

## Vogtle 1

### 3Q/2012 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:** G Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **Ineffective corrective action renders Unit 1A ESF chiller inoperable**

A NRC identified, non-cited violation (NCV) for failure to meet the requirements of 10 CFR 50, Appendix B, Criterion XVI was identified. Specifically, the licensee's failure to follow the requirements of 10 CFR 50, Appendix B, Criterion XVI to promptly identify and correct a condition adverse to quality. The condition adverse to quality was that the Unit 1A Engineered Safety Features (ESF) chiller purge compressor resistance temperature detector (RTD) was discovered out of its thermo well. The licensee reinstalled the RTD and took no additional corrective actions. During a subsequent walkdown by a resident inspector and system engineer, they found the RTD not in its thermo well and they informed the control room operators. The licensee's investigation revealed that the RTD's thermo well threads had been cross threaded. The licensee's immediate action was to install a clamping device to hold the RTD inside the thermo well. The licensee has entered the issue into their corrective action program (CR 51198) and has initiated actions to permanently correct the issue with the Unit 1A ESF chiller purge compressor RTD.

This issue is more than minor because it is associated with a cornerstone attribute and adversely affects the objective of the Mitigating Systems cornerstone. Specifically, the performance deficiency is an equipment performance issue which affects the availability, reliability, and capability of the A train ESF chiller to perform its intended safety function. The finding was determined to be Green because the event did not represent an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time. The inspectors determined that the cause of this finding was related to the Corrective Action Program component of the Problem Identification and Resolution cross-cutting area due to less-than-adequate problem evaluation. [P.1(c)]. Specifically, the corrective maintenance actions used to resolve the issue of the purge unit RTD becoming dislodged from its thermo well were less than adequate. (Section 1R12)

Inspection Report# : [2012004](#) (*pdf*)

**Significance:** G Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Failure to follow procedures renders safety related battery chargers inoperable**

The inspectors identified a self-revealing NCV of Technical Specification (TS) 5.4.1, for two instances of failure to properly implement approved maintenance procedures and work order instructions. Specifically, maintenance electricians inadvertently removed the 2BD1CB safety related battery charger from service while attempting to perform a routine quarterly battery surveillance on the 2DD1CB battery charger. When the '2BD1CA/2BD1CB Trouble' alarm was received in the control room, the operators immediately contacted the electricians and the work was halted. Battery charger 2BD1CB was restored to service within 31 minutes. In the second instance, maintenance

electricians inadvertently rendered both battery chargers for the 1CD1 safety-related battery inoperable during load-sharing adjustments on the 1CD1CB battery charger. The licensee restored the 1CD1CA battery charger to service within a few minutes. The licensee entered both of these issues into their corrective action program (CR 445343 & 457102 respectively).

The inspectors concluded that this finding was more than minor because it impacted the Reactor Safety Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and affected the cornerstone attribute of equipment performance. Specifically, the unintentional opening of the AC input breakers to the 2BD1CB, 1CD1CA and 1CD1CB battery chargers resulted in the chargers being declared inoperable for several minutes. The inspectors used the Phase 1 Initial Screening and Characterization of Findings (IMC 0609.04 Exhibit 1) to characterize the finding. Since the inspectors answered “No” to all of the Table 4a Mitigating Systems Cornerstone questions, the inspectors concluded that the finding was of very low safety significance (Green). 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 procedure use and self/peer checking. [H.4(a)] (Section 1R22)

Inspection Report# : [2012003](#) (pdf)

**Significance:**  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to ensure Unit 1 and Unit 2 reactor coolant process variables can be maintained within those predicted for a loss of normal ac power for a large main control room fire.**

Green: A Green NRC identified NCV of Unit 1 Operating License Condition 2.G and Unit 2 Operating License Condition 2.G for failure to implement and maintain in effect all provisions of the approved Fire Protection Program (FPP) as described in the FSAR for the facility. Specifically, the licensee failed to ensure that, during post-fire safe shutdown, Unit 1 and Unit 2 reactor coolant process variables would be maintained within those predicted for a loss of normal ac power. The licensee entered this issue into their corrective action program (CAP) as Condition Report (CR) 2010112114.

The finding was determined to be more than minor because it was associated with the Reactor Safety Mitigating Systems cornerstone attribute of protection against external factors (i.e. fire) and it affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

The inspectors determined that this performance deficiency did not have a cross-cutting aspect because it did not represent current licensee performance.

Inspection Report# : [2011005](#) (pdf)

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## Barrier Integrity

**Significance:**  Sep 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to follow procedure results in a misplaced fuel assembly**

A self-revealing NCV of technical specification (TS) 5.4.1 was identified for failure to follow procedure 93641-C

Rev.19.2, Development and Implementation of the Fuel Shuffle Sequence Plan during spent fuel pool fuel moves in preparation for an upcoming full core off-load. As a result, a fuel assembly was moved to an unintended, unanalyzed location and remained unanalyzed for 50 days. Upon discovery, the licensee immediately performed an analysis, determined that the location was suitable for the fuel assembly, and verified that all other fuel assemblies moved during the reshuffle sequence were located in their correct locations. This issue was entered into the licensee's corrective action program as Condition Report (CR) 523617.

The inspector determined that the failure to follow procedure 93641-C is a performance deficiency. This finding was more than minor because it was associated with the Human Performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, a spent fuel assembly was stored in a location for which it had not been analyzed for 50 days. IMC 0609, "Significance Determination Process," Phase 1 screening worksheet of the SDP, instructed the inspector to process this finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." Checklist 4 from IMC 0609, Appendix G, Attachment 1 was determined to be the most appropriate because the water level was greater than 23 feet and the time to boil was greater than two hours in the Spent Fuel Pool. Using Checklist 4, the inspectors determined that the finding did not require a quantitative assessment because the licensee met the Technical Specifications for the spent fuel pool, specifically water level and boron concentration. Therefore, this finding was determined to be of very low safety significance (Green). 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 procedure use and self/peer checking. [H.4(a)] (Section 1R20)

Inspection Report# : [2012004](#) (*pdf*)

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## **Miscellaneous**

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