

Vogtle 1

4Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Barrier Integrity

Significance:  Sep 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

MOV program procedures were inadequate with regard to periodicity of preventive maintenance activities for stem lubrication

A self-revealing NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified. Specifically, Vogtle Electric Generating Plant’s (VEGP) MOV preventative maintenance (PM) procedures lacked specific instructions that provided an adequate frequency for performing valve stem lubrication, which resulted in test failures of safety-related MOVs and affected the reliability of the MOVs’ safety functions. The licensee removed the hardened grease, re-lubricated and successfully tested the MOVs. They have entered the issue into their corrective action program and are in the process of revising existing maintenance procedures to change the PM frequency from 54 months to 36 months for long stem, safety-related MOV stem lubrication.

The finding was more than minor because if left uncorrected other safety related MOVs could be affected by the inadequate stem lubrication PM frequencies. The finding is associated with the configuration control attribute of the Barrier Integrity (BI) Cornerstone and affected the cornerstone objective of providing reasonable assurance that physical design barriers (e.g., containment) protect the public from radionuclide releases caused by accidents or events. Specifically, Containment Spray (CS) pump sump suction isolation MOVs experienced test failures and were declared inoperable, which required operability evaluations, thereby challenging their reliability and capability to perform their safety function. Using the Phase 1 worksheet in Attachment 4 of Manual Chapter 0609, “Significance Determination Process,” the finding affected the BI cornerstone and was of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment. Although the CS sump suction MOV’s condition affected the mitigating system cornerstone, the finding analysis was assigned to the BI cornerstone because it best reflected the dominant risk of the finding. This finding has a cross-cutting aspect in the area of PI&R, Corrective Action Program, because VEGP did not thoroughly evaluate problems such that the resolutions addressed the causes and extent of condition [P.1(c)]. Specifically, VEGP failed to thoroughly evaluate previous conditions of degraded and hardened grease on safety-related valves, such that the extent of the condition was considered and the cause was resolved.

Inspection Report# : [2009004](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

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*)

Last modified : March 01, 2010