

Vogtle 2

4Q/2013 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Operations and Maintenance Procedures Results in High RCP Seal Leakoff Flow and Manual Reactor Trip

Green A self-revealing non-cited violation (NCV) of 10 CFR 50 Appendix B Criterion V, "Instructions, Procedures, and Drawings" was identified for failure to provide adequate work instructions in the operations procedure used to change out the reactor coolant system (RCS) filter. Specifically, operations procedure 13213-1/2, "Backflushable Filter System," which is used to change out the RCS filter, did not provide adequate instructions and/or precautions to prevent excessive air intrusion (and the subsequent localized crud burst within the chemical and volume control system (CVCS) late in core life) when flushing and venting the RCS filter housing. The licensee conducted a root cause investigation and entered the event into their corrective action program (condition report (CR) 597293). The licensee immediately created a Standing Order for Operation of CVCS in relation to RCP seals, and revised procedure 13213-1/2, "Backflushable Filter System" to provide instructions to significantly reduce the amount of air intrusion from changing out the RCS filter.

The finding was more than minor because it was associated with the procedure quality attribute of the reactor safety - initiating events cornerstone and it adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the failure to provide adequate work instructions to operations personnel resulted in a 'localized' crud burst at the reactor coolant pump (RCP) seals causing RCP seal leakoff flow rates to exceed administrative limits for continued pump operation and a subsequent manual reactor trip. Because the inspectors answered "No" to all of the IMC 0609 Appendix A (dated June 19, 2012) Exhibit 1, Section B, "Initiating Events Screening Questions," the inspectors concluded that the finding was of very low safety significance (Green). Since the inadequate procedures have existed since plant start-up, this violation is not indicative of current licensee performance and does not have an associated cross-cutting aspect assigned. (Section 1R11)

Inspection Report# : [2013002](#) (*pdf*)

Mitigating Systems

Significance:  Aug 30, 2013

Identified By: NRC

Item Type: FIN Finding

Failure to Correct a Condition Affecting EDG Recovery Capability under Station Blackout Conditions

Green. The team identified a Green finding for the licensee's failure to follow guidance in nuclear management procedure NMP-GM-002-001, "Corrective Action Program Instructions," Version 30.1, which resulted in their failure to correct a condition that adversely affected the implementation of the station's mitigating strategies for a station blackout (SBO). This was a performance deficiency. The licensee entered the issue into their corrective action

program as Condition Report 673722, and performed an evaluation that determined the ‘as-found’ condition would not prevent successful implementation of their SBO mitigating strategies.

The performance deficiency was more than minor because it affected the Mitigating Systems cornerstone attribute of Design Control and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the capability of the emergency diesel generator air start system following the SBO coping duration was not ensured since the licensee did not adequately evaluate and address the test acceptance criteria for the air start check valves, as captured in Condition Report 599089. The finding was determined to be of very low safety significance (Green) because the finding was a deficiency affecting the design of a mitigating structure, system, or component, confirmed not to have resulted in the loss of functionality. The cause of the finding was indicative of current licensee performance and involved the Corrective Action component of the Problem Identification and Resolution cross-cutting area, because the licensee failed to thoroughly evaluate a problem involving a deficiency in their SBO mitigation strategies such that the resolution addressed the cause of the deficiency. [P.1(c)].

Inspection Report# : [2013007](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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.

Miscellaneous

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