

# Vogtle 1

## 4Q/2003 Plant Inspection Findings

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### Initiating Events

**Significance:**  Apr 05, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

#### **Failure to Follow Chemical Control Procedures Results in Excessive Steam Generator Sodium Concentrations and Dual Unit Forced Shutdowns**

Failure to follow chemistry control procedures resulted in the wrong corrosion control chemicals being added to the feedwater systems on both units and the unplanned forced shutdown of Unit 1 and Unit 2 to Mode 5, Cold Shutdown, due to high sodium concentrations in both units' feedwater systems.

A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified. This finding is greater than minor because it affected the initiating events cornerstone objective by causing a perturbation of plant secondary side chemistry resulting in the unplanned forced shutdown of both units. The finding is of very low safety significance because the consequence of the chemical addition error was limited to the unplanned forced shutdown of both units. The direct cause of this finding involved the cross-cutting area of Human Performance.

Inspection Report# : [2003002\(pdf\)](#)

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### Mitigating Systems

**Significance:**  Dec 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Adequately Perform Containment Closeout Inspection Resulted in Possible Loss of Post-Accident Recirculation Function of the Residual Heat Removal System**

An NRC-identified NCV of Technical Specification (TS) 5.4.1.a was identified for failure to perform an adequate Unit 1 containment closeout inspection in accordance with plant procedures.

This finding is greater than minor because it affected the equipment performance attribute of the Mitigating System Cornerstone, in that, the failure to perform an adequate closeout inspection resulted in debris left in containment that could have resulted in inadequate net positive suction head for the Residual Heat Removal (RHR) system in the recirculation phase during a design basis loss of coolant accident (LOCA). This would have affected the cornerstone objective of ensuring the availability, reliability and capability of systems (i.e. RHR in recirculation) that respond to initiating events (such as a design basis LOCA). The direct cause of this finding involved the cross-cutting area of Human Performance.

Inspection Report# : [2003005\(pdf\)](#)



**Significance:** Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Reactivate Part 55 Licenses in Accordance with Procedure**

A non-cited violation was identified for the failure of multiple Part 55 licensees to reactivate Reactor Operator and Senior Reactor Operator licenses in accordance with procedure 10010-C, Operator Qualification Program, Revision (Rev) 2.

This finding is greater than minor because it is associated with human performance attributes of license reactivation that affect operational safety. The finding was evaluated using the Operator Requalification Human Performance SDP (IMC 0609 Appendix I) and determined of very low safety significance because more than 20 percent of the reactivation records reviewed failed to meet the requirements.

Inspection Report# : [2003004\(pdf\)](#)

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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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## **Physical Protection**

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## **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 : March 02, 2004