

# Vogle1

## 4Q/2007 Plant Inspection Findings

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### Initiating Events

**Significance:**  Mar 31, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

#### **Inadequate Work Instructions for Maintenance Resulted in the Failure of Unit 1 Loop 2 Main Feedwater Regulating Valve**

A self-revealing finding was identified for poor work practices associated with the installation of the loop 2 main feedwater regulating valve (MFRV) electro-pneumatic transducer. The transducer was mounted in a manner that did not prevent water ingress and allow drainage. During washdown activities in the vicinity of the MFRV water entered the transducer causing the loop 2 MFRV to close. When the MFRV could not re-opened from the control room, operators manually tripped the reactor.

This finding is more than minor because it affected the procedure quality attribute of the Initiating Events cornerstone in that inadequate installation instructions caused transducer failure which resulted in a manual reactor trip. 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. This finding is directly related to the complete and accurate procedures aspect of the Human Performance cross-cutting area because the procedure did not incorporate the vendor's recommendations.

Inspection Report# : [2007002](#) (*pdf*)

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### Mitigating Systems

**Significance:**  Jun 04, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Safety-Related 480 VAC Molded Case Circuit Breakers On MCC 1ABF, 1BBF, 2ABF, and 2BBF Not Tested**

The inspectors identified a violation of 10 CFR 50, Appendix B, Criterion XI, Test Control, for failure to implement a test program to assure that all installed safety related molded case circuit breakers (MCCBs) will perform satisfactorily in service. Under postulated electrical fault conditions, failure of one of these circuit breakers to operate properly would lead to either a loss of power to safety-related components or lead to a potential for compromising other equipment on a single fault that the MCCB was designed to isolate. The 1A, 1B, 2A, and 2B motor driven auxiliary feedwater pump (MDAFWP) recirculation valve motor operators and the MDAFWP room cooler fans for both trains at both units receive their power through MCCBs.

This finding is more than minor because it is associated with the Mitigating Systems Cornerstone attribute of Procedure Quality. It impacts the cornerstone objective of ensuring the availability, reliability, and operability of the MDAFW pumps to perform their intended safety function during a design basis event. The inspectors assessed the finding using the SDP and determined the finding was of very low safety significance (Green) because the inspectors found no documented history of in-service failures of MCCBs rendering safety-related equipment inoperative. This issue is documented in the corrective action program as condition report (CR) 2007105855.

Inspection Report# : [2007006](#) (*pdf*)

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**Significance:**  Jun 04, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

## Maximum Differential Pressure for Containment Emergency Sump Isolation Valves Not Calculated

The inspectors identified a violation of 10 CFR 50, Appendix B, Criterion III, Design Control, for failure to evaluate the impact of an increase of the residual heat removal (RHR) system pressure during the RHR pump operation in a minimum flow alignment in determining the maximum dP across the containment emergency sump isolation valves 1/2-HV-8811A/B, which could have challenged the capability of these motor operated valves (MOVs) to open following a small break loss of coolant accident (SBLOCA). Maximum system pressure would occur following a SBLOCA.

This finding is more than minor because it is associated with the Mitigating Systems Cornerstone attribute of Design Control. It impacts the cornerstone objective of ensuring the availability, reliability, and operability of the containment emergency sump isolation valves to perform their safety function during a SBLOCA event. The calculation deficiencies represented reasonable doubt regarding the operability of MOVs 1/2-HV-8811A/B pending the outcome of additional calculations initiated after the inspectors questioned the condition. The lack of an accurately calculated maximum dP across these MOVs created the possibility for repairs or modifications to be performed while using an incorrect dP value as a design input. The inspectors assessed the finding using the SDP and determined the finding was of very low safety significance (Green) because there was not a loss of safety system function based upon the inspector's verification of the SNC analysis that the containment emergency sump isolation valves 1/2-HV-8811A/B were currently operable. This issue is documented in the corrective action program as CR 2007100247 and CR 2007105848.

Inspection Report# : [2007006](#) (*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

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# Public Radiation Safety

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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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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