

Vogle 1

1Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Human Performance Error Results in Unplanned Reactivity Addition

Green. A self-revealing non-cited violation of TS 5.4, Procedures, was identified when the licensed control room operator failed to perform step 4.3.5.10.b of procedure 3010- 1, Boron Thermal Regeneration System, Rev 57. Failure to properly perform this step resulted in approximately 500 gallons of unborated water being added to the VCT causing an inadvertent positive reactivity addition to the Unit 1 reactor.

The failure to place handswitch 1-HS-7054 in the CLOSED position as required by procedure is a performance deficiency. The minor screening criteria in IMC 0612, Power Reactor Inspection Reports, Appendix B, was not used due to the lack of clear guidance regarding inadvertent reactivity additions. Therefore, in consultation with the NRR program office, regional management determined this finding is more than minor because the licensed operator failed to properly implement procedure 13010-C which resulted an inadvertent positive reactivity addition causing reactor power to briefly increase above 100%. The finding, assessed using the Significance Determination Process, was determined to be of very low safety significance (Green) because the resulting transient did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. The inspectors determined this finding was related to the Work Practices component of the Human Performance cross-cutting area in that the licensed operator did not have the procedure in-hand during use as required by procedure 00054-C, Rules for Performing Procedures, Rev. 19. [H.4(b)] (Section 40A3)

Inspection Report# : [2008004](#) (*pdf*)

Mitigating Systems

Barrier Integrity

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedures Associated with Degraded Ability to Detect Boric Acid Leakage

A NRC-identified non-cited violation of 10 CFR 50, Appendix B, Criterion V, was identified for lack of procedures to address compensatory measures for containment conditions which would mask indications of boric acid leakage. A combination of condensation and leaking containment cooler coils produced a white, crystalline film in large portions of the lower levels of containment that would reduce the adequacy of visual inspections performed to detect boric acid leakage on susceptible components. The licensee entered the deficiency into their corrective action program for resolution.

This finding is more than minor because it affected the procedure quality attribute of the Barrier Integrity Cornerstone in that there were no additional measures taken to discriminate between boric acid leakage and the white residue present in containment which masked actual boric acid leakage. The finding is of very low safety significance because

no degradation discovered called into question the operability of an affected component.
Inspection Report# : [2008003](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Unauthorized Entries Into High Radiation Areas

Two examples of a self-revealing non-cited violation of Technical Specification 5.7.1, High Radiation Area, [were] identified for unauthorized entry into High Radiation Areas (HRAs). Inadequate communication between workers and Health Physics department resulted in licensee personnel breaching HRA boundaries without prior knowledge of the radiological conditions. The licensee had entered these issues into the corrective action program as Condition Reports 2007105476 and 2007108830.

This finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of Human Performance and adversely affects the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The finding was evaluated using the Occupational Radiation Safety Significance Determination Process and was determined to be of very low safety significance because it not related to As Low As Reasonably Achievable (ALARA) planning, did not involve an overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. This finding involved the cross-cutting aspect of Human Performance, Work Practices [H.4.a] because the HRA events were a direct result of poor communications during pre-job briefings and a willingness on the part of licensee personnel to proceed in the face of uncertainty.

Inspection Report# : [2008005](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Feb 27, 2009

Identified By: NRC

Item Type: FIN Finding

Vogtle PI&R Summary

The team concluded that, in general, problems were identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution, as evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner. However, the team identified examples of minor problems, including closing of a corrective action prior to completion and closing of a corrective action without clear documentation of what was performed.

The team determined that overall audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.

Inspection Report# : [2009006](#) (*pdf*)

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