

Vogtle 2

Initiating Events

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Significance: Jun 30, 2001

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to fully open a sliding link in accordance with TS surveillance procedure 14236-2, SGFPT A and SGFPT B Trip TADOT.

Unit 2 TS 5.4.1.a requires that written procedures be implemented covering the activities listed in Regulatory Guide 1.33, Rev. 2, Appendix A, February 1978. The failure to fully open a sliding link in accordance with TS surveillance procedure 14236-2, SGFPT A and SGFPT B Trip TADOT, on April 7, 2001, was a violation of TS 5.4.1.a. This failure resulted in a loss of main feedwater flow and subsequent manual reactor trip. This issue was placed in the licensee's corrective action program as CR 2001000694.

Inspection Report# : [2001003\(pdf\)](#)G

Significance: Dec 14, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

A Non-cited violation was identified for inadequate Procedural Guidance for Establishing Nuclear Service Cooling Water System (NSCW) Single Pump Operation.

A non-cited violation (NCV) of Technical Specification (TS) 5.4.1.a. was identified for an inadequate abnormal operating procedure (AOP). The procedural guidance contained in AOP 18021-C, Loss of Nuclear Service Cooling Water System (NSCW), directed the operators to use a system operating procedure that did not provide adequate guidance to establish NSCW single pump operation for the condition that was being addressed by AOP 18021-C. This finding had a credible impact on safety, in that, the inadequate guidance in AOP 18021-C could affect the ability of the operators to establish cooling to the reactor coolant pump (RCP) seals in a timely manner to reduce the likelihood of a RCP seal loss of coolant accident following a loss of both trains of the NSCW system. This finding was of very low safety significance based on the minimal risk increase associated with a non-proceduralized recovery action in the control room, given ample time to accomplish the task and sufficient indications and general training to know what to do, versus taking the same recovery action with the benefit of a procedure.

Inspection Report# : [2001008\(pdf\)](#)

Mitigating Systems

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Significance: May 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Prevent Recurrence of Chemical Residue Accumulation on EDG Overspeed Trip Valves

The inspectors identified that the licensee failed to implement adequate corrective actions in response to jacket water leakage and chemical residue accumulation which had previously resulted in the failure of both overspeed trip vent valves on the 1A Emergency Diesel Generator (EDG). This finding was also a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action. This finding was more than minor because a failure of the overspeed trip vent valves could result in engine damage during an overspeed condition. The finding was of very low safety significance because no loss of safety function of the EDG occurred.

Inspection Report# : [2001003\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety



Significance: Dec 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO SURVEY RADIOACTIVE MATERIAL AS REQUIRED BY 10 CFR 20.1501

10 CFR 20.1501 requires licensee's perform surveys that are reasonable under the circumstances to evaluate radiological hazards. The licensee failed to perform adequate surveys resulting in a package containing radioactive material being released offsite on November 9, 2000. This violation was entered in the licensee's corrective action program as CR 2000002181. The inspectors reviewed this licensee identified violation and determined the violation was of very low significance.

Inspection Report# : [2000005\(pdf\)](#)

Physical Protection



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

DISQUALIFYING BACKGROUND INFORMATION NOT PROCESSED PER LICENSEE PROCEDURES

A non-cited violation of licensee procedures as required by 10 CFR Part 73.55 was identified due to the licensee failing to promptly enter potentially disqualifying information into the Plant Access Data System (PADS) for an individual who had apparently failed to provide accurate criminal history information during employee screening. Also, telephone contact was not made with other utilities where the individual was actively badged, notifying them of the information. The licensee received the criminal history information on March 29, 1999. PADS was not updated until September 20, 2000. Using the Physical Protection Significance Determination Process, this finding was determined to be of very low significance due to the absence of a malevolent act. It was more than minor because the individual was able to access two other Nuclear Plants after the licensee had received the potentially disqualifying information from the criminal history check. This information is relied upon by other utilities participating in the PADS program and may have led to a decision by the other utilities to deny the worker unescorted access.

Inspection Report# : [2000006\(pdf\)](#)

Miscellaneous

Significance: N/A Jan 26, 2001

Identified By: NRC

Item Type: FIN Finding

ANNUAL BASELINE INSPECTION FOR PROBLEM IDENTIFICATION AND RESOLUTION

Overall, the licensee's Corrective Action Program (CAP) was effective at identifying, evaluating, and correcting problems. The threshold for entering problems into the CAP was low, resulting in a large number of Condition Reports (CRs). Problems entered into the CAP were adequately evaluated and appropriate actions were taken to resolve the problem. One exception was noted concerning the resolution of human performance errors associated with configuration control of components. Although the problem had been previously identified by the licensee as a management priority, the number of instances had remained elevated since the previous NRC team inspection of the CAP in March 2000. The problem was not captured in a single overall CAP trend CR. Therefore, a comprehensive analysis of the scope of the problem and a comprehensive corrective action plan was not developed. Although additional and appropriate corrective actions were taken by the licensee, they were not coordinated or tracked by the CAP. Some instances of incorrect classification, evaluation, and documentation of low-level CRs were noted. System engineers were found to use the CAP effectively to address equipment issues. Quality Assurance organization audits were effective in identifying issues but licensee self-assessments were inconsistent in scope and format. Self-assessment findings were not always entered into the CAP which was also noted on the previous NRC inspection of corrective action. A safety conscious work environment was found where employees felt free to raise safety issues in CRs or the employee concerns program.

Inspection Report# : [2001002\(pdf\)](#)

Last modified : March 26, 2002