

Vogtle 2

3Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Human performance error renders 2BEDG inoperable

A self-revealing non-cited violation (NCV) was identified for a human performance error associated with inadvertently racking out the 2B emergency diesel generator (EDG) output breaker. The system operator racked out the incorrect breaker while performing lockout 2-DT-09-1217-00289 on the Auxiliary Component Cooling Water (ACCW) system. As a result, the 2B EDG was temporarily rendered inoperable. Licensee immediately restored the 2B EDG to operable status by returning the output breaker to the 'connect' position. The licensee entered the issue into their corrective action program.

This issue is more than minor because it is associated with a cornerstone attribute and adversely affected the objective of the Mitigating Systems cornerstone. Specifically, the performance deficiency is a human performance error which affected the availability, reliability, and capability of the B train emergency core cooling system to respond to a loss of coolant accident during a loss of off-site power. The finding was determined to be of very low safety significance (Green) because the event did not represent an actual loss of safety function of a single train for greater than its Technical Specification (TS) allowed outage time. The inspectors determined that the cause of this finding was related to the Work Practices component of the Human Performance cross-cutting area due to less-than-adequate human error prevention techniques [H.4(a)]. Specifically, peer checking techniques were less than adequate.

Inspection Report# : [2009004](#) (*pdf*)

Significance:  Sep 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Human performance error renders NSCW pump #5 inoperable

A self-revealing non-cited violation (NCV) was identified for a human performance error associated with failure of an operator to verify that the discharge valve on the Nuclear Service Cooling Water (NSCW) pump #5 went closed after securing the pump as required by the operating procedure. As a result, NSCW pump #5 was rendered inoperable for several hours. Licensee immediately effected repairs to the discharge valve MOV and returned the NSCW pump #5 to operable status.

This issue is more than minor because it is associated with a cornerstone attribute and adversely affected the objective of the Mitigating Systems cornerstone. Specifically, the performance deficiency is a human performance error which affected the availability, reliability, and capability of the A train emergency core cooling system to respond to a loss of coolant accident. The finding was determined to be of very low safety significance (Green) because the event did not represent an actual loss of safety function of a single train for greater than its TS allowed outage time. The inspectors determined that the cause of this finding was related to the Work Practices component of the Human Performance cross-cutting area due to less-than-adequate human error prevention techniques [H.4(a)]. Specifically, self checking techniques were less than adequate.

Inspection Report# : [2009004](#) (*pdf*)

Barrier Integrity

Significance:  Sep 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

MOV program procedures were inadequate with regard to periodicity of preventive maintenance activities for stem lubrication

A self-revealing NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified. Specifically, Vogtle Electric Generating Plant’s (VEGP) MOV preventative maintenance (PM) procedures lacked specific instructions that provided an adequate frequency for performing valve stem lubrication, which resulted in test failures of safety-related MOVs and affected the reliability of the MOVs’ safety functions. The licensee removed the hardened grease, re-lubricated and successfully tested the MOVs. They have entered the issue into their corrective action program and are in the process of revising existing maintenance procedures to change the PM frequency from 54 months to 36 months for long stem, safety-related MOV stem lubrication.

The finding was more than minor because if left uncorrected other safety related MOVs could be affected by the inadequate stem lubrication PM frequencies. The finding is associated with the configuration control attribute of the Barrier Integrity (BI) Cornerstone and affected the cornerstone objective of providing reasonable assurance that physical design barriers (e.g., containment) protect the public from radionuclide releases caused by accidents or events. Specifically, Containment Spray (CS) pump sump suction isolation MOVs experienced test failures and were declared inoperable, which required operability evaluations, thereby challenging their reliability and capability to perform their safety function. Using the Phase 1 worksheet in Attachment 4 of Manual Chapter 0609, “Significance Determination Process,” the finding affected the BI cornerstone and was of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment. Although the CS sump suction MOV’s condition affected the mitigating system cornerstone, the finding analysis was assigned to the BI cornerstone because it best reflected the dominant risk of the finding. This finding has a cross-cutting aspect in the area of PI&R, Corrective Action Program, because VEGP did not thoroughly evaluate problems such that the resolutions addressed the causes and extent of condition [P.1(c)]. Specifically, VEGP failed to thoroughly evaluate previous conditions of degraded and hardened grease on safety-related valves, such that the extent of the condition was considered and the cause was resolved.

Inspection Report# : [2009004](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Unauthorized Entries Into High Radiation Areas

Two examples of a self-revealing non-cited violation of Technical Specification 5.7.1, High Radiation Area, [were] identified for unauthorized entry into High Radiation Areas (HRAs). Inadequate communication between workers and Health Physics department resulted in licensee personnel breaching HRA boundaries without prior knowledge of the radiological conditions. The licensee had entered these issues into the corrective action program as Condition Reports 2007105476 and 2007108830.

This finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone

attribute of Human Performance and adversely affects the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The finding was evaluated using the Occupational Radiation Safety Significance Determination Process and was determined to be of very low safety significance because it not related to As Low As Reasonably Achievable (ALARA) planning, did not involve an overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. This finding involved the cross-cutting aspect of Human Performance, Work Practices [H.4.a] because the HRA events were a direct result of poor communications during pre-job briefings and a willingness on the part of licensee personnel to proceed in the face of uncertainty.
Inspection Report# : [2008005](#) (*pdf*)

Public Radiation Safety

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.

Miscellaneous

Significance: N/A Feb 27, 2009

Identified By: NRC

Item Type: FIN Finding

Vogtle PI&R Summary

The team concluded that, in general, problems were identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution, as evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner. However, the team identified examples of minor problems, including closing of a corrective action prior to completion and closing of a corrective action without clear documentation of what was performed.

The team determined that overall audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.

Inspection Report# : [2009006](#) (*pdf*)

Last modified : December 10, 2009