

Vogtle 2 2Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to properly implement a maintenance procedure caused a Reactor Trip

A self-revealing non-cited violation (NCV) of Technical Specifications (TS) 5.4.1.a, Procedures, was identified for the licensee's failure to properly implement procedure 24750-2, "Steam Generator Level (Narrow Range) Protection Channel II 2L-519 Channel Operational Test and Channel Calibration." During testing of Unit 2 loop 1 steam generator (S/G) narrow range channel 2L-519 the channel was not removed from scan resulting in a reactor trip. The licensee's immediate corrective actions were to remove the technicians performing the calibration from maintenance duties for formal remediation. The licensee documented this condition in CR 10230073.

The performance deficiency (PD) was more than minor because it adversely effected the Initiating Events cornerstone objective in that the failure to properly remove channel 2L-519 from scan resulted in a reactor trip. The finding was determined to be Green because the PD did not result in a loss of mitigation equipment used to transition the reactor to a stable shutdown condition. The finding was assigned a cross cutting aspect of Avoid Complacency because maintenance technicians failed to implement appropriate error reduction tools to verify that the correct channel was removed from scan for testing. (H.12)

Inspection Report# : [2016002](#) (*pdf*)

Mitigating Systems

Significance: G Dec 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Implement Preventive Maintenance Procedure for 7300 Process Protection and Control System Printed Circuit Board

A Green self-revealing NCV of TS 5.4.1, "Procedures," was identified for the licensee's failure to implement replacement schedules for 7300 process protection and control (PP&C) system cards in accordance licensee fleet maintenance procedures. As a result, failure of a 7300 PP&C card rendered the Unit 2 B train of nuclear service water system (NSCW) inoperable. The violation was entered into the licensee's corrective action program as condition report (CR) 10124315 and corrective action report (CAR) 261373.

The failure to implement replacement schedules for 7300 PP&C system cards in accordance with maintenance procedure NMP-MA-015 was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective in that the failure of the 7300 PP&C card affected the availability of the Unit 2B train of NSCW. The finding screened as having very low safety significance (i.e. Green) because it did not

represent an actual loss of function of at least a single train for greater than its TS allowed outage time. No cross-cutting aspect was assigned to this finding because the inspectors determined that the cause of the finding was not indicative of current licensee performance because the licensee has established a change management process that would prevent the Performance Deficiency from occurring.

Inspection Report# : [2015004](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: FIN Finding

NRC Biennial Written Examinations Did Not Meet Qualitative Standards

An NRC-identified finding was identified when between 20 and 40 percent of the written examination questions administered to licensed operators during the biennial requalification examination did not meet the requirements of NMP-TR-424, “Licensed Operator Continuing Training Exam Development,” and NUREG-1021, “Operator Licensing Examination Standards For Power Reactors,” Revision 10

The inspectors determined that the failure to ensure that biennial written examinations met the qualitative standards for written examinations was a performance deficiency (PD). The PD was more than minor because it was associated with the Human Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective in that the quality of biennial written examinations potentially impacted the licensee’s ability to appropriately evaluate licensed operators. The significance of the finding was determined to be Green because between 20 and 40 percent of the questions reviewed did not meet the standard. No cross-cutting aspect was identified that would be considered a contributor to the cause of the finding.

Inspection Report# : [2015003](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Maintain Requalification Examination Integrity

An NRC-identified Non-cited Violation (NCV) of 10 CFR 55.49, “Integrity of examinations and tests,” was identified for the licensee’s failure to adhere to requirements of NMP-TR-424, License Operator Continuing Training Exam Development, Version 3.1. NMP-TR-424 was the procedure that the licensee used to implement industry standard ACAD 07-001, Guidelines for the Continuing Training of Licensed Personnel. ACAD 07-001 is a methodology which can be used to fulfill 10 CFR 55.59(c), “Requalification program requirements” and 10 CFR 55.4, “Systems approach to training (SAT).” This violation has been entered into the licensee’s corrective action program (CAP) as condition report (CR) 10115484.

The inspectors determined that the licensee’s failure to adhere to overlap standards in NMP-TR-424 was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the Human Performance attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone objective in that the failure to adhere to examination overlap standards adversely affected the quality of the administration of the operating exams. The finding was determined to be of very low safety significance (Green) because there was no evidence that a licensed operator had actually gained an unfair advantage on an examination required by 10 CFR 55.59. The finding was directly related to the cross-cutting aspect of procedure adherence of the cross-cutting area of Human Performance because the training staff did not follow the guidance for all licensed operators’ 2014 annual operating exam [H.8].

Inspection Report# : [2015003](#) (*pdf*)

Significance:  Jul 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Fully Close and Latch Plant Fire Doors

An NRC-identified Green non-cited violation of Vogtle Units 1 and 2 Operating License Conditions 2.G, was identified for the licensee's failure to ensure that fire doors V22108L1A67, V12111L1238, and V12111L1A41 in 3-hour rated fire barriers were fully closed and latched, as required by the approved fire protection program (FPP) and National Fire Protection Association (NFPA) Code 80-1983, Fire Doors and Windows (Vogtle NFPA Code of Record). The licensee took corrective actions and declared fire door V22108L1A67 inoperable and established a roving fire watch. The inoperable door was entered into the licensee's corrective action program as condition report (CR) 10067247 and was repaired the next day. For doors V12111L1238 and V12111L1A41, the licensee immediately removed materials that were interfering with the latching of the doors and entered these into their corrective action program as CR 10096004 and CR10096008 respectively. Because these two conditions were corrected as soon as they were brought to the licensee's attention by the inspectors, no fire watch was required to be established.

The licensee's failure to ensure the three fire doors were fully closed and latched as required by the approved FPP and NFPA Code 80-1983 was determined to be a performance deficiency. This performance deficiency was more than minor because it affected the reactor safety mitigating systems cornerstone attribute of protection against external events (i.e., fire) and adversely affected the fire protection defense-in-depth element involving fire confinement and control of fires that do occur to protect systems important to safety. The finding was screened in accordance with NRC Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," Attachment 4, "Initial Characterization of Findings," which determined that an IMC 0609, Appendix F, "Fire Protection Significance Determination Process," review was required as the finding involved the ability to confine a fire. The finding category of "Fire Confinement" was assigned, based upon that element of the FPP being impacted. Using IMC 0609, Appendix F, Attachment 1, "Fire Protection Significance Determination Process Worksheet," the inspectors determined that the finding was of very low safety significance (Green) at Task 1.4.3, Question C, based upon observation that a fully functioning, automatically actuated, fire suppression system was installed on both sides of fire doors V12111L1238 and V12111L1A41 and on one side of fire door V22108L1A67. The inspectors determined that the finding had a cross-cutting aspect of "Procedure Adherence" in the Human Performance area because individuals did not follow processes and procedures for ensuring that fire doors were properly closed and latched after passing through the doors [H.8]. [Section 1R05.02.b(1)]

Inspection Report# : [2015007](#) (pdf)

Barrier Integrity

Emergency Preparedness

Significance:  May 13, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Adequately Maintain Emergency Response Facilities

The inspectors identified a non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50.54(q)(2), for the licensee's failure to maintain the effectiveness of its emergency plan by ensuring that adequate emergency facilities and equipment to support emergency response are provided and maintained as required by 10 CFR 50.47(b)(8). Specifically, the effectiveness of the emergency plan was reduced by a change to the Technical Support Center (TSC) functionality requirements in Technical Requirements Manual (TRM) TR 13.13.1, Emergency

Response Facilities, Revision 1. The requirement to maintain climate control was removed without an adequate basis to support removal. The procedure change had been in place since September 2013, and until a corrected revision is issued, a Standing Order has been put in place. The licensee entered this finding into the corrective action program (CAP) as condition report (CR) 10221041.

The inspectors determined that the performance deficiency was more than minor because it was associated with the procedure quality attribute of the Emergency Preparedness (EP) cornerstone, adversely affected the associated cornerstone objective, and would have affected the emergency response organization's ability to effectively perform their duties had an emergency been declared and TSC climate control non-functional. The finding was evaluated using the EP significance determination process and was identified as having very low safety significance (Green) because it was a failure to comply with NRC requirements and was not a loss of the planning standard function or the overall function of the TSC. The finding was associated with a cross-cutting aspect in the Change Management component of the Human Performance area because the licensee failed to use a systematic process for evaluating and implementing change so that nuclear safety remains the overriding priority. [H.3]

Inspection Report# : [2016502](#) (*pdf*)

Occupational Radiation Safety

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Unauthorized Entry into a High Radiation Area

A self-revealing NCV of Technical Specification (TS) 5.7.1, "High Radiation Area," for an unauthorized entry into a high radiation area (HRA). The radiological aspects were not discussed in the pre-job brief, the health physics (HP) technician in containment did not challenge the crew as to whether or not they received their HRA briefing, and the crew did not follow adequate radiological safety practices, such as reading instructions on the HRA posting prior to entry and not leaning against piping. The licensee entered this issue into the CAP as CR 870060

The entry into a HRA without meeting the entry requirements specified in T.S. 5.7.1 was a performance deficiency. This performance deficiency was more than minor because it was associated with the Occupational Radiation Safety cornerstone attribute of Human Performance and adversely affected the cornerstone objective in that workers who enter HRAs with inadequate knowledge of current radiological conditions could receive unintended occupational exposures. The finding was evaluated using the Occupational Radiation Safety Significance Determination Process and determined to be of very low safety significance (Green). This finding does not involve a cross-cutting aspect because it is not current license performance.

Inspection Report# : [2015003](#) (*pdf*)

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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