Vogtle 1
3Q/2004 Plant Inspection Findings

Initiating Events

Significance: G Jun 26, 2004
Identified By: NRC
Item Type: FIN Finding
Inadequate Feedpump Turbine Control Valve Work Instruction
A self-revealing finding for inadequate feedpump turbine control valve work instructions was identified which resulted in the loss of feedwater flow control and a subsequent manual reactor trip.

This finding is greater than minor because it affected the procedure quality attribute of the Initiating Events cornerstone and affected the cornerstone objective by resulting in a reactor trip. The finding was determined to be of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, it did not contribute to a loss of mitigation equipment functions, and it did not increase the likelihood of a fire or internal/external flood.
Inspection Report# : 2004004*(pdf)*

Mitigating Systems

Significance: G Jun 26, 2004
Identified By: NRC
Item Type: FIN Finding
Failure to Perform Timely and Appropriate Operability Evaluation of AFW Valve Degradation
A finding was identified by the inspectors for failure to perform a timely and appropriate operability assessment to address a common cause equipment degradation identified with the AFW discharge control valves.

The failure to perform a timely and appropriate operability evaluation for the common cause valve degradation is greater than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because, although the motor driven AFW discharge control valves with the missing cotter pins were considered degraded, the pilot plug assembly retaining nuts for all the valves were still held in place by the disrupted metal on the valve stem threads, therefore the immediate functional capability of the valves was not actually impacted. The direct cause of this finding involved the cross-cutting area of Problem Identification and Resolution.
Inspection Report# : 2004004*(pdf)*

Significance: G Jun 26, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate NSCW Operating Procedure
An violation of TS 5.4.1.a was identified by the inspectors for failure to maintain adequate Unit 1 and Unit 2 Nuclear Service Cooling Water (NSCW) system operating procedures.

This finding is greater than minor because it affected the Mitigating Systems cornerstone attribute of configuration control and affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences by rendering the automatic NSCW heat removal function inoperable. This finding is of very low safety significance because the duration did not exceed the 72 hour allowed outage time for one inoperable NSCW train and it did not represent an actual loss of service water safety function.
Inspection Report# : 2004004*(pdf)*

Significance: G 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)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: G Jun 26, 2004
Identified By: NRC
Item Type: FIN Finding
Failure to Implement Adequate Administrative Control Over Keys to Very High Radiation Areas
A finding was identified by the inspectors for inadequate control of keys to Very High Radiation Areas (VHRAs).

This finding is greater than minor because if left uncorrected the issue could become a more significant safety concern, in that, someone could gain unauthorized access to a VHRA. The finding is of very low safety significance because there was no overexposure, there was no evidence of unauthorized access into a VHRA, and the licensee's ability to assess dose was not compromised.
Inspection Report# : 2004004*(pdf)*

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

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