

# Vogle 2

## 1Q/2007 Plant Inspection Findings

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### 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*)

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### 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*)

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### Barrier Integrity

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## 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*)

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## Occupational Radiation Safety

**Significance:** **G** Dec 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to use only NIOSH certified respiratory protection equipment.**

The inspectors identified a non-cited violation of 10 CFR Part 20.1703(a) for the use of respiratory protection equipment that had not been certified as safe by the National Institute for Occupational Safety and Health (NIOSH). The licensee discontinued use of the respiratory protection equipment and the issue was entered into the corrective action program under condition report (CR) number 2006111584.

The finding is more than minor because it is associated with the Occupational Radiation Safety cornerstone attribute of Equipment and Instrumentation and adversely affects the cornerstone objective of protecting worker health and safety from exposure to radiation. When using non-NIOSH approved respirators to limit intake of radioactive material, the potential exists to put workers in a situation that may be more hazardous than the radiological danger that the respirator is meant to protect against (e.g. loss of air flow). The finding was determined to be of very low safety significance because it was not an As Low As Reasonably Achievable (ALARA) planning issue, there was no overexposure nor potential for overexposure, and the licensee's ability to assess dose was not compromised.

Inspection Report# : [2006005](#) (*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

**Significance:** N/A Feb 16, 2007

Identified By: NRC

Item Type: FIN Finding

### **Identification and Resolution of Problems Inspection Summary**

No findings of significance were identified. The licensee was generally effective in identifying problems at a low threshold and entering them into the corrective action program. The licensee properly prioritized issues entered into the corrective action program (CAP) and routinely performed evaluations that were technically accurate and of sufficient depth to address the issue documented in the condition reports (CRs). Station management has recently been providing increased focus and attention on the quality of root cause and apparent cause determinations based on the results of any internal self assessments. Improvements were noted in the documents produced over the past quarter. Operating experience was found to be used both proactively and reactively by personnel involved in the corrective action program. The licensee's programmatic self-assessments and audits were generally effective in identifying weaknesses in the corrective action program. Weaknesses in the performance of required effectiveness reviews by the department(s) responsible for specific CRs were identified by the inspectors which have the potential to allow similar events to occur at the station by not ensuring corrective action deficiencies are identified and corrected. The inspectors concluded that the workers at Vogtle felt free to report safety concerns.

Inspection Report# : [2007009](#) (*pdf*)

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