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The Southern Electric System

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Docket Nos. 50-424
50-425

U. S. Nuclear Regulatory Commission
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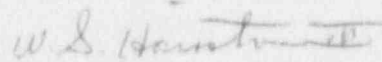
Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
REPLY TO A NOTICE OF VIOLATION

Pursuant to 10 CFR 2.201, Georgia Power Company (GPC) submits the enclosed information in response to the violations identified in Inspection Report Nos. 50-424/90-19 and 50-425/90-19 which concerns the inspection conducted by a NRC Special Inspection Team on August 6-17, 1990. The report's primary conclusion is that VEGP is operated in a safe manner and in accordance with the applicable legal requirements of your agency. The Team identified two technical violations as well as several operational practices which, notwithstanding compliance with regulatory requirements, could be improved. The enclosures to this letter address the two cited violations as well as the Team's operational observations.

Should you have any questions, please contact this office.

Sincerely,



W. G. Hairston, III

WGH, III/NJS/gm

Enclosures

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ENCLOSURE 1

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 & 2
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

- A. "Technical Specification 3.6.3 requires that the containment isolation valves (CIVs) be operable in Modes 1, 2, 3, and 4. With one or more of the CIVs inoperable, at least one isolation valve must be maintained operable in each affected penetration that is open and the inoperable valves must be restored to the operable status within 4 hours or be in Hot Standby within the next 6 hours and in Cold Shutdown within the following 30 hours.

Contrary to the above, on August 7, 1990, the NRC identified that CIVs 2HV-2792A, 2HV-2792B, 2HV-2791B, and 2HV-2793B were opened and, thus, inoperable during surveillance testing of the hydrogen monitor system for a total of 18 hours and 47 minutes on Unit 1 while in Mode 1 and 21 hours and 11 minutes on Unit 2 while in Mode 1 without complying with the limiting condition for operation (LCO) action statement. (50-424/90-19-02; 50-425/90-19-02)

This is a Severity Level IV violation (Supplement I)."

Admission or Denial of the Violation

The violation occurred as stated. However, the valve numbers listed are for Unit 2 only.

Reason for the Violation

Georgia Power Company (GPC) maintains that the technically proper method of performing the required quarterly channel calibration involves opening the subject valves. This allows verification of the flowpath as well as the flowrate delivered by the pump. As stated in the inspection report, this practice poses little risk since the penetrations and associated equipment have been demonstrated to be capable of withstanding full containment design pressure. Furthermore, these penetrations are subject to regular leakage assessment pursuant to Technical Specification (TS) 6.7.4. However, since the allowed outage time of the TS action statement was exceeded, the violation of the Technical Specifications occurred as stated.

Other factors potentially contributed to the occurrence of this violation. During the development of the Unit 1 TS prior to issuance of the Unit 1 Operating License, the table of containment isolation valves, which appears in the Westinghouse Standard Technical Specifications as Table 3.6-1, was relocated from the Unit 1 TS to the FSAR as Table 16.3-4. This table, as it appears in the Standard Technical Specifications, contains a footnote which would allow certain valves to be opened periodically under administrative control. However, when this table was relocated to the FSAR this footnote was not carried over. Had the appropriate footnote been carried over in the FSAR table and applied to the subject valves, GPC believes that there would have been no violation of the TS.

ENCLOSURE 1 (CONTINUED)

REPLY TO A NOTICE OF VIOLATION NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

Furthermore, Table 6.2.4-1 of the FSAR contributed to the confusion surrounding these valves. In this table, the valves listed in the violation and their counterparts on the Unit 2 Train B Containment Hydrogen Monitors and the Unit 1 monitors are identified as CIVs. Their normal and shutdown positions are shown as closed, but the post-accident position is shown as open which is consistent with the operation of the hydrogen monitors. However, they are shown as being subject to Type C Local Leak Rate Testing (LLRT). With the exception of the containment spray supply valves (HV-9001A and B), which are normally closed but open automatically on an Engineered Safety Feature Actuation System (ESFAS) signal, all penetrations which are required to be open during post-accident conditions are subject to Type A Integrated Leak Rate Testing (ILRT). Since the hydrogen monitors are required to be in service under post-accident conditions, there was a perception that this equipment represented an extension of the containment boundary.

Corrective Steps That Have Been Taken and the Results Achieved

Procedures 24551-1 and 2, "Containment Hydrogen Monitor Train A Analog Channel Operational Test and Channel Calibration," and 24552-1 and 2, "Containment Hydrogen Monitor Train B Analog Channel Operational Test and Channel Calibration," have been revised to eliminate the need to open the subject valves. Channel calibrations of these monitors which have been performed subsequent to the August 6-17 inspection have been accomplished without opening these valves.

Corrective Steps Which Will Be Taken to Avoid Further Violations

The above steps are sufficient to prevent further violations. However, GPC believes that the proper method of performing the channel calibration on the hydrogen monitors involves opening the subject valves. Therefore, we intend to pursue a future licensing document change (e.g., TS amendment or FSAR revision) which will allow these valves to be opened periodically under administrative control without entering the LCO. Leakage from the piping associated with the hydrogen monitors will continue to be controlled pursuant to TS 6.7.4a, "Primary Coolant Sources Outside Containment."

Date When Full Compliance Will Be Achieved

Full compliance was achieved with the revision of Procedures 24551-1 and 2, and 24552-1 and 2. Procedures 24551-1 and 2 were revised on August 31, 1990 and 24552-1 and 2 were revised on August 27, 1990.

ENCLOSURE 1 (CONTINUED)

REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

- B. "Technical Specification 4.2.5.3 requires that the reactor coolant system (RCS) flow rate be determined by precision heat balance before operation above 75 percent of rated thermal power. Furthermore, this specification requires that, within 7 days prior to performing the RCS flow measurement, the instrumentation used for performing the precision heat balance shall be calibrated.

Contrary to the above, the licensee failed to calibrate, within seven (7) days prior to use, the instrumentation used during the performance of the precision heat balances required by TS 4.2.5.3 and performed on April 23, 1990. (50-424/90-19-01; 50-425/90-19-01)

This is a Severity Level IV violation (Supplement I)."

Admission or Denial of the Violation

The violation occurred as stated. This event was identified by GPC prior to this inspection and reported in LER 50-424/1990-015 dated August 8, 1990.

Reason for the Violation

The reason for the violation was cognitive personnel error. Plant Procedure 88075-C, "Precision Heat Balance," required the calibration of special test instrumentation used for performing the heat balance, but did not require the calibration of plant computer points which are used for obtaining input values for feedwater temperatures. Plant management had interpreted the calibration requirement of Technical Specification (TS) 4.2.5.3 to apply only to special test instrumentation which is installed and removed specifically for the precision heat balance, and not installed plant instrumentation covered by the plant calibration program. However, even though the feedwater temperature computer points were being calibrated on a routine basis, they had not historically been calibrated within the seven day interval specified by TS 4.2.5.3. Plant management now agrees that this interpretation of the calibration requirement was incorrect in not including the feedwater temperature computer points, thus resulting in an inadequate procedure.

Corrective Steps That Have Been Taken and the Results Achieved

1. Reactor Engineering reperformed the most recent precision heat balance flow calculations for Unit 1 and Unit 2. Based on the average drift indicated by subsequent calibration of the feedwater temperature computer points, conservative values for feedwater temperatures were determined and used in reperforming these calculations. While the new calculations showed the Reactor Coolant System (RCS) flow rate to be slightly less than previously calculated, the new calculated flow rate was still well above the minimum value established by TS 3.2.5.

ENCLOSURE 1 (CONTINUED)

REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

2. A Record Correction Notice (RCN) was initiated for Procedure 88014-C, "Reactor Coolant System flow Measurement," documenting the results of corrective step number 1 above.
3. Procedure 88075-C was revised to require the calibration of the feedwater temperature computer points within seven days prior to the performance of the precision heat balance.

Corrective Steps Which Will Be Taken to Avoid Further Violations

The corrective steps discussed above are sufficient to preclude further violations.

Date When Full Compliance Will Be Achieved

Compliance was achieved on 4-26-90 with the initiation of the RCN for Procedure 88014-C. Procedure 88075-C was revised on 8-22-90.

ENCLOSURE 2

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 & 2
RESPONSE TO OPERATIONAL PRACTICES
IDENTIFIED IN NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

As requested in the letter transmitting the subject inspection report, GPC submits the following response to the operational practices as annotated in the Inspection Summary.

1. "The licensee's method for TS interpretations allowed the operations manager to be solely responsible for the approval and distribution of the interpretations. The inspection team was concerned that the intent of the TS may be changed by the interpretations without an interdepartmental review and approval of the interpretations, such as would be provided by a plant review board (PRB) review."

Response

GPC has given significant consideration to this observation and we are in agreement with respect to the benefit of additional review to ensure that Technical Specification (TS) interpretations do not change the intent of the TS. At the same time, GPC views it as essential that a qualified individual be designated as responsible for the resolution of interpretations and that prompt interpretations be provided to assure concrete guidance.

As stated above, GPC TS interpretations are not designed to modify the intent or breadth of the Technical Specifications but merely to provide a consistent clarification of the specifications for the on-shift operations crews. The Operations Manager, being the senior member of plant management required to maintain a Senior Reactor Operator's License, is the appropriate approval authority for the TS interpretations generated. This is essential for prompt application of the TS. We expect the Operations Manager to continue to provide verbal guidance on a day-to-day basis. For those cases where interpretations are put in writing, procedural controls will be developed and implemented which will ensure that TS interpretations are reviewed by appropriate personnel. Specifically, the Manager of Technical Support will review the interpretations and he will be responsible for obtaining the appropriate departmental reviews, including licensing personnel as well as consulting with the NRC staff, as appropriate. While some of these reviews may be retrospective, such as interpretations required for prompt application, this broadened review should address the area of concern raised during the inspection. These procedural controls will be developed and implemented by February 10, 1991. A review of all current TS interpretations subject to these controls will be completed by March 15, 1991.

2. "The licensee's method for interdepartmental review of procedures appeared to rely on the procedure writer's judgment or another department's request. As evidenced by the lack of an Operations Department review of Surveillance

ENCLOSURE 2 (CONTINUED)

RESPONSE TO OPERATIONAL PRACTICES IDENTIFIED IN NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

Procedure 24551-2, "Containment Hydrogen Monitor Analog Operability Test and Channel Calibration," this methodology had not ensured that all procedures that affect the Operations Department receive that department's review and concurrence. The inspection team concluded that the licensee's method of performing intra- and interdepartmental reviews of procedures needed improvement."

Response

Administrative Procedure 00051-C, "Procedure Review and Approval," requires that the department procedure coordinators obtain intra- and interdepartment reviews, as necessary, for technical content, accuracy, completeness and quality. Comments are solicited and resolved with department managers, or their designated reviewers during procedure development, revision or review. Departmental procedures which affect areas of responsibility of other departments are required to be reviewed by the affected departments. Prior to review by the responsible department manager, the procedure coordinator is required to obtain verification from each department affected by changes being made to the procedure, that they have reviewed the procedure changes, and their concerns have been addressed.

To help prevent instances such as the one identified pertaining to Procedure 24551-2, "Containment Hydrogen Monitor Analog Channel Operational Test and Channel Calibration," each department procedure coordinator has been briefed on this event and the importance of obtaining a proper review.

3. "The licensee indicated that the LCO action requirements of TS 3.7.8, "Snubbers," allowed voluntary entry into the LCO for the performance of snubber modifications (i.e., replacement with fixed struts). The licensee's voluntary entry into the LCO (during modes when the snubbers were required to be operational) was performed as an operational convenience and not in conjunction with other pre-planned testing or maintenance. In addition, the method used for the nuclear service cooling water (NSCW) modifications resulted in an unnecessary reduction in the availability of the engineered safety features equipment. These voluntary entries into LCOs were not necessary and were performed in order to reduce the scope of the subsequent refueling outage."

ENCLOSURE 2 (CONTINUED)

RESPONSE TO OPERATIONAL PRACTICES
IDENTIFIED IN NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

Response

GPC maintains that there are instances where voluntary entry into a LCO action statement for the purpose of implementing a design change is appropriate, provided the activity is accomplished within the provisions of the Technical Specifications and proper consideration has been given to the impact on plant safety. It is our policy to implement design changes on safety related systems for the purpose of improving system reliability in a timely manner and thereby enhancing plant safety. Furthermore, this is to be done in conjunction with other preplanned testing or maintenance whenever possible.

GPC evaluated the process of implementing the snubber modifications, and, while it is true that the modifications could have been made at a time during the outage when operability requirements were reduced, GPC believes that, with the exception of the NSCW modifications, our actions were justified. It is our judgment that the snubber reduction program does result in a more reliable piping support system and, therefore, was a benefit to safety accomplished in a timely manner without significant risk.

GPC acknowledges that the manner in which the modifications to the NSCW system were performed was not in keeping with our philosophy of minimizing the unavailability of safety related systems. Our evaluations of future design modifications will include heightened sensitivity to this type of issue and will be consistent with regulatory requirements.

4. "The licensee indicated that the LCO for TS 3.0.3, "Shutdown Actions," allowed a total of seven hours to achieve hot standby and that a reduction in reactor power was not required until three hours after entry of the LCO. This position was based on their ability to go from Mode 1 to Mode 4 (hot standby) within four hours."

Response

When limiting conditions for operation are not met, except as provided in the associated action requirements, at VEGP, actions are initiated to place the unit in a mode in which the specification does not apply in accordance with Technical Specification (TS) 3.0.3. Upon entry into TS 3.0.3, the Unit Shift Supervisor should evaluate the plant situation and formulate a course of action. This should include actions to prepare for and complete a safe and controlled shutdown as well as actions to correct the condition which called for TS 3.0.3 entry, considering plant safety first and foremost, not lost power production, and in accordance with regulatory requirements.

In some cases there may be a high degree of confidence that the technical issues can be resolved or repairs made promptly to restore component operability. In such an event, an immediate power reduction is not advisable, and an unnecessary operational transient should be avoided. Nevertheless, actions are to be taken to ensure that an orderly unit

ENCLOSURE 2 (CONTINUED)

RESPONSE TO OPERATIONAL PRACTICES
IDENTIFIED IN NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

shutdown will be completed within allowable times, while repairs or attempts to resolve operability issues proceed. Within the first hour, notifications to load dispatchers and management should be made, contingency outage implementation planning should begin, and unit shutdown procedures should be initiated. Furthermore, in those cases in which it becomes apparent that timely resolution of the condition will not occur, an orderly power reduction will begin to assure that the plant is put in a safe configuration in compliance with all requirements. In order to ensure a broad understanding of this policy, GPC will provide written guidance for use by the operators in implementing TS 3.0.3 by March 1, 1991.

5. "The licensee's method of certifying the qualifications for plant equipment operators (PEOs) was not correctly performed. The training evaluator delegated the responsibility for evaluating performance of trainee PEO rounds to a qualified PEO. The evaluator (without discussions with the qualified PEO) certified that the rounds were satisfactorily completed based on the qualified PEO's initials, even though the qualified PEO had not observed the performance of the trainee's rounds. In addition, the licensee had not conducted a management review of the implementation of the on-the-job training for PEOs."

Response

It is our policy that evaluators accompany trainee PEOs on rounds. This policy has apparently not been consistently implemented by some evaluators. We have reminded the evaluators of their responsibilities in these areas.

This was identified as a concern during the self evaluation process in 1990 (although it was not identified as a specific weakness) and a new module was developed for the management observation program as a result. This module provides for line management to observe "on-the-job training" (OJT) being conducted by evaluators and trainees. This should assist management in remaining aware of and correcting potential weaknesses in the conduct of OJT. In addition, the training department will periodically evaluate the OJT program.

6. "The licensee's method of identifying the actual expectations for plant equipment operators involving the minimum acceptable performance of general inspections was neither well defined in procedures nor, in some instances, by on-the-job training (OJT)."

Response

GPC acknowledges that inconsistencies exist in performance of rounds by PEOs. Procedure 10001-C, "Logkeeping," provides guidance for Plant Equipment Operators (PEOs) for general inspections while performing rounds. Section 3.3 states, "Refer to Table 1 for inspection criteria when performing rounds. These are the minimum criteria to which an operator must

ENCLOSURE 2 (CONTINUED)

RESPONSE TO OPERATIONAL PRACTICES
IDENTIFIED IN NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

inspect his assigned area...." We believe that operators should be expected to use good judgement and go beyond minimum requirements in observing equipment and identifying and correcting problems. Performance of rounds will be reviewed during the next cycle of requalification training for PEOs. This training will be completed by April 15, 1991. Moreover, we are in the process of adding an additional Support Shift Supervisor to each shift whose responsibilities will include observation of rounds performed by PEOs, plant walkdowns and plant material conditions.

7. "The licensee's method of authorizing excess overtime in the Operations Department was considered a weakness because of the lack of recent work history information, frequent "after the fact" authorization of excess overtime, and the potential conflicting responsibilities of the authorizing official. The inspection team also concluded that excess overtime may have been performed by certain individuals. In addition, the non-supervisory staffing policy had the potential to result in unbalanced experience levels on the night shifts."

Response

GPC agrees that the implementation of Procedure 00005-C, "Overtime Authorizations," was weak and all supporting documentation on overtime authorizations could not be located. In order to correct this weakness, plant management reemphasized adherence to Procedure 00005-C and imposed stricter administrative controls on the overtime allowed prior to the Fall 1990 Unit 2 Refueling Outage.

Procedure 00005-C requires department managers to evaluate and approve the use of overtime, in accordance with TS 6.2.2e. In addition the General Manager Nuclear Plant (GMNP) or his designee will review the excessive overtime to assure that time in excess of the guidelines was properly authorized and that assignment of excess overtime does not become routine. A memorandum has been issued by the GMNP to all supervisory personnel concerning the use of overtime and the requirements for approval of overtime.

Finally, staffing is reviewed by management to ensure that the proper number of qualified personnel are on site at all times.

8. "The licensee's method of holding periodic mini-safety meetings for Operations Department personnel was not properly fulfilling the administrative procedure requirements."

ENCLOSURE 2 (CONTINUED)

RESPONSE TO OPERATIONAL PRACTICES
IDENTIFIED IN NRC INSPECTION REPORT NOS. 50-424/90-19 AND 50-425/90-19

Response

Plant Procedure 00250-C, "Safety Committee and General Safety Meeting," provides guidance on mini safety meetings. Since this inspection, GPC has been distributing a bimonthly safety newsletter to all department Managers with a list of selected topics for foremen and supervisors to use in their mini safety meetings. Each department utilizes the signoff on the back of the newsletter to list the names of personnel who attended the mini safety meetings.

The Operations Department is now conducting mini safety meetings at shift briefings utilizing the guidance provided in Procedure 00250-C.

9. "The licensee's method for implementing the Quality Concern Program had a potential weakness with respect to the method of exit interviews and the assignment of the investigations."

Response

In light of the various methods of submitting concerns to the Quality Concern Program available to GPC workers, and the small percentage of personal exit interviews not conducted relative to the number of exits that have occurred, the effectiveness of the Program is not believed to have been significantly reduced with respect to the method of exit interviews.

We agree that the assignment of an investigation to parties directly involved in an allegation is not appropriate. To protect against this practice, the Quality Concern Program (QCP) Coordinator considers this when assigning an investigator. However, it has always been our practice to use site resources in these investigations. This arrangement was conceived primarily because of the knowledge and understanding that a department manager would have in the subject matter. Unless directly involved in the allegation, these managers are not perceived as being biased or subject to a conflict of interest.

As recognized in the program's developmental stages, a weakness may exist if the sole resolution of concerns was dependent upon departmental input. Because of this, one of the primary responsibilities of the QCP Coordinator is to assure independence. So that he can function in this capacity, he reports to the Assistant General Manager - Support. If the QCP Coordinator is doubtful of independence, an investigation can be assigned to someone from offsite.