

Vogtle 1

1Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Mar 31, 2005

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Properly Sequence Plant Activities Causes Unanticipated Reactor Coolant System Drain Path

A self-revealing non-cited violation (NCV) was identified for failure to properly sequence plant activities which resulted in an unanticipated Unit 1 reactor coolant system (RCS) drain path.

This finding is of greater than minor significance because it affected the configuration control attribute of the initiating events cornerstone and affected the cornerstone objective in that it created an unanticipated RCS drain path. 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. The residual heat removal system remained operable during the transient and a large volume of makeup water was available. This finding also involved the cross-cutting aspect of human performance, in that, the improper sequencing of activities created an unanticipated drain path.

Inspection Report# : [2005002\(pdf\)](#)**G****Significance:** Jun 26, 2004

Identified By: NRC

Item Type: FIN Finding

Inadequate Feedpump Turbine Control Valve Work Instruction

A self-revealing finding for inadequate feedpump turbine control valve work instructions was identified which resulted in the loss of feedwater flow control and a subsequent manual reactor trip.

This finding is greater than minor because it affected the procedure quality attribute of the Initiating Events cornerstone and affected the cornerstone objective by resulting in a reactor trip. The finding was determined to be of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, it did not contribute to a loss of mitigation equipment functions, and it did not increase the likelihood of a fire or internal/external flood.

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

Mitigating Systems

G**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\(pdf\)](#)**G****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

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 : June 17, 2005