



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
SAM NUNN ATLANTA FEDERAL CENTER  
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ATLANTA, GEORGIA 30303-8931**

January 26, 2005

Southern Nuclear Operating Company, Inc.  
ATTN: D. E. Grissette, Jr.  
Vice President - Vogtle Project  
P. O. Box 1295  
Birmingham, AL 35201-1295

**SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC INTEGRATED INSPECTION  
REPORT 05000424/2004006 AND 05000425/2004006**

Dear Mr. Grissette:

On December 31, 2004, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at your Vogtle Electric Generating Plant (VEGP), Units 1 and 2. The enclosed integrated inspection report documents the inspection results, which were discussed on January 13, 2005, with Mr. T. Tynan and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

This report documents one self-revealing finding of very low safety significance (Green) which was determined to involve a violation of NRC requirements. However, because of its very low safety significance and because it has been entered into your corrective action program, the NRC is treating this violation as a non-cited violation (NCV) consistent with Section VI.A of the NRC Enforcement Policy. If you contest this NCV, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the United States Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at VEGP.

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Sincerely,

**/RA/**

Malcolm T. Widmann, Chief  
Reactor Projects Branch 2  
Division of Reactor Projects

Docket Nos.: 50-424, 50-425  
License Nos.: NPF-68, NPF-81

Enclosure: Inspection Report 05000424/2004006  
and 05000425/2004006  
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

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**U. S. NUCLEAR REGULATORY COMMISSION**

REGION II

Docket Nos.: 50-424, 50-425

License Nos.: NPF-68, NPF-81

Report Nos.: 05000424/2004006 and 05000425/2004006

Licensee: Southern Nuclear Operating Company, Inc. (SNC)

Facility: Vogtle Electric Generating Plant

Location: 7821 River Road  
Waynesboro, GA 30830

Dates: September 26 - December 31, 2004

Inspectors: G. McCoy, Senior (Sr.) Resident Inspector  
T. Morrissey, Resident Inspector  
L. Miller, Sr. Emergency Preparedness Inspector (Section 1EP4)

Approved by: Malcolm T. Widmann, Chief  
Reactor Projects Branch 2  
Division of Reactor Projects

## SUMMARY OF FINDINGS

IR 05000424/2004-006, 05000425/2004-006; 09/26/2004 - 12/31/2004; Vogtle Electric Generating Plant, Units 1 and 2; Operator Performance During Non-Routine Plant Evolutions.

The report covered a three-month period of inspection by resident inspectors and a regional emergency preparedness inspector. One Green non-cited violation was identified. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

### A. NRC-Identified and Self-Revealing Findings

#### Cornerstone: Mitigating Systems

- Green. A self-revealing non-cited violation was identified for failure to correctly implement a surveillance procedure which resulted in an automatic reactor trip.

This finding is greater than minor because it affected the human performance attribute of the initiating events cornerstone which resulted in an unplanned reactor trip. The finding is of very low safety significance (Green) because it did not contribute to the likelihood that any mitigation equipment or functions would not be available. This finding also involved the cross-cutting aspect of Human Performance. (Section 1R14)

### B. Licensee-Identified Violations

None.

## REPORT DETAILS

### Summary of Plant Status

Unit 1 operated at essentially full rated thermal power (RTP) throughout the inspection period.

Unit 2 operated at essentially full RTP until November 20 when an automatic reactor trip occurred during surveillance testing of the Solid State Protection System. The unit was restarted on November 22 and returned to essentially full RTP on November 26. The unit operated at essentially full RTP for the remainder of the inspection period.

## 1. REACTOR SAFETY

### **Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity**

#### 1R01 Adverse Weather Protection

##### a. Inspection Scope

Seasonal Readiness Review. The inspectors performed a walkdown of the following two systems to verify they would remain functional during low temperature conditions. The inspectors reviewed preventative maintenance activities associated with heat tracing and freeze protection systems to verify they were appropriately scheduled and completed prior to the onset of cold weather. The inspectors reviewed compensatory actions to verify they were implemented for degraded or inoperable heat trace and freeze protection equipment. Additionally, the inspectors reviewed the condition report (CR) database to verify that adverse weather related items were being identified and appropriately resolved. Documents reviewed are listed in the Attachment.

- Unit 1 and Unit 2 auxiliary feedwater (AFW)
- Unit 1 and Unit 2 nuclear service cooling water (NSCW)

##### b. Findings

No findings of significance were identified.

#### 1R04 Equipment Alignment

##### a. Inspection Scope

Partial Walkdowns. The inspectors performed partial walkdowns of the following three systems to verify correct system alignment. The inspectors checked for correct valve and electrical power alignments by comparing positions of valves, switches, and breakers to the procedures and drawings listed in the Attachment. Additionally, the inspectors reviewed the condition report (CR) database to verify that equipment alignment problems were being identified and appropriately resolved.

- Unit 2 train A high head safety injection (HHSI) system during train B HHSI pump maintenance
- Unit 1 train B safety injection (SI) system during train A SI pump maintenance
- Unit 2 train A and B motor driven AFW systems after maintenance

Complete Walkdowns. The inspectors conducted a detailed review of the accessible portions of the Unit 2 train B emergency diesel generator (EDG). The inspectors used licensee procedures 11145-2, Diesel Generator Alignment, 13145-2, Diesel Generators, and drawings 2X4DB170-2, 2X4AK01-00158, 2X4AK01-155-7, and 2X4AK01-00159-8 to verify system alignment, electrical power availability, labeling, hanger and support installation, and support systems status. The inspectors also reviewed system health reports, maintenance rule monthly reports, CRs, and outstanding maintenance work orders to verify that alignment and equipment discrepancies were being identified and appropriately resolved.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors walked down the following nine plant areas to verify the licensee was controlling combustible materials and ignition sources as required by licensee procedures 92015-C, Use, Control, and Storage of Flammable/Combustible Materials, and 92020-C, Control of Ignition Sources. The inspectors assessed the observable condition of fire detection, suppression, and protection systems and reviewed the licensee's fire protection Limiting Condition for Operation log and CR database to verify that the corrective actions for degraded equipment were identified and appropriately prioritized. The inspectors also reviewed the licensee's fire protection program to verify the requirements of Updated Final Safety Analysis Report (UFSAR) Section 9.5.1, Fire Protection Program, and Appendix 9A, Fire Hazards Analysis, were met. Documents reviewed are listed in the Attachment.

- Unit 2 train B cable spreading room
- Unit 2 train A and B component cooling water (CCW) pump rooms
- Unit 1 north main steam isolation valve room
- Unit 2 vital batteries and associated chargers rooms
- Unit 1 train A SI pump room
- Unit 2 train A NSCW building and tunnels
- Unit 2 trains A and B piping penetration filtration unit rooms
- Unit 1 train A HHSI pump room
- Unit 1 train A cable spreading room

b. Findings

No findings of significance were identified.



#### 1R06 Flood Protection

##### a. Inspection Scope

Internal Flood Protection. The inspectors walked down the following two areas which contained risk-significant structures, systems, and components below flood level to verify flood barriers were in place. Motor controllers and terminal boxes that could become potentially submerged were inspected to ensure that the sealing gasket material was intact and undamaged. The inspectors reviewed selected alarm response procedures to verify setpoints for alarm and sump pump operation were consistent with the UFSAR, the setpoint index, and Technical Specifications (TS). Documents reviewed are listed in the Attachment.

- Unit 1 AFW building
- Unit 2 AFW building

##### b. Findings

No findings of significance were identified.

#### 1R07 Heat Sink

##### a. Inspection Scope

The inspectors reviewed the test data for licensee procedure 83306-C, CCW and ACCW Heat Exchanger Testing, conducted April 18, 2004, to verify the heat exchanger met pre-established acceptance criteria. The inspectors reviewed the heat exchanger trend information and discussed historical performance with engineering personnel. Additionally, the inspectors reviewed the licensee's CR database to verify heat exchanger performance issues were being identified and appropriately resolved.

##### b. Findings

No findings of significance were identified.

#### 1R11 Licensed Operator Requalification

##### a. Inspection Scope

The inspectors evaluated operator performance on October 12 during licensed operator simulator training associated with Requalification Segment 20044. The simulator scenario covered operator actions resulting from a malfunction of the pressurizer spray or pressure relief system. The inspectors specifically assessed the following areas:

- Correct use of the abnormal and emergency operating procedures including licensee procedure 18000-C, Pressurizer Spray, Safety or Relief Valve Malfunction
- Ability to identify and implement appropriate TS actions
- Clarity and formality of communications in accordance with procedure 10000-C, Conduct of Operations

- Proper control board manipulations including critical operator actions
- Quality of supervisory command and control
- Effectiveness of post-evaluation critique

b. Findings

No findings of significance were identified.

1R12 Maintenance Effectiveness

a. Inspection Scope

The inspectors reviewed the following two equipment problems and associated licensee CRs to evaluate the effectiveness of the licensee's handling of equipment performance problems and to verify the licensee's maintenance efforts met the requirements of 10 CFR 50.65 (the Maintenance Rule) and licensee procedure 50028-C, Engineering Maintenance Rule Implementation. The reviews included adequacy of the licensee's failure characterization, establishment of performance criteria or 50.65 (a)(1) performance goals, and adequacy of corrective actions. Other documents reviewed during this inspection included control room logs, system health reports, the maintenance rule database, and maintenance work orders (MWOs). Also, the inspectors interviewed system engineers and the maintenance rule coordinator to assess the accuracy of identified performance deficiencies and extent of condition. Documents reviewed are listed in the Attachment.

- CR 2004001930, Unit 2 train B engineered safety feature (ESF) chiller failed to start during testing
- CR 2004150746, Unit 1 train B emergency diesel generator jacket water cooling leak repairs

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed the following six risk significant and emergent MWOs to verify plant risk was properly assessed by the licensee prior to conducting the activities. The inspectors reviewed risk assessments and risk management controls implemented for these activities to verify they were completed in accordance with licensee procedure 00354-C, Maintenance Scheduling, and 10 CFR 50.65(a)(4). The inspectors also reviewed the CR database to verify that maintenance risk assessment issues were being appropriately identified and resolved.

- Replace inoperable Unit 2 containment cooler #1 fan breaker (MWO 2040316001)
- Unit 1 train A essential chilled water (ECW) system outage (MWO's 1030257701 1040193501 and 1040206001)

- Unit 1 train B SI system and associated room cooler outage (MWO's 1020340301, 1040291601, 1040287301, 1040291801 and 1040089101)
- Repair of Unit 2 loop 2 Tave instrument 2TI-422 (MWO 2040408801)
- Unit 2 train B HHSI system and associated room cooler outage (MWO's 2020264001, 2040254701, 2040245001, and 2020295501)
- Unit 1 train B HHSI pump and room cooler outage (MWO's 1030236601, 1040292901, 1040293101, 1040286101, and 1030238201)

b. Findings

No findings of significance were identified.

1R14 Operator Performance During Non-Routine Plant Evolutions

a. Inspection Scope

For the two non-routine plant evolutions described below, the inspectors reviewed the operating crew's performance, operator logs, control board indications, and plant computer data to verify that operator response was in accordance with the associated plant procedures. Documents reviewed are listed in the Attachment.

- November 20, 2004 Unit 2 reactor trip and recovery in accordance with licensee procedures 19000-C and 19001-C
- November 21, 2004, Unit 2 reactor startup in accordance with licensee procedures 12003-C, Reactor Startup (Mode 3 to Mode 2)

b. Findings

Introduction. A Green self-revealing non-cited violation (NCV) was identified for failure to correctly implement a surveillance procedure which resulted in an automatic reactor trip.

Description. On November 20, an automatic reactor trip occurred while performing licensee surveillance procedure 14421-2, Solid State Protection System and Reactor Trip Breaker Train B Operability Test. Prior to the trip, the train B solid state protection system (SSPS) test switch was in the "inhibit" position, and the train A SSPS test switch was in the "operate" position. Step 5.9.17 of procedure 14421-2 required the operator to place the train B SSPS test switch in the "A+B" position. The operator went to the train A SSPS panel and repositioned the SSPS test switch from the "operate" position to the "A+B" position, which required passing through the "inhibit" position. With both trains' SSPS test switches momentarily in the "inhibit" position, the SSPS inserted an automatic reactor trip signal as designed.

Analysis. This finding is greater than minor because it affected the human performance attribute of the initiating events cornerstone which resulted in an unplanned reactor trip. The finding is of very low safety significance (Green) because it did not contribute to the likelihood that any mitigation equipment or functions would not be available. This finding also involved the cross-cutting aspect of Human Performance.

Enforcement. TS 5.4.1.a. requires that written procedures be implemented covering the activities listed in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978, which includes procedures for surveillance tests of the SSPS. Procedure 14421-2, Solid State Protection System and Reactor Trip Breaker Train B Operability Test, Revision 15, Section 5.9.17, required that the train B SSPS test switch be placed in the A+B position. Contrary to the above, on November 20, 2004, operations personnel erroneously operated the train A SSPS test switch causing an automatic reactor trip. Because this finding was of very low safety significance and has been entered into the licensee's corrective action program as CR 2004151063, this violation is being treated as an NCV in accordance with Section VI.A of the NRC Enforcement Policy: NCV 05000425/2004006-01, Failure to Correctly Implement a Surveillance Procedure.

#### 1R15 Operability Evaluations

##### a. Inspection Scope

The inspectors reviewed the following seven evaluations to verify they met the requirements licensee procedure NMP-GM-002, Corrective Action Program, and NMP-GM-002-GL02, Corrective Action Program Details and Expectations Guideline. This scope included a review of the technical adequacy of the evaluations, the adequacy of compensatory measures, and the impact on continued plant operation.

- CR 2004003932, Unit 1 power range detector N43 - slight shift in core average flux
- CR 2004151028, Unit 2 piping penetration sump backed up into both containment spray pump rooms
- CR 2004151209, Unit 1 CST 1 and 2 drain piping, corroded fasteners on non-isolable flanges
- CR 2004150848, Unit 2 digital metal impact monitoring system alarms
- CR 2004151452, Unit 1 train A degraded CCW flow to the spent fuel pool heat exchanger
- CR 2004150746, Unit 1 train B EDG cooling water leakage
- CR 2004150051, Unit 1 train A CCW pump room cooler housing top cover missing mounting screws

##### b. Findings

No findings of significance were identified.

#### 1R19 Post-Maintenance Testing

##### a. Inspection Scope

The inspectors either observed post-maintenance testing or reviewed the test results for the following six maintenance activities to verify that the testing met the requirements of licensee procedure 29401-C, Work Order Functional Tests, for ensuring equipment operability and functional capability was restored. The inspectors also reviewed the test procedures to verify the acceptance criteria was sufficient to meet the TS operability requirements.

- Unit 1 train A ECW system outage (MWO's 1030257701, 1040193501 and 1040206001)
- Unit 1 train B SI system and associated room cooler outage (MWO's 1020340301, 1040291601, 1040287301, 1040291801 and 1040089101)
- Unit 2 train B HHSI system and associated room cooler outage (MWO's 2020264001, 2040254701, 2040245001, and 2020295501)
- Unit 1 train B HHSI pump and room cooler outage (MWO's 1030236601, 1040292901, 1040293101, 1040286101, and 1030238201)
- Unit 1 AMSAC repairs (MWOs 10410245, 1041024501 and procedure 54804-1)
- Unit 1 train B EDG jacket water weld repairs (MWO 1040503401)

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed the following five surveillance test procedures and either observed the testing or reviewed test results to verify that testing was conducted in accordance with the licensee's procedures and that the acceptance criteria adequately demonstrated that the equipment was operable. Additionally, the inspectors reviewed the CR database to verify that the licensee had adequately identified and implemented appropriate corrective actions for surveillance test problems.

Surveillance Tests

- 14643-2, SSPS Slave Relay K641 Train B Test Auxiliary Feedwater
- 14980A-1, Diesel Generator Operability Test (1A monthly test)

In-Service Tests

- 14810-1, TDAFW Pump & Check Valve IST Response Time Test
- 14805-1, Residual Heat Removal Pump and Check Valve IST and Response Time Tests (1A)

Reactor Coolant System Leak Detection

- 14905-1, RCS Leakage Calculation (Inventory Balance)

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors evaluated the following Temporary Modification (TM) and associated 10 CFR 50.59 screening against the system design basis documentation and UFSAR to verify that the modification did not adversely affect the safety functions of important

safety systems. Additionally, the inspectors reviewed licensee procedure 00307-C, Temporary Modifications, to assess if the modification was properly developed and implemented.

- TM 2004-V1T062, Install Reverse Osmosis Unit to the Unit 1 Refueling Water Storage Tank

b. Findings

No findings of significance were identified.

**Cornerstone: Emergency Preparedness**

1EP4 Emergency Action Level (EAL) and Emergency Plan Changes

a. Inspection Scope

The inspectors reviewed a selected sample of changes made to the Emergency Response Plan (ERP) since June 2003 against the requirements of 10 CFR 50.54(q) to determine whether any of the changes decreased ERP effectiveness. The subject changes, which were incorporated in ERP Revision 37, did not include modifications to the EALs. Documents reviewed are listed in the Attachment.

b. Findings

No findings of significance were identified.

**4. OTHER ACTIVITIES**

4OA1 Performance Indicator (PI) Verification

a. Inspection Scope

The inspectors sampled licensee submittals for the PIs listed below to verify the accuracy of the PI data reported during the indicated period. The PI definitions and guidance contained in procedures 00163-C, NRC Performance Indicator Preparation and Submittal; 50025-C, Reporting of Mitigating System Performance Indicator Unavailability; and NEI 99-02, Regulatory Assessment Indicator Guideline, Rev. 2, were used to verify the basis in reporting for each data element.

Mitigating Systems Cornerstone

- Safety System Unavailability - High Pressure Injection System
- Safety System Unavailability - Residual Heat Removal System

The inspectors reviewed operator log entries, maintenance rule database, monthly operating reports, and monthly PI Summary reports for the PI data submitted by the licensee for Unit 1 and Unit 2 during the period from October 2003 through September 2004.

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems

1. Daily Screening of Corrective Action Items

a. Inspection Scope

As required by Inspection Procedure 71152, Identification and Resolution of Problems, and in order to help identify repetitive equipment failures or specific human performance issues for follow-up, the inspectors performed a daily screening of items entered into the licensee's corrective action program. This review was accomplished by either attending daily screening meetings that briefly discussed major CRs, or accessing the licensee's computerized corrective action database and reviewing each CR that was initiated.

b. Findings and Observations

No findings of significance were identified.

2. Annual Sample Review

a. Inspection Scope

The inspectors reviewed one issue to evaluate the effectiveness of the licensee's corrective actions for important safety issues documented in CR 2004003672. The condition report was associated with a procedure error during the sluicing of resin from the steam generator blowdown demineralizers and resulted in the contamination of several rooms in the auxiliary building. This issue was chosen because it involved operations personnel, a cross-cutting human performance issue, and radiation control practices. The inspectors assessed whether the issue was identified in a timely manner; documented accurately and completely; properly classified and prioritized; adequately considered extent of condition, generic implications, common cause, and previous occurrences; adequately identified root and apparent causes; and, identified appropriate corrective actions. Also, the inspectors reviewed licensee procedure NMP-GM-002-GL02 to verify the issue was processed in accordance with procedural requirements. Documents reviewed are listed in the Attachment.

b. Findings and Observations

No findings of significance were identified. The inspectors determined the licensee properly identified the issue, determined the root and apparent cause, considered extent of condition and previous occurrences, and that corrective actions were appropriate and were scheduled and prioritized.



### 3. Semi-Annual Trend Review

#### a. Inspection Scope

As required by Inspection Procedure 71152, Identification and Resolution of Problems, the inspectors performed a review of the licensee's corrective action program and associated documents to identify trends that could indicate the existence of a more significant safety issue. The inspector's review was focused on repetitive equipment issues, but also considered trends in human performance errors. The results of daily inspector corrective action item screening discussed in Section 4OA2.1, licensee trending efforts, and licensee human performance assessments were also reviewed. The inspector's review nominally considered the six month period of January 2004 through June 2004, although some examples expanded beyond those dates when the scope of the trend warranted. Documents reviewed included licensee quarterly corrective action trending reports, engineering system health monitoring reports, major plant issues reports, department self-assessment activities, and Quality Assurance Department audit reports. Documents reviewed are listed in the Attachment.

#### b. Findings and Observations

No findings of significance were identified. The inspectors evaluated the licensee's trending methodology and observed that the licensee has performed a detailed review. The licensee routinely reviewed the cause codes, involved organizations, key words, and system links to identify potential trends in their corrective action program data. The inspectors compared the licensee's reviews with the results of the inspectors daily screening and did not identify any discrepancies or potential trends in the data which the licensee had failed to identify.

### 4OA3 Event Follow-up

#### 1. Unit 2 Automatic Reactor Trip

##### a. Inspection Scope

The inspectors reviewed the licensee's actions associated with the reactor trip and safety injection that occurred on November 20. The inspectors observed plant parameters for mitigating systems and fission product barriers, evaluated performance of systems and operators, and confirmed proper classification and reporting of the event. Documents reviewed are listed in the Attachment.

##### b. Findings

No findings of significance were identified.

#### 2. (Closed) Licensee Event Report (LER) 05000425/2004003-00: Inoperable ESF Room Cooler Results in a Condition Prohibited by the Technical Specifications

On October 22, 2004, the licensee identified that a Unit 2 auxiliary relay cabinet room cooler was seismically inoperable due to an improperly restrained access door. The



door was found closed and latched, however, to maintain seismic qualification, the door is required to be held closed with clips screwed to the frame or locked closed with a padlock. A padlock was installed and the cooler returned to operable status. The licensee determined that this condition existed since initial unit startup in 1989. The inspectors reviewed an engineering evaluation that determined that the safety related components in the room would have performed their intended function even if the room cooler door had opened as a result of a seismic event. No new findings of significance were identified by the inspectors. This condition constitutes a violation of minor significance that is not subject to enforcement action in accordance with Section IV of the NRC's Enforcement Policy. This issue is documented in the licensee's corrective action program as CR 2004150416.

#### 40A4 Cross-Cutting Aspects of Findings

A Green NCV involving the cross-cutting aspect of Human Performance is documented in Section 1R14. A lack of attention to detail during the performance of the SSPS surveillance procedure resulted in the operation of the SSPS test switch in the wrong train causing an automatic reactor trip.

#### 40A6 Meetings, Including Exit

On January 13, 2005, the resident inspectors presented the inspection results to Mr. T. Tynan and other members of his staff, who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

## SUPPLEMENTAL INFORMATION

### KEY POINTS OF CONTACT

#### Licensee personnel:

W. Bargeron, Assistant General Manager - Plant Support  
R. Brown, Training and Emergency Preparedness Manager  
C. Buck, Chemistry Manager  
W. Burmeister, Engineering Support Manager  
S. Douglas, Operations Manager  
K. Dyar, Security Manager  
W. Kitchens, Nuclear Plant General Manager  
I. Kochery, Health Physics Manager  
T. Tynan, Assistant General Manager - Operations

#### NRC personnel:

M. Widmann, Chief, Region II Reactor Project Branch 2

### LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

#### Opened and Closed

|                     |     |  |
|---------------------|-----|--|
| 05000424/2004006-01 | NCV | Failure to Correctly Implement Surveillance Procedure (Section 1R14) |
|---------------------|-----|--|

#### Closed

|                     |     |   |
|---------------------|-----|---|
| 05000425/2004003-00 | LER | Inoperable ESF Room Cooler Results in a Condition Prohibited by the Technical Specifications (Section 4OA3.2) |
|---------------------|-----|---|

### LIST OF DOCUMENTS REVIEWED

#### **Section 1R01: Adverse Weather**

##### Procedures

11877-1/2, Cold Weather Checklist  
11901-1/2, Heat Tracing System Alignment  
13901-1/2, Heat Tracing System  
50050-C, Heat Tracing Program

#### **Section 1R04: Equipment Alignment**

##### Procedures

11006-2, Chemical and Volume Control System Alignment  
13006-2, Chemical and Volume Control System  
11610-2, Auxiliary Feedwater System Alignment  
11105-1, Safety Injection System Alignment  
13105-1, Safety Injection System

##### Drawings

2X4DB116-1/2, Chemical & Volume Control System No. 1208  
2X4DB161-1/2, P&I Diagram, Auxiliary Feedwater System, No. 1302

1X4DB121, Safety Injection System, No. 1204

### **Section 1R05: Fire Protection**

#### Procedures

92720-1, Zone 20 - Auxiliary Building - CVCS Pump Room Train A Fire Fighting Preplan  
 92732-1, Zone 32 - Auxiliary Building - Level B Fire Fighting Preplan  
 92736-2, Zone 37 - Auxiliary Building - Level A, CCW Pumps, Train "B" Fire Fighting Preplan  
 92736-2, Zone 36 - Auxiliary Building - Level A, CCW Pumps, Train A Fire Fighting Preplan  
 92756A-2, Zone 56A - Control Building - Level B Fire Fighting Preplan  
 92756B-2, Zone 56A - Control Building - Level B Fire Fighting Preplan  
 92777A-2, Zone 77A - Control Building - Level B Fire Fighting Preplan  
 92777B-2, Zone 77A - Control Building - Level B Fire Fighting Preplan  
 92778A-2, Zone 78A - Control Building - Level B Fire Fighting Preplan  
 92778B-2, Zone 78B - Control Building - Level B, Train "A" Battery Room Fire Fighting Preplan  
 92779A-2, Zone 79A - Control Building - Level B Fire Fighting Preplan  
 92779B-2, Zone 79A - Control Building - Level B Fire Fighting Preplan  
 92795-1, Zone 95 -Control Building -Level A Fire Fighting Preplan  
 92804-1, Zone 104 - MSIV Room North Level 1 Fire Fighting Preplan  
 92820-1, Zone 120 - Control Building - Level 2 Fire Fighting Preplan  
 92845-2, Zone 145 - NSCW Cooling Tower 2A Mechanical and Electrical Tunnels 2T2A, 2T3A, and 2T5A Fire Fighting Preplan  
 92847-2, Zone 147 - Auxiliary Building - Level 2 Fire Fighting Preplan  
 92860A-2, Zone 160A - NSCW pumphouse - Train A Fire Fighting Preplan  
 92872-2, Zone 172 - Auxiliary Building - Level 2 Fire Fighting Preplan

### **Section 1R06: Flood Protection**

#### Procedures

13220-C, Control Building & Fuel Handling Building Drain Systems

#### Design Documents

DC-1003, Flooding - Interdiscipline  
 VEGP UFSAR 3.4, Water Level (Flood) Design

### **Section 1R12: Maintenance Effectiveness**

Maintenance Rule Database:2001-8/2004 for Unit 2 Essential Chilled Water  
 Maintenance Rule Database:2001-8/2004 for Emergency Diesel Generators

#### Condition Reports

2004001942, ESF Chiller Agastat relay failure  
 2004002735, 2B ESF Chiller Breaker cubicle door not secured  
 2004150916, 1B EDG jacket water leaks at the Dresser coupling

#### Work Orders

1040503401, repair 1B EDG jacket water leaks  
 1040468601, rework jacket water leak under 1B EDG left bank turbocharger

**Section 1R14: Operator Performance During Non-Routine Plant Evolutions and Events**

Unit 2 operating logs for November 20, 2004

Emergency Operating Procedure 19000-C Reactor Trip or Safety Injection

**Section 1EP4: Emergency Action Level (EAL) and Emergency Plan Changes**

Vogtle Electric Generating Plant (VEGP) Emergency Plan for Units 1 and 2, Rev. 37

Emergency Notification, 91002-C, Rev. 42

Duties of the Emergency Director, 91102-C, Rev. 22

Duties of the OSC Manager, 91104-C, Rev. 19

Duties of the Engineering Manager (TSC), 91107-C, Rev. 11

Duties of the Maintenance Manager (TSC), 91108-C, Rev. 9

**Section 4OA2: Identification and Resolution of Problems****Quarterly Trend Reports**

VEGP Quarterly Trend Report for Nov, Dec 2003 and Jan 2004

VEGP Quarterly Trend Report for Feb, Mar and Apr 2004

VEGP Quarterly Trend Report for May, June and July 2004

**Self Assessments**

System Monitoring and Health Reporting dtd 2/04

Integration of Human Performance in the Classroom dtd 2/04

Security Patrol and Barrier Checks dtd 3/04

2R10 Outage Personal Protective Equipment and Electrical Safety dtd 5/04

Operations Department Clearance Errors dtd 2/04

Maintenance Procedure Use dtd 3/04

Lifting and Rigging dtd 1/04

Preventive Maintenance Feedback dtd 1/04

Emergency Planning - Facility Activation Drill dtd 2/04

Quality Assurance and Quality Control dtd 3/04

**Quality Assurance Audits**

Operations Department Training dtd 1/04

Technical Specifications and Surveillances dtd 1/04

Balance of Plant Instrument Calibration dtd 1/04

Corrective Action Program dtd 2/04

Effluent and Environmental Monitoring dtd 5/04

Emergency Planning and Implementing Procedures dtd 4/04

Engineering System Health Reports for first and second quarter 2004

**Section 4OA3: Event Follow-up**

Condition Report 2004151063, Reactor trip on Unit 2 during SSPS testing

Emergency Operating Procedure 19000-C Reactor Trip or Safety Injection