

Vogtle 2

4Q/2004 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Correctly Implement a Surveillance Procedure

A self-revealing non-cited violation was identified for failure to correctly implement a surveillance procedure which resulted in an automatic reactor trip.

This finding is greater than minor because it affected the human performance attribute of the initiating events cornerstone which resulted in an unplanned reactor trip. The finding is of very low safety significance (Green) because it did not contribute to the likelihood that any mitigation equipment or functions would not be available. This finding also involved the cross-cutting aspect of Human Performance.

Inspection Report# : [2004006\(pdf\)](#)

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\(pdf\)](#)

Mitigating Systems

Significance:  Sep 25, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Effective Corrective Actions For Containment Closeout Inspections

A non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failing to implement effective corrective actions to ensure loose debris that could impact the post-accident recirculation function of the RHR system was removed from containment.

Since this condition had a potential safety significance greater than Green, a regional Senior Reactor Analyst performed a Phase III significance determination analysis to determine the actual safety significance. The Phase III analysis only considered the LOCAs (small, medium or large) that could dislodge un-jacketed steam generator insulation. This was due to the key assumption that both the loose debris and the steam generator insulation were necessary to lose the RHR recirculation safety function. Using the SDP Notebook under the Phase II evaluation for the three dominant accident sequences and after applying the appropriate adjustments to the accident sequences for the actual plant condition and exposure time, this finding was determined to be of very low safety significance (Green). The direct cause of this finding involved the cross-cutting area of Problem Identification and Resolution.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Aug 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Fire Protection Pre-fire Plan to Ensure Adequate Environmental Conditions for Operators to Access Required Equipment

A non-cited violation of Operating License Condition 2.G, was identified for an inadequate fire brigade fire fighting pre-plan. The pre-plan was inadequate in that it gave instructions for the fire brigade to vent smoke and hot gases into an area that the operators needed to access to perform local manual actions. Specifically, the fire fighting pre-plan (92773-2) for Fire Zone (FZ) 73 of the Control Building directed the fire brigade to vent smoke and hot gases out of the fire area (FZ 73) into room RB-33 (FZ 80). However, RB-33 is the only available route for an operator to enter room RB-29. The operator is required to enter room RB-29 during a fire in FZ 73 in order to perform local manual actions to prevent spurious opening of pressurizer power operated relief valve (PORV) PV-0455A. If the fire brigade had vented smoke and toxic gases into RB-33, it could have resulted in a failure to prevent spurious opening of PORV PV-0455A. Upon identification, the licensee revised the fire fighting pre-plan (92773-2) to vent the smoke into a stairwell rather than room RB-33.

This finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective, in that movement of smoke and hot toxic gases as directed could prohibit operator access to equipment that was supposed to remain unaffected by a particular fire. This finding was determined to be of very low safety significance because other fire protection features, such as passive fire barriers, automatic fire suppression, and safe shutdown capability from the main control room were still available.

Inspection Report# : [2004007\(pdf\)](#)

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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\(pdf\)](#)

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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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

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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

Significance: N/A Nov 19, 2004

Identified By: NRC
Item Type: FIN Finding

Biennial Problem Identification and Resolution Inspection Summary

The inspection team determined that the licensee was identifying plant deficiencies at an appropriate low level and entering them into the corrective action program. After reviewing condition reports, conducting system walkdowns, and examining equipment tracking databases, the team identified some minor deficiencies. During system walkdowns, the inspectors identified three minor conditions adverse to quality that had not been identified by the licensee. Also, inspectors identified several minor documentation discrepancies. Quality Assurance audits were effective at identifying issues at a very low level. The licensee adequately prioritized issues and evaluations were technically accurate and of sufficient depth. Formal root cause evaluations using widely accepted methods were adequate in determining the root and contributing causes of problems. Corrective actions to fix problems were appropriate and timely. Because the licensee had identified a number of problems related to human error which were not restricted to any one group, the licensee had implemented a site wide human performance improvement initiative. The inspectors did not identify any reluctance on the part of the employees to document safety concerns in the corrective action program.

Inspection Report# : [2004008\(pdf\)](#)

Last modified : March 09, 2005