Vogtle 2
3Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2004
Identified By: Self-Revealing
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 it 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

Significance: G 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)*

Barrier Integrity

Emergency Preparedness

Significance: G Sep 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Adequate Respiratory Protection Equipment for Emergency Response
An NRC-identified non-cited violation of 10 CFR 50.47(b)(10) was identified for the failure to provide adequate respiratory protection equipment for emergency response, compromising the protective actions developed for the plume exposure pathway for emergency workers.

This finding is greater than minor because it is associated with the Emergency Preparedness cornerstone attribute of Response Organization Performance and adversely affects the cornerstone objective of ensuring the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Failure to provide appropriate respiratory protective equipment for a required worker could result in the individual being unable to perform his emergency response function. The finding was evaluated using the

Emergency Preparedness Significance Determination Process, Sheet 1. The finding was a failure to comply that was a planning standard problem, was not a risk-significant planning standard problem, and did not involve a planning standard function failure. For these reasons, the inspectors concluded that the issue is of very low safety significance.
Inspection Report# : 2005004*(pdf)*

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)*

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