedure to disable the Auxiliary Feedwater (AFW) actuation signal prior to breaking condenser vacuum.

This finding is greater than minor because it affected the human performance attribute of the Initiating Events cornerstone and affected the cornerstone objective, in that, it caused an unplanned engineered safety features actuation. The finding is of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to a reactor trip with the loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flood. The direct cause of this finding involved the cross-cutting area of Human Performance.

Inspection Report# : [2004004\(pdf\)](#)

Significance:  Sep 27, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Provide a Suitable Reactor Vessel Vent Results in Inaccurate Reactor Vessel Level Indication

A self-revealing NCV was identified for failure to maintain a suitable reactor vessel vent path which resulted in inaccurate reactor vessel water level indication and lower than expected reactor vessel level.

This finding was greater than minor because it affected the initiating events cornerstone objective of configuration control of shutdown equipment. The finding determined to be of very low safety significance because all of the equipment, procedures, and policies that are expected to be maintained in the five shutdown safety functional areas were met.

Inspection Report# : [2003004\(pdf\)](#)

Mitigating Systems

Significance:  Jun 26, 2004

Identified By: NRC

Item Type: FIN Finding

Failure to Perform Timely and Appropriate Operability Evaluation of AFW Valve Degradation

A finding was identified by the inspectors for failure to perform a timely and appropriate operability assessment to address a common cause equipment degradation identified with the AFW discharge control valves.

The failure to perform a timely and appropriate operability evaluation for the common cause valve degradation is greater than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because, although the motor driven AFW discharge control valves with the missing cotter pins were considered degraded, the pilot plug assembly retaining nuts for all the valves were still held in place by the disrupted metal on the valve stem threads, therefore the immediate functional capability of the valves was not actually impacted. The direct cause of this finding involved the cross-cutting area of Problem Identification and Resolution.

Inspection Report# : [2004004\(pdf\)](#)

Significance:  Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate NSCW Operating Procedure

An violation of TS 5.4.1.a was identified by the inspectors for failure to maintain adequate Unit 1 and Unit 2 Nuclear Service Cooling Water (NSCW) system operating procedures.

This finding is greater than minor because it affected the Mitigating Systems cornerstone attribute of configuration control and affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences by rendering the automatic NSCW heat removal function inoperable. This finding is of very low safety significance because the duration did not exceed the 72 hour allowed outage time for one inoperable NSCW train and it did not represent an actual loss of service water safety function.

Inspection Report# : [2004004\(pdf\)](#)

Significance: TBD Jun 26, 2004

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Adequately Perform Containment Closeout Inspection

An apparent violation of TS 5.4.1.a was identified by the inspectors having potential safety significance greater than very low significance for failure to perform an adequate Unit 2 containment closeout inspection in accordance with approved procedures prior to entering Mode 4, Hot Shutdown.

This finding is greater than minor because it affected the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective, in that, the failure to perform an adequate containment closeout inspection resulted in debris left in containment that could have resulted in inadequate net positive suction head for both trains of the Residual Heat Removal system in the recirculation phase during a design basis loss of coolant accident. This finding will remain open pending completion of a final significance determination

Inspection Report# : [2004004\(pdf\)](#)

G

Significance: Dec 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Perform Containment Closeout Inspection Resulted in Possible Loss of Post-Accident Recirculation Function of the Residual Heat Removal System

An NRC-identified NCV of Technical Specification (TS) 5.4.1.a was identified for failure to perform an adequate Unit 1 containment closeout inspection in accordance with plant procedures.

This finding is greater than minor because it affected the equipment performance attribute of the Mitigating System Cornerstone, in that, the failure to perform an adequate closeout inspection resulted in debris left in containment that could have resulted in inadequate net positive suction head for the Residual Heat Removal (RHR) system in the recirculation phase during a design basis loss of coolant accident (LOCA). This would have affected the cornerstone objective of ensuring the availability, reliability and capability of systems (i.e. RHR in recirculation) that respond to initiating events (such as a design basis LOCA). The direct cause of this finding involved the cross-cutting area of Human Performance.

Inspection Report# : [2003005\(pdf\)](#)

G

Significance: Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Reactivate Part 55 Licenses in Accordance with Procedure

A non-cited violation was identified for the failure of multiple Part 55 licensees to reactivate Reactor Operator and Senior Reactor Operator licenses in accordance with procedure 10010-C, Operator Qualification Program, Revision (Rev) 2.

This finding is greater than minor because it is associated with human performance attributes of license reactivation that affect operational safety. The finding was evaluated using the Operator Requalification Human Performance SDP (IMC 0609 Appendix I) and determined of very low safety significance because more than 20 percent of the reactivation records reviewed failed to meet the requirements.

Inspection Report# : [2003004\(pdf\)](#)

G

Significance: Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Risk Assessment For Reduced Vessel Level Conditions

A NCV of 10 CFR 50.65(a)(4) was identified for failure to properly assess and manage the increase in risk of RCS level instrumentation unavailability during a Unit 2 RCS leak repair shutdown outage.

The failure to properly assess risk following changes to planned availability of RCS level instrumentation was greater than minor because it affected the configuration control attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events (such as a loss of RCS inventory in reduced level conditions). The finding was determined to be of very low safety significance because all of the equipment, procedures, and policies that are expected to be maintained in the five shutdown safety functional areas were met.

Inspection Report# : [2003004\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 26, 2004

Identified By: NRC

Item Type: FIN Finding

Failure to Implement Adequate Administrative Control Over Keys to Very High Radiation Areas

A finding was identified by the inspectors for inadequate control of keys to Very High Radiation Areas (VHRAs).

This finding is greater than minor because if left uncorrected the issue could become a more significant safety concern, in that, someone could gain unauthorized access to a VHRA. The finding is of very low safety significance because there was no overexposure, there was no evidence of unauthorized access into a VHRA, and the licensee's ability to assess dose was not compromised.

Inspection Report# : [2004004\(pdf\)](#)

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : September 08, 2004