

Vogtle 2

3Q/2006 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2006

Identified By: Self-Revealing

Item Type: FIN Finding

Poor Workmanship and Inadequate Work Instructions for Maintenance on Reactor Coolant Pump Resulted in a Reactor Trip Due

A self-revealing finding was identified for inadequate work instructions and poor work practices associated with the installation of a surge arrestor design change on the Unit 2 loop 4 reactor coolant pump (RCP). This condition resulted in short circuiting in the surge arrestor cable which resulted in a trip of the loop 4 RCP and subsequent reactor trip.

The inspectors determined that the cause of this finding was related to the work practices aspect of the human performance cross-cutting area because the work instructions did not contain adequate detail to properly install the surge arrestor cable. This finding is greater than minor because it affected the human performance and procedure quality attributes of the Initiating Event Cornerstone in that the installed loop 4 surge arrestor cable was incorrect in type and size and was incorrectly installed. The finding was determined to be of very low safety significance (Green) because it did not increase the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2006004\(pdf\)](#)

Mitigating Systems

Significance:  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify Instruments with Environmental Qualification Deficiencies

The inspectors identified an NCV of 10CFR50, Appendix B, Criterion XVI, for a failure to promptly identify and correct a condition adverse to quality. During an environmental qualification (EQ) self-assessment in June, 2005, the licensee discovered that two Rosemount differential pressure transmitters with potentially damaged environmental seals between the electronics and the pressure sensing sections of the instrument. This violation has been entered in the licensee corrective action program as CR 2006109187

The finding is of more than minor significance because it affects the equipment availability and reliability attribute of the Mitigating Systems cornerstone objective in that the damaged seals reduced the reliability of safety-related systems. The NRC Region II Senior Reactor Analyst (SRA) determined that the Phase 2 significance evaluation process does not properly address this finding. Therefore, a Phase 3 significance determination evaluation was performed. The dominant accident sequence involved a Medium Break Loss of Coolant Accident followed by the failure of three channels of the Engineered Safety Features Actuation System, one due to a failed EQ seal and the other two via random failure. The Phase 3 results were that the finding was of very low safety significance (Green) since only one pressurizer pressure transmitter was affected.

Inspection Report# : [2006004\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Significance: **W** Aug 31, 2006

Identified By: NRC

Item Type: VIO Violation

White Finding Involving Failure to Identify A Weakness During an Emergency Exercise Critique Associated with an RSPS.

The NRC identified a Violation for failure of the licensee's exercise critique process to properly identify a weakness associated with a risk-significant planning standard (RSPS) that was determined to be a Drill/Exercise Performance (DEP) Performance Indicator (PI) opportunity failure during a full-scale exercise. The AV is associated with emergency preparedness planning standards 10 CFR 50.47(b)(14) and 10 CFR 50.47(b)(4) and the requirements of Section IV.F.2.g of Appendix E to 10 CFR Part 50. This finding was not entered into the licensee's corrective action program.

The failure of the licensee's exercise critique process was a performance deficiency. This finding was greater than minor because it was associated with the Emergency Preparedness Cornerstone and affected the cornerstone objective to ensure that the licensee was capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The finding was an identified weakness that demonstrated a level of performance that could preclude effective implementation of the Emergency Plan in an actual emergency. This finding was also determined to potentially have greater significance because the licensee's exercise critique process failed to properly identify a weakness associated with an RSPS that was determined to be a DEP PI opportunity failure during a full-scale exercise.

Inspection Report# : [2006011\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : December 21, 2006