

## Vogtle 2

# 3Q/2004 Plant Inspection Findings

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## Initiating Events

**G****Significance:** Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Follow Unit Operating Procedure**

A self-revealing NCV of Technical Specification (TS) 5.4.1.a was identified for failure to follow the Unit 2 operating procedure to disable the Auxiliary Feedwater (AFW) actuation signal prior to breaking condenser vacuum.

This finding is greater than minor because it affected the human performance attribute of the Initiating Events cornerstone and affected the cornerstone objective, in that, it caused an unplanned engineered safety features actuation. The finding is of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to a reactor trip with the loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flood. The direct cause of this finding involved the cross-cutting area of Human Performance.

Inspection Report# : [2004004\(pdf\)](#)

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## Mitigating Systems

**G****Significance:** Sep 25, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Implement Effective Corrective Actions For Containment Closeout Inspections**

A non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failing to implement effective corrective actions to ensure loose debris that could impact the post-accident recirculation function of the RHR system was removed from containment.

Since this condition had a potential safety significance greater than Green, a regional Senior Reactor Analyst performed a Phase III significance determination analysis to determine the actual safety significance. The Phase III analysis only considered the LOCAs (small, medium or large) that could dislodge un-jacketed steam generator insulation. This was due to the key assumption that both the loose debris and the steam generator insulation were necessary to lose the RHR recirculation safety function. Using the SDP Notebook under the Phase II evaluation for the three dominant accident sequences and after applying the appropriate adjustments to the accident sequences for the actual plant condition and exposure time, this finding was determined to be of very low safety significance (Green). The direct cause of this finding involved the cross-cutting area of Problem Identification and Resolution.

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Aug 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Fire Protection Pre-fire Plan to Ensure Adequate Environmental Conditions for Operators to Access Required Equipment**

A non-cited violation of Operating License Condition 2.G, was identified for an inadequate fire brigade fire fighting pre-plan. The pre-plan was inadequate in that it gave instructions for the fire brigade to vent smoke and hot gases into an area that the operators needed to access to perform local manual actions. Specifically, the fire fighting pre-plan (92773-2) for Fire Zone (FZ) 73 of the Control Building directed the fire brigade to vent smoke and hot gases out of the fire area (FZ 73) into room RB-33 (FZ 80). However, RB-33 is the only available route for an operator to enter room RB-29. The operator is required to enter room RB-29 during a fire in FZ 73 in order to perform local manual actions to prevent spurious opening of pressurizer power operated relief valve (PORV) PV-0455A. If the fire brigade had vented smoke and toxic gases into RB-33, it could have resulted in a failure to prevent spurious opening of PORV PV-0455A. Upon identification, the licensee revised the fire fighting pre-plan (92773-2) to vent the smoke into a stairwell rather than room RB-33.

This finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective, in that movement of smoke and hot toxic gases as directed could prohibit operator access to equipment that was supposed to remain unaffected by a particular fire. This finding was determined to be of very low safety significance because other fire protection features, such as passive fire barriers, automatic fire suppression, and safe shutdown capability from the main

control room were still available.  
Inspection Report# : [2004007\(pdf\)](#)

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**Significance:** 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\(pdf\)](#)

**G**

**Significance:** 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\(pdf\)](#)

**G**

**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\(pdf\)](#)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## Occupational Radiation Safety

**Significance:**  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\(pdf\)](#)

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## Public Radiation Safety

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## Physical Protection

[Physical Protection](#) information not publicly available.

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## Miscellaneous

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