Vogtle 1

Initiating Events

Significance: G Apr 20, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Loss of Main Feedwater Leads to Unplanned ESF Actuation and Manual Reactor Trip
Unit 1 Technical Specification (TS) 5.4.1.a requires that written procedures be implemented covering the activities listed in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978, which includes administrative procedures covering authorities and responsibilities for safe operation. Licensee Procedure 10000-C, Conduct of Operations, Revision 50, requires that for any abnormal conditions or indications, the shift operating crew take appropriate actions to stabilize the plant. The failure to take appropriate actions in response to lowering steam generator water levels was a failure to follow Procedure 10000-C. This violation of TS 5.4.1.a is being treated as a non-cited violation. The failure resulted in an unexpected reactor trip and a challenge to safety systems. This [violation] was placed in the licensee's corrective action program as CR 2002001458.
Inspection Report# : 2002002*(pdf)*

Significance: G Dec 14, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
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. [T]he licensee has included this [violation] in their corrective action program as Condition Report (CR) 2001002851[.]
Inspection Report# : 2001008*(pdf)*

Significance: G Dec 30, 2000
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
INADEQUATE TECHNICAL SPECIFICATION (TS) SURVEILLANCE PROCEDURE RESULTS IN REACTOR TRIP
Unit 1 TS 5.4.1.a requires that written procedures shall be established, implemented and maintained covering the activities listed in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. The failure to have an adequate TS surveillance procedure for conducting reactor protection system testing on December 9, 2000, was a violation of TS

5.4.1.a. This violation was entered in the licensee's corrective action program as CR 2000002309. The inspectors reviewed this licensee identified violation and determined the violation was of very low significance.
Inspection Report# : 2000005*(pdf)*

Mitigating Systems

Significance: G Jun 29, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Scaffold Construction Procedure - Two Examples
A Non-Cited Violation of Technical Specification 5.4.1.a was identified for plant personnel failing to follow safety related maintenance activity procedures associated with the construction of scaffold near/around safety-related equipment in containment and a Nuclear Service Cooling Water pump. The procedure violations resulted in numerous scaffold construction deviations that were not evaluated for adequacy by engineering to ensure that safety-related equipment would not be adversely impacted by the scaffold during a seismic event. This finding was of very low safety significance because the procedure deviations would most likely not have resulted in the actual collapse of the scaffold during a design basis seismic event. However, failure to follow scaffold construction procedures was identified as a widespread problem due to the multiple examples that were identified. [The violation has been entered into the licensee's corrective action program as CRs 2002001346, 2002001392, and 2002001697.] The direct cause of this finding involved the cross-cutting area of Human Performance (Sections 1R19 and 1R20).
Inspection Report# : 2002002*(pdf)*

Significance: G Jun 29, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Isolation of the Designated Boration Flow Path
Unit 1 Technical Specification (TS) 5.4.1.a requires that written procedures be implemented covering the activities listed in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978, which includes equipment control activities such as locking and tagging. Licensee Procedure 00304-C, Equipment Clearance and Tagging, Revision 45, Section 4.2.2.3.f, requires that clearances be evaluated for impact on component/system operability and configuration control. The failure to properly evaluate the impact of Clearance 10215123 resulted in the isolation of the designated boration flow path established by Procedure 14406-1, Boron Injection Flow Path Verification - Shutdown. This finding is of very low safety significance since core alterations and positive reactivity additions were not in progress and another boration flow path was available. This issue was placed in the licensee's corrective action program as CR 2002001251. (Green)
Inspection Report# : 2002002*(pdf)*

Significance: G Mar 07, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Improperly Wired Interlocks Affects ECCS Recirculation Valve
Unit 1 Technical Specification (TS) 3.5.2 requires that two trains of ECCS shall be available when in modes 1, 2 and 3. The licensee discovered that, due to valve wiring errors, a loss of A train power (single failure) would have prevented the establishment of High Pressure Recirculation from the control room from either train. This was a violation of TS

3.5.2 which was caused by human performance errors. This issue was placed in the licensee's corrective action program as CR's 2002000723 and 2002001223. Additional information on this issue can be found in Section 4OA3 of this report. (Green)
Inspection Report# : 2002002*(pdf)*

Significance: G Dec 29, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Follow Procedure was a Violation of Unit 1 Technical Specification 4.1.a.
NCV 50-424/01-06-01was issued for a licensee identified violation. Unit 1 Technical Specification (TS) 5.4.1.a requires that written procedures be implemented covering the activities listed in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Regulatory Guide 1.33, Appendix A includes equipment control activities such as equipment locking and tagging. The failure to correctly position breaker 1BA03-15 in the disconnect position as required by the clearance step was a failure to follow licensee Procedure 00304-C, Equipment Clearance and Tagging, and was a violation of TS 5.4.1. a. This failure rendered the adjacent breakers (1B Containment Spray pump and Component Cooling Water pump #6) inoperable for a period of approximately 17.5 hours. This issue was placed in the licensee's corrective action program as CR 2001001914.
Inspection Report# : 2001006*(pdf)*

Significance: G 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)*

Significance: G Dec 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO TEST SAFETY INJECTION VALVE WITH INSTRUCTIONS APPROPRIATE TO THE CIRCUMSTANCES RESULTS IN INOPERABILITY OF SAFETY INJECTION SYSTEM
10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality shall be prescribed by documented instructions or procedures of a type appropriate to the circumstances. On September 17, 2000, the licensee failed to perform testing of valve 1HV8802A with instructions appropriate to the circumstances, resulting in the failure to adequately control the system configuration and the inadvertent entry into TS 3.0.3 due to rendering both trains of SI inoperable. This violation was entered in the licensee's corrective action program as CR 2000001563. The inspectors reviewed this licensee identified violation and determined the violation was of very low significance.
Inspection Report# : 2000005*(pdf)*

Barrier Integrity

Significance: G Jun 29, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Ineffective Implementation of Containment Equipment Hatch Emergency Closure Administrative Controls
A Non-Cited Violation of Technical Specification 5.4.1.a was identified for plant personnel failing to follow safety related maintenance activity procedures associated with emergency closure of the containment equipment hatch during reactor vessel refueling. The procedure violations had the potential to affect the licensee's capability to promptly close the containment equipment hatch during a fuel handling accident. The finding was of very low safety significance because no fuel handling event actually occurred requiring implementation of the containment equipment hatch emergency closure procedure and the discrepancies identified would likely not have resulted in preventing the licensee's capability of closing the equipment hatch at the time the issue was identified. In addition, the licensee's analyses of a fuel handling accident without closure of the equipment hatch does not result in radiological exposures to the public or control room operators that exceed regulatory limits. [The violation has been entered into the licensee's corrective action program as CRs 2002001165, 2002001172, and 2002001322.] The direct cause of this finding involved the cross-cutting area of Human Performance (Section 1R20).
Inspection Report# : 2002002*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: G 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 significanceon.
Inspection Report# : 2000005*(pdf)*

Physical Protection

Significance: G 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 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 : August 29, 2002