

Vogtle 1

1Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Assemble CCW Valve 1HV11817 Results in CCW Transient

Green. The improper reassembly of a Component Cooling Water isolation valve resulted in the loss of CCW inventory when CCW relief valves lifted. A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified for maintenance personnel failure to follow valve reassembly procedures in March 2002. This finding is greater than minor because it affected the mitigating system cornerstone objective of equipment unavailability and reliability, in that, the lifting of system relief valves challenged the CCW system inventory. The finding is of very low safety significance because the CCW inventory loss was not in excess of the normal system makeup capability.

Inspection Report# : [2002004\(pdf\)](#)

Significance:  Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Correct EDG TS Surveillance Preconditioning Problem

Green. A Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failing to implement adequate corrective actions for unacceptable preconditioning of the Emergency Diesel Generators (EDGs) prior to Technical Specification surveillance testing. This preconditioning was identified by the NRC in May 2001 and again in July 2002. Licensee corrective actions were ineffective at preventing recurrence of this condition. This finding was of very low significance because no actual loss of EDG safety function or undetected EDG performance condition actually occurred. The direct cause of this finding involved the cross-cutting area of Problem Identification and Resolution (Section 1R22.1).

Inspection Report# : [2002003\(pdf\)](#)

Significance:  Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify and Correct Unit 1, Component Cooling Water Pump #2 Bearing Degradation Problem

Green. A Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failing to take prompt and effective corrective actions following degraded pump inboard oil bearing analysis results associated with Unit 1, Component Cooling Water (CCW) Pump #2. This finding was of concern because it rendered

the CCW pump inoperable, but of very low safety significance because no actual loss of CCW safety function occurred. The direct cause of this finding involved the cross-cutting area of Problem Identification and Resolution (Section 1R22.2).

Inspection Report# : [2002003\(pdf\)](#)

Significance:  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\(pdf\)](#)

Barrier Integrity

Significance:  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

Physical Protection

Significance: SL-IV Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Falsification of Security Access Control System Records

A Severity Level IV, non-cited violation of 10 CFR 50.9 was identified for the failure to maintain the results of a drug screening test and the associated entry in the licensee's Access Control System database complete and accurate in that the site Fitness-for-Duty Coordinator deliberately altered information indicating a specimen was negative for drugs when it was, in fact, positive for marijuana and amphetamines. Because this issue involved willfulness on the part of a licensee employee and inaccurate information which impacts the regulatory process, it was not subject to the provisions of the Reactor Oversight Process, and was dispositioned in accordance with traditional enforcement. The finding was determined to be greater than minor because a barrier was lost in the physical security system in that the failure to properly categorize and report a positive drug test result had the potential to allow unescorted plant access to an individual who did not meet access requirements.

Inspection Report# : [2002004\(pdf\)](#)

Miscellaneous

Significance: N/A Jan 03, 2003

Identified By: NRC

Item Type: FIN Finding

Biennial Problem Identification and Resolution Inspection

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. Recent events, including two reactor trips during low power feed water operations, and a dual unit shutdown due to secondary chemistry problems, were caused in part by human performance errors combined with weak supervisory oversight. The licensee is currently addressing these common root causes and developing corrective actions. Some instances of missed problem identification were noted. System engineers were found to use the CAP effectively to address equipment issues. Quality Assurance organization audits were effective in identifying issues. Self-assessments were appropriate and findings were entered into the CAP. A safety conscious work environment was found where employees felt free to raise safety issues in CRs or the employee concerns program.

Inspection Report# : [2002005\(pdf\)](#)

Last modified : May 30, 2003