

Vogtle 2

2Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Correctly Implement a Surveillance Procedure

A self-revealing non-cited violation was identified for failure to correctly implement a surveillance procedure which resulted in an automatic reactor trip.

This finding is greater than minor because it affected the human performance attribute of the initiating events cornerstone which resulted in an unplanned reactor trip. The finding is of very low safety significance (Green) because it did not contribute to the likelihood that any mitigation equipment or functions would not be available. This finding also involved the cross-cutting aspect of Human Performance.

Inspection Report# : [2004006\(pdf\)](#)

Mitigating Systems

G**Significance:** Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Adequate Corrective Actions to Preclude Repetitive Failure of Unit 2 Channel 2 OTDT Instrument

An NRC-identified non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, was identified for the failure to preclude repetition of a significant condition adverse to quality concerning the failure of the Unit 2 reactor protection system channel 2 over-temperature delta-temperature instrument.

This finding is of more than minor significance because it affected the mitigating systems cornerstone attribute of equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events. This violation is of very low safety significance because the event did not involve a reduction in the defense-in-depth for reactor protection loop over-temperature delta-temperature setpoint channels. This finding also involved the cross-cutting aspect of problem identification and resolution in that the licensee failed to properly identify or address these issues in the corrective action system.

Inspection Report# : [2005003\(pdf\)](#)**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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Significance: N/A Nov 19, 2004

Identified By: NRC

Item Type: FIN Finding

Biennial Problem Identification and Resolution Inspection Summary

The inspection team determined that the licensee was identifying plant deficiencies at an appropriate low level and entering them into the corrective action program. After reviewing condition reports, conducting system walkdowns, and examining equipment tracking databases, the team identified some minor deficiencies. During system walkdowns, the inspectors identified three minor conditions adverse to quality that had not been identified by the licensee. Also, inspectors identified several minor documentation discrepancies. Quality Assurance audits were effective at identifying issues at a very low level. The licensee adequately prioritized issues and evaluations were technically accurate and of sufficient depth. Formal root cause evaluations using widely accepted methods were adequate in determining the root and contributing causes of problems. Corrective actions to fix problems were appropriate and timely. Because the licensee had identified a number of problems related to human error which were not restricted to any one group, the licensee had implemented a site wide human performance improvement initiative. The inspectors did not identify any reluctance on the part of the employees to document safety concerns in the corrective action program.

Inspection Report# : [2004008\(pdf\)](#)

Last modified : August 24, 2005