

# Vogle 2

## 2Q/2012 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to follow procedures renders safety related battery chargers inoperable**

The inspectors identified a self-revealing NCV of Technical Specification (TS) 5.4.1, for two instances of failure to properly implement approved maintenance procedures and work order instructions. Specifically, maintenance electricians inadvertently removed the 2BD1CB safety related battery charger from service while attempting to perform a routine quarterly battery surveillance on the 2DD1CB battery charger. When the '2BD1CA/2BD1CB Trouble' alarm was received in the control room, the operators immediately contacted the electricians and the work was halted. Battery charger 2BD1CB was restored to service within 31 minutes. In the second instance, maintenance electricians inadvertently rendered both battery chargers for the 1CD1 safety-related battery inoperable during load-sharing adjustments on the 1CD1CB battery charger. The licensee restored the 1CD1CA battery charger to service within a few minutes. The licensee entered both of these issues into their corrective action program (CR 445343 & 457102 respectively).

The inspectors concluded that this finding was more than minor because it impacted the Reactor Safety Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and affected the cornerstone attribute of equipment performance. Specifically, the unintentional opening of the AC input breakers to the 2BD1CB, 1CD1CA and 1CD1CB battery chargers resulted in the chargers being declared inoperable for several minutes. The inspectors used the Phase 1 Initial Screening and Characterization of Findings (IMC 0609.04 Exhibit 1) to characterize the finding. Since the inspectors answered "No" to all of the Table 4a Mitigating Systems Cornerstone questions, the inspectors concluded that the finding was of very low safety significance (Green). The inspectors determined that the cause of this finding was related to the Work Practices component of the Human Performance cross-cutting area due to less than adequate procedure use and self/peer checking. [H.4(a)] (Section 1R22)

Inspection Report# : [2012003](#) (pdf)

**Significance:**  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Work Practice Error Renders Unit 2 TDADF Pump Inoperable**

Green: A self-revealing NCV of technical specification (TS) 5.4.1 was identified for failure to properly implement approved maintenance procedures. Specifically, maintenance technicians failed to properly re-land control wires, as required by procedure, on the Unit 2 turbine-driven auxiliary feedwater (TDAFW) pump following preventive maintenance activities. Once the loose wire connections inside junction box 2CWJB2729 were identified, the licensee immediately tightened the connections per procedure. The licensee entered this issue into their corrective action program (CR 404401 and CR 407192).

The finding was considered more than minor because it impacted the Reactor Safety Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent

undesirable consequences and affected the cornerstone attribute of equipment performance. Specifically, loose wires in the control circuit for the TDAFW pump prevented the trip and throttle valve from operating correctly and caused the TDAFW pump to be declared inoperable for several hours. The inspectors used the Phase 1 Initial Screening and Characterization of Findings (IMC 0609.04 Exhibit 1) to characterize the finding. Since the inspectors answered “No” to all of the Table 4a Mitigating Systems Cornerstone questions, the inspectors concluded that the finding was of very low safety significance (Green). The inspectors determined that the cause of this finding was related to the Work Practices component of the Human Performance cross-cutting area due to failure to follow procedures. [H.4(b)] (Section 1R22)

Inspection Report# : [2012002](#) (pdf)

**Significance:** G Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Human Performance Error Results in Inoperability of TDAFW Pump**

• Green: A Green self-revealing non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified. Specifically, the licensee inadvertently operated the Unit 2 turbine driven auxiliary feedwater (TDAFW) pump with the suction source isolated. As a result, the TDAFW pump operated with no suction source for a period of 1 minute 20 seconds and was rendered inoperable for a period of approximately 22 hours. The licensee immediately secured the pump when suction and discharge pressures became erratic and unstable. The licensee performed an engineering evaluation and assessment to ensure the pump was not damaged as a result of running the pump with the suction valves closed. The licensee entered this issue into their corrective action program (CAP) as CR 358773.

This issue was more than minor because it adversely affected an objective of the Mitigating Systems cornerstone. Specifically, the performance deficiency affected the availability, reliability, and capability of the Unit 2 TDAFW pump to provide secondary decay heat removal. The finding was determined to be Green because the event did not represent an actual loss of safety function of a single train for greater than its technical specification (TS) allowed outage time. The inspectors determined that the cause of this finding was related to the Work Practices component of the Human Performance cross-cutting area due to less-than-adequate human error prevention techniques [H.4(a)]. Specifically, procedural place keeping techniques were less than adequate.

Inspection Report# : [2011005](#) (pdf)

**Significance:** G Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to ensure Unit 1 and Unit 2 reactor coolant process variables can be maintained within those predicted for a loss of normal ac power for a large main control room fire.**

Green: A Green NRC identified NCV of Unit 1 Operating License Condition 2.G and Unit 2 Operating License Condition 2.G for failure to implement and maintain in effect all provisions of the approved Fire Protection Program (FPP) as described in the FSAR for the facility. Specifically, the licensee failed to ensure that, during post-fire safe shutdown, Unit 1 and Unit 2 reactor coolant process variables would be maintained within those predicted for a loss of normal ac power. The licensee entered this issue into their corrective action program (CAP) as Condition Report (CR) 2010112114.

The finding was determined to be more than minor because it was associated with the Reactor Safety Mitigating Systems cornerstone attribute of protection against external factors (i.e. fire) and it affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

The inspectors determined that this performance deficiency did not have a cross-cutting aspect because it did not represent current licensee performance.

Inspection Report# : [2011005](#) (pdf)

**G****Significance:** Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Installation of non-conforming safety-related breakers due to a failure to implement corrective action to prevent recurrence to address a significant condition adverse to quality**

An NRC-identified Green NCV of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, was identified for failure to develop and implement adequate corrective action to prevent recurrence (CAPR) in response to a significant condition adverse to quality (SCAQ) associated with E-MAX safety-related breaker front cover mounting screws. The licensee performed a field walk-down of all installed E-MAX breakers and identified a total of six breakers that had been inadvertently installed with the top right-hand front cover plate screw not removed. The licensee immediately removed the suspect screws and implemented corrective actions to address future E-MAX breaker installations. The licensee entered this issue into their corrective action program (CAP) as CR 332562.

The finding was considered more than minor because it impacted the Reactor Safety Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and affected the cornerstone attribute of equipment performance. Specifically, the inadequate corrective action allowed for the installation of non-conforming safety-related breakers that incurred unplanned unavailability to implement the associated temporary modification and also decreased reliability during the time the breaker was in-service without the temporary modification installed. The inspectors determined that the cause of this finding was related to the Corrective Action Program component of the Problem Identification and Resolution cross-cutting area due to the licensee's failure to take appropriate corrective actions to address safety issues in a timely manner, commensurate with their safety significance and complexity [P.1(d)]. (Section 4OA2.2)

Inspection Report# : [2011004](#) (*pdf*)

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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# Miscellaneous

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