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C. K. McCoy
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LCV-0007

Docket Nos. 50-424
50-425

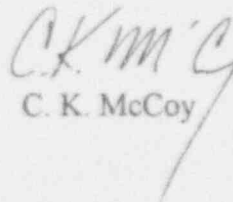
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
REPLY TO A NOTICE OF VIOLATION

Pursuant to 10 CFR 2.201, Georgia Power Company (GPC) submits the enclosed response to the violations identified in Inspection Reports 50-424/93-04 and 50-425/93-04 concerning the inspection conducted by Mr. B. Bonser during the period of February 28 through March 27, 1993.

Sincerely,


C. K. McCoy

CKM/NJS

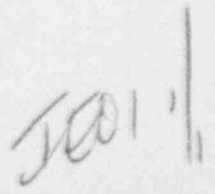
Enclosure

xc: Georgia Power Company
Mr. W. B. Shipman
Mr. M. Sheibani
NORMS

U. S. Nuclear Regulatory Commission
Mr. S. D. Ebnetter, Regional Administrator
Mr. D. S. Hood, Licensing Project Manager, NRR
Mr. B. R. Bonser, Senior Resident Inspector, Vogtle

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ENCLOSURE 1

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 & 2 REPLY TO A NOTICE OF VIOLATION NRC INSPECTION REPORTS 50-424;425/93-04

The following is a transcription of the violation as cited in the Notice of Violation (NOV):

"Technical Specifications (TS) 6.7.1a and 6.7.1f require that written procedures be established, implemented, and maintained covering activities delineated in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, and activities implemented in the Offsite Dose Calculation Manual (ODCM).

Regulatory Guide 1.33, Rev. 2, February 1978, delineates the types of safety-related activities that should be covered by written procedures for startup, operation, shutdown, and procedures for performing maintenance.

The ODCM describes the methodology and parameters to be used in the calculation of offsite doses due to radioactive liquids and gaseous effluents. Procedure 35110-C, Chemistry Control of the Reactor Coolant System implements in part the ODCM.

Procedure 14805-1, Residual Heat Removal Pump and Check Valve IST and Response Time Tests-Train B, step 5.2.9, requires that RHR valve 1-HV-8716A be closed and independently verified to be closed.

Procedure 14612-2, SSPS Slave Relay K603 Train A Test Safety Injection, step 5.15.4, requires that equipment, including centrifugal charging pump A and B miniflow valve, 2HV-8110, be restored to the status recorded in an earlier step.

Procedure 35110-C, step 4.5.5.3, requires in part that if reactor coolant system Dose Equivalent Iodine (DEI)-131 has increased by a factor of three, change out plant vent gaseous monitor charcoal and particulate filters at least once per 24 hours for at least 7 days.

Procedure 13431-1, 120V AC Vital Instrument Distribution System, Checklist 1, step 2.C. requires that handswitch A-HS-2532C be placed to the TEST/BLOCK CHAN II position.

Contrary to the above, procedures were not implemented as required by TS 6.7.1a and 6.7.1f, in that,

1. On March 3, 1993, licensed operators failed to follow procedure 14805-1, step 5.2.9 when Residual Heat Removal (RHR) valve 1-HV-8716B was closed instead of valve 1-HV-8716A and when this error was independently verified incorrectly.
2. On March 18, 1993, a licensed operator failed to follow procedure 14612-2, step 5.15.4, when centrifugal charging pump (CCP) miniflow isolation valve, 2HV-8110, was incorrectly left closed while restoring valves to their positions recorded in an earlier step in the procedure.

ENCLOSURE 1 (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 & 2
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424;425/93-04

3. On March 16, 1993, following the Unit 1 plant shutdown when DEI increased by more than a factor of three, chemistry technicians failed to follow procedure 35110-C, step 4.5.5.3, when plant vent gaseous monitor filters were not changed out at the required frequency.
4. On March 23, 1993, a licensed operator failed to follow procedure 13431-1, step 2.c, in that, handswitch A-HS-2532C was incorrectly placed to the TEST/BLOCK CHAN I position instead of the CHAN II position.

This is a Severity Level IV violation (supplement 1)."

RESPONSE TO VIOLATION--EXAMPLE 1 (50-424;425/93-04-01)

Admission or Denial of the Violation

This example of the violation occurred as stated in the NOV.

Reason for the Violation

This example occurred as a result of the failure of the responsible individuals to perform self-checking and verification during the performance of the procedural step and during the performance of the independent verification process.

Corrective Steps Which Have Been Taken and the Results Achieved

1. The operators responsible for this event have been disciplined concerning their inappropriate and/or inadequate actions which contributed to this event.
2. Shift briefings were held to discuss this event with emphasis placed on the importance of self-checking and independent verification.

Corrective Steps Which Will Be Taken to Avoid Further Violations

Corrective actions have been completed and no further action is warranted at this time.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on March 3, 1993, at 2138 EST, when valve 1-HV-8716B was opened and valve 1-HV-8716A was closed, thereby restoring Train A RHR to service.

ENCLOSURE 1 (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 & 2
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424;425/93-04

RESPONSE TO VIOLATION--EXAMPLE 2 (50-424;425/93-04-01)

Admission or Denial of the Violation

This example of the violation occurred as stated in the NOV.

Reason for the Violation

This example occurred as a result of operators failing to perform self-verification of procedural actions and ensure that valve 2HV-8110 was restored to the open position.

Corrective Steps Which Have Been Taken and the Results Achieved

1. The operators responsible for this event have been disciplined with emphasis placed on self-verification during procedure performance and attention to detail.

Corrective Steps Which Will Be Taken to Avoid Further Violations

Corrective actions have been completed and no further action is warranted at this time.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on March 18, 1993, at 1221 EST, when valve 2HV-8110 was reopened.

RESPONSE TO VIOLATION--EXAMPLE 3 (50-424;425/93-04-01)

Admission or Denial of the Violation

This example of the violation occurred as stated in the NOV.

Reason for the Violation

This example occurred as a result of personnel not being aware that the filters were required to be changed on March 16, 1993, due to an inadequate turnover between Chemistry shift foremen that resulted in a failure to communicate the necessary filter changeout frequency.

ENCLOSURE 1 (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 & 2 REPLY TO A NOTICE OF VIOLATION NRC INSPECTION REPORTS 50-424;425/93-04

Corrective Steps Which Have Been Taken and the Results Achieved

1. Personnel responsible for this event have been counseled on the importance of completing surveillance requirements.
2. A summary of this event has been placed in the Chemistry Department required reading file. This action should ensure personnel are cognizant of the causes and consequences of this event and reemphasize the importance of procedural adherence.
3. Appropriate procedures have been revised that will enhance the statusing and shift turnover process.

Corrective Steps Which Will Be Taken to Avoid Further Violations

Corrective actions have been completed and no further action is warranted at this time.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on March 17, 1993 at 0825 EST, at which time the gaseous monitor filters were changed resulting in compliance with the ODCM.

RESPONSE TO VIOLATION--EXAMPLE 4 (50-424;425/93-04-01)

Admission or Denial of the Violation

This example of the violation occurred as stated in the NOV.

Reason for the Violation

This example occurred as a result of an operator's failure to block the correct channel, CHAN II, for ARE-2533A/B prior to changing the power supply for instrument panel 1BY2B from its alternate to its normal power supply. Although training had discussed procedures for blocking these monitors, the training was not sufficiently detailed.

Corrective Steps Which Have Been Taken and the Results Achieved

Monitors ARE-2533A/B were placed in the blocked position, monitors ARE-2532A/B were returned to service, and the fuel handling building normal HVAC was placed in service on March 23, 1993, at 0215 EST, thereby resulting in compliance with Procedure 13431-1.

ENCLOSURE 1 (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 & 2 REPLY TO A NOTICE OF VIOLATION NRC INSPECTION REPORTS 50-424;425/93-04

Corrective Steps Which Will Be Taken to Avoid Further Violations

1. Procedures 13431-1/2 will be revised by June 1, 1993, to enhance format and equipment identification terminology. Labeling for the block handswitch will be evaluated for enhancements to switch identification.
2. Operator requalification training will be enhanced by July 1, 1993, to include a review of this event.
3. This event will be added to the Operations reading book by July 1, 1993, to ensure licensed operators are fully cognizant of this event and its causes.
4. The Operations Department will evaluate the use of independent verification for procedure steps that place a PERMS monitor in and/or out of blocked position to prevent an ESFAS actuation.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on March 23, 1993, at 0215 EST, when monitors ARE-2533A/B were placed in the blocked position, monitors ARE-2532A/B were returned to service, and fuel handling building normal HVAC was placed in service.

In addition to the corrective actions taken to address the specific examples above, Plant Vogtle has adopted and is promoting the use of the industry self-verification program called "STAR." This program reminds plant personnel to: **STOP, THINK, ACT, and REVIEW** anytime component manipulations or equipment alterations are being made. Plant personnel using these techniques will become more aware of the self-checking and independent verification process and our procedural requirements for performing them.

Additionally, the Operations Manager has briefed operators for each shift on specific events and has communicated management expectations for procedural compliance and attention to detail.