

February 6, 1996

EA 96-011

Georgia Power Company
ATTN: Mr. C. K. McCoy
Vice President
Vogtle Electric Generating Plant
P. O. Box 1295
Birmingham, AL 35201

SUBJECT: NRC INSPECTION REPORT NOS. 50-⁴324, ⁴325/94-09 AND
50-⁴324, ⁴325/95-28

Dear Mr. McCoy:

This letter refers to inspections conducted during the periods March 20 - April 23, 1994 and November 16 - December 16, 1995, at the Vogtle Electric Generating Plant. During the inspections, the NRC examined the facts and circumstances surrounding your identification of an apparent falsification of a battery maintenance data sheet by an electrician. As a result of our initial review of the matter, an Unresolved Item was identified.

As discussed in detail in the subject Inspection Reports, during a routine review of the Maintenance Work Order package associated with battery maintenance, you identified a potential record falsification by an electrician. Your subsequent investigation of the incident established that the electrician performed work on April 3, 1994, under Procedure 27915-C, General Battery Maintenance, which required the measurement, adjustment, and documentation of voltage readings for a battery cell which was on an equalize charge. On April 7, 1994, this electrician replaced out-of-tolerance voltage readings with procedurally acceptable values, and dated the correction April 3, 1994, after being questioned by a co-worker regarding out-of-tolerance data he had recorded on the maintenance data sheet on April 3. Your interviews with the electrician revealed that he was aware that the voltage readings taken on April 3, 1994, exceeded procedural guidance and that he knowingly took no action to correct the condition or to inform his supervisor. At the conclusion of your investigation, the electrician's employment was terminated with Georgia Power Company.

As an employee at a nuclear power plant, the electrician is expected to perform all work in accordance with procedures and to document all records of activities completely and accurately. As determined by your investigation, the electrician's actions in April 1994 did not adhere to these standards. Accordingly, on February ----, 1996, a letter was issued to the individual re-enforcing NRC's expectations in this regard (Enclosure).

As stated in Inspection Report 50-⁴324, ⁴325/95-28, the NRC's review of this matter has been completed. Although the falsification of records is a serious matter of regulatory concern, it has been decided, pursuant to Section VII.B.1

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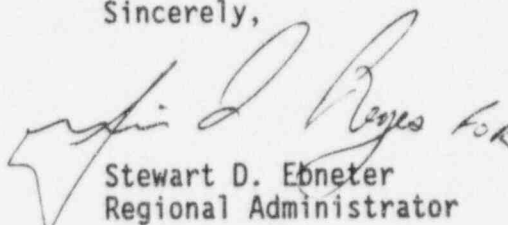
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of the Enforcement Policy and after consultation with the Office of Enforcement, that no action will be taken with respect to Georgia Power Company in this case. The bases for this decision are: 1) you identified the record falsification; 2) the violation appeared to be the isolated act of one individual who held a low level position in your organization; 3) you conducted a prompt and thorough investigation; 4) you implemented appropriate corrective action, including disciplinary action against the individual involved; and 5) the resultant violation of Procedure 27915-C was of minor safety consequence.

This letter serves to clarify the closure of the Unresolved Item No. 50-324, 325/94-09-01 in Inspection Report 50-324, 325/95-28 and completes NRC action in this matter. No formal response to this letter is required. In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

If you should have any questions regarding this letter, please contact Mr. Pierce Skinner, Chief, Branch 2, Division of Reactor Projects, at 404-331-6299.

Sincerely,



Stewart D. Ebner
Regional Administrator

Enclosure: As Stated

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

cc w/encl:
J. D. Woodard
Senior Vice President
Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

J. B. Beasley
General Manager, Plant Vogtle
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cc w/encl: Cont'd on Page 3

cc w/encl (cont'd):

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 BKeeling, CA
 LNorton, OIG
 RPedersen, OE
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 MSkinner, RII (IFS entry required)
 RTrojanowski, RII
 RWoodruff, RII
 KClark, RII
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 D. Hood, NRR
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*sent to OE 2/5/96
for informational review*

NRC Senior Resident Inspector
 U.S. Nuclear Regulatory Commission
 8805 River Road
 Waynesboro, GA 30830

SEND TO PUBLIC DOCUMENT ROOM?								YES	NO
OFFICE	RII:DRP	RII:DRP	RII:DRP	RII:EICS	RII:ORA	RII:ORA	HQ:OE		
SIGNATURE	<i>[Signature]</i>		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
NAME	PSKINNER	JJOHNSON	EMERCHOFF	BURYC	CEVANS	MEYES	JLBERMAN		
DATE	02/2/96	02/ /96	02/5/96	02/5/96	02/05/96	02/6/96	02/5/96		
COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO		



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0189

February 6, 1996

IA 95-004

Mr. James A. Graham
[HOME ADDRESS DELETED
UNDER 10 CFR 2.790]

SUBJECT: NRC INSPECTION REPORT NOS. 50-324, 325/94-09 AND
50-324, 325/95-28

Dear Mr. Graham:

This letter refers to an inspection conducted by the Nuclear Regulatory Commission (NRC), Region II, on March 20 - April 23, 1994 and November 16 - December 16, 1995, at the Vogtle Electric Generating Plant. During the inspections, the NRC examined the facts and circumstances surrounding an incident identified by Georgia Power Company (licensee) involving an apparent falsification of a battery maintenance data record. The reports documenting the NRC inspection are provided as Enclosures 1 and 2.

The licensee's investigation of this matter concluded that while you were employed by Georgia Power Company as an electrician at the Vogtle Electric Generating Plant, you falsified documentation associated with battery maintenance performed on April 3, 1994. Specifically, the licensee determined that on April 3, 1994, you performed work under Procedure 27915-C, General Battery Maintenance, which required the measurement, adjustment, and documentation of voltage readings for a battery cell which was on an equalize charge. On April 7, 1994, you replaced out-of-tolerance voltage readings with procedurally acceptable values, and dated the correction April 3, 1994, after being questioned by a co-worker regarding out-of-tolerance data you had recorded on the maintenance data sheet on April 3. Based on the results of their review, the Georgia Power Company subsequently terminated your employment at Plant Vogtle.

On January 30, 1995, we received correspondence from you which discussed your position in this case. In that letter, you acknowledged that you altered the battery maintenance record as described above; however, you asserted that it was not done with any willful intent. You further provided an explanation of the factors contributing to your actions. Irrespective of the specific motivations and circumstances surrounding your alteration of the maintenance data sheet with inaccurate information on April 7, 1994, you should be aware that the Commission's regulations at 10 CFR 50.9(a), "Completeness and Accuracy of Information," provide, in part, that information required by the Commission's regulations or license conditions to be maintained by the licensee shall be complete and accurate in all material respects. In addition, 10 CFR 50.5(a)(2) prohibits employees from deliberately submitting any information to a licensee that the person knows to be inaccurate in some respect material to the NRC.

Certified Mail Number: P 291 242 526
RETURN RECEIPT REQUESTED

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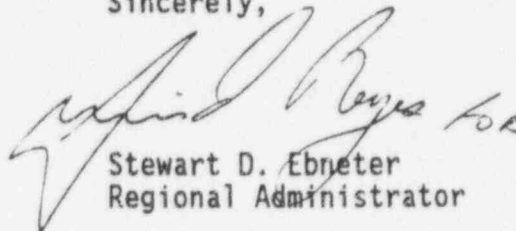
The NRC relies on accurate records of activities at nuclear power facilities to ensure the health and safety of the public and, therefore, expects no less than full compliance with all applicable requirements. You should be aware that NRC regulations (i.e., 10 CFR 50.5, "Deliberate Misconduct," of which a copy is provided as Enclosure 3) allow enforcement actions to be issued directly against unlicensed persons who deliberately submit any information to a licensee that the person knows to be inaccurate. Similarly, an order may be issued to prohibit an individual from engaging in licensed activities at all NRC-licensed facilities. A violation of this regulation may also lead to criminal prosecution.

While the NRC is not initiating an enforcement action against you in this matter, we are issuing this letter to emphasize to you the NRC's expectation that work assigned to you while employed at any NRC-licensed facility must be performed in the manner prescribed by procedures and the results of such work must be accurately recorded. Should you be found to have committed deliberate violations in the future, significant enforcement action may be taken against you.

No reply to this letter is required. However, should you desire to provide a response, please submit it within 30 days to the undersigned at the U. S. Nuclear Regulatory Commission, Region II, 101 Marietta St., N.W., Atlanta, Georgia, 30323. In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, records or documents compiled for enforcement purposes are placed in the NRC Public Document Room (PDR). Therefore, a copy of this letter with your address removed, as well as any reply you choose to provide, will be placed in the PDR..

If you have any questions or comments, please contact Mr. Pierce Skinner, Chief, Branch 2, Division of Reactor Projects, at (404) 331-6299.

Sincerely,



Stewart D. Ebner
Regional Administrator

- Enclosures: 1. Inspection Report 50-324, 325/94-09
2. Inspection Report 50-324, 325/95-28
3. 10 CFR 50.5, "Deliberate Misconduct"



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30333-0199

MAY 17 1994

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

Georgia Power Company
ATTN: Mr. C. K. McCoy
Vice President
Vogtle Electric Generating Plant
P. O. Box 1295
Birmingham, AL 35201

Gentlemen:

SUBJECT: NRC INSPECTION REPORT NOS. 50-424/94-09 AND 50-425/94-09

This refers to the inspection conducted by B. Bonser of this office on March 20 - April 23, 1994. The inspection included a review of activities authorized for your Vogtle facility. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed report.

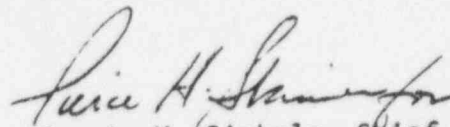
Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

Within the scope of the inspection, no violations or deviations were identified.

In accordance with 10 CFR 2.790(a), a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

Should you have any questions concerning this letter, please contact us.

Sincerely,


Marvin V. Sinkule, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Enclosure:
NRC Inspection Report

cc w/encl: (See page 2)

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Enclosure 1

cc w/encl:

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General Manager, Plant Vogtle
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cc w/encl cont'd: (See page 3)

Georgia Power Company

3

MAY 17 1994

cc w/encl cont'd:

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UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W., SUITE 2900
 ATLANTA, GEORGIA 30323-0199

Report Nos.: 50-424/94-09 and 50-425/94-09

Licensee: Georgia Power Company
 P. O. Box 1295
 Birmingham, AL 35201

Docket Nos.: 50-424 and 50-425

License Nos.: NPF-68 and NPF-81

Facility Name: Vogtle 1 and 2

Inspection Conducted: March 20, 1994 - April 23, 1994

Inspector:	<u><i>B. R. Bonser</i></u>	<u>5.17.94</u>
	B. R. Bonser, Senior Resident Inspector	Date Signed
	<u><i>R. D. Starkey</i></u>	<u>5.17.94</u>
	R. D. Starkey, Resident Inspector	Date Signed
	<u><i>P. A. Balmain</i></u>	<u>5.17.94</u>
	P. A. Balmain, Resident Inspector	Date Signed
	<u><i>D. A. Seymour</i></u>	<u>5.17.94</u>
	D. A. Seymour, Project Inspector	Date Signed

Approved by:	<u><i>P. Skinner</i></u>	<u>5/17/94</u>
	P. Skinner, Chief Reactor Projects Section 3B Division of Reactor Projects	Date Signed

SUMMARY

Scope: This routine inspection entailed inspection in the following areas: plant operations, surveillance, maintenance, and follow-up of open items.

Results: One unresolved item was identified.

The unresolved item involved the falsification of a battery maintenance datasheet. Additional NRC review is pending prior to resolution of this issue (paragraph 4c).

The inspectors observed the licensee's control room enhancements and control room chart recorder replacements and noted these as improvements in main control room facilities (paragraph 2f).

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REPORT DETAILS

1. Persons Contacted

Licensee Employees

J. Beasley, General Manager Nuclear Plant
S. Bradley, Reactor Engineering Supervisor
*W. Burmeister, Manager Engineering Support
S. Chesnut, Manager Engineering Technical Support
*C. Christiansen, SAER Supervisor
C. Coursey, Maintenance Superintendent
R. Dorman, Manager Training and Emergency Preparedness
G. Frederick, Manager Maintenance
*W. Gabbard, Nuclear Specialist, Technical Support
M. Griffis, Manager Plant Modifications
M. Hobbs, I&C Superintendent
*K. Holmes, Manager Operations
*G. Hooper, Engineering Supervisor, Technical Support
*D. Huyck, Nuclear Security Manager
*W. Kitchens, Assistant General Manager Plant Support
R. LeGrand, Manager Health Physics and Chemistry
*G. McCarley, ISEG Supervisor
R. Moyer, Plant Engineering Supervisor
M. Sheibani, Nuclear Safety and Compliance Supervisor
C. Stinespring, Manager Administration
*J. Swartzwelder, Manager Outage and Planning
C. Tynan, Nuclear Procedures Supervisor
J. Williams, Supervisor Work Planning and Controls

Other licensee employees contacted included technicians, supervisors, engineers, operators, maintenance personnel, quality control inspectors, and office personnel.

Oglethorpe Power Company Representative

*T. Mozingo

NRC Resident Inspectors

B. Bonser
D. Starkey
*P. Balmain

*Attended Exit Interview

An alphabetical list of abbreviations is located in the last paragraph of the inspection report.

2. Plant Operations (71707)

a. General

The inspection staff reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, Technical Specifications, and administrative controls. Control logs, shift supervisors' logs, shift relief records, LCO status logs, night orders, standing orders, and clearance logs were routinely reviewed. Discussions were conducted with Plant Operations, Maintenance, Chemistry, Health Physics, Engineering Support and Technical Support personnel. Daily plant status meetings were routinely attended.

Activities within the control room were monitored during shifts and shift changes. Actions observed were conducted as required by the licensee's procedures. The complement of licensed personnel on each shift met or exceeded the minimum required by TS. Direct observations were conducted of control room panels, instrumentation and recorder traces important to safety. Operating parameters were verified to be within TS limits. The inspectors also reviewed DCs to determine whether the licensee was appropriately documenting problems and implementing corrective actions.

Plant tours were taken during the reporting period on a routine basis. They included, but were not limited to the turbine building, the auxiliary building, electrical equipment rooms, cable spreading rooms, NSCW towers, DG buildings, AFW buildings, and the low voltage switchyard.

During plant tours, housekeeping, security, equipment status and radiation control practices were observed. The inspector identified housekeeping discrepancies at the hydrogen storage area and the Unit 1 and 2 Condenser Air Ejector Radiation Monitor skids. The inspector identified an unsecured gas cylinder and an improperly grounded hydrogen tube trailer in the hydrogen storage area and miscellaneous debris in the radiation monitor skids. The inspector informed control room and Chemistry personnel and these discrepancies were corrected.

b. Unit 1 Summary

The unit operated at 100% power throughout the inspection period.

c. Unit 2 Summary

The unit began the period at 100% power. Power was decreased to 95% on March 29, to perform maintenance on low pressure feedwater heater instrumentation. On March 31, power was returned to 100%. On April 5, power was again decreased to 95% for further feedwater heater instrumentation work, and 100% power was resumed on

April 6. On April 14, power was reduced to 90% to allow repairs to a packing leak on the manual bypass valve around the 2A HDP drain tank normal level control valve. Following completion of the valve repair, the unit was returned to 100% power where it remained through the remainder of the reporting period.

d. Review of Overtime Administration

During this inspection period the inspector reviewed the licensee's administration of overtime in the areas of operations, maintenance, health physics, radiological waste, and chemistry. This review encompassed the last two refueling outages, 1R4 and 2R3, which occurred in the spring and fall of 1993 respectively. The inspector used the guidance provided in T.S. 6.2.2.e, Plant Staff, and Procedure 00005-C, Overtime Authorization, in conducting this review. The inspector noted that maintenance worked the greatest amount of OT during each of the last two outages, followed by operations, health physics, radiological waste, and chemistry. Also noted was that each group worked a higher weekly average of OT during refueling outage 2R3 than during the refueling outage 1R4. Examples of this are: maintenance worked approximately 6026 hrs/week during 1R4 versus 7144 hrs/week during 2R3, and operations worked approximately 1143 hrs/week during 1R4 versus 1475 hrs/week during 2R3.

The inspector reviewed the process by which OT in excess of TS guidelines was approved and reviewed, and the documentation of that approval and review. The inspector concluded that, although there was a large amount of OT worked during the last two refueling outages, the licensee appropriately approved, reviewed, and controlled OT according to TS and procedural guidance. The inspector did not identify any concerns with regard to the licensee's administration of overtime.

e. Operation with Failed Fuel

During this inspection period, the inspector reviewed the licensee's analysis of reactor coolant chemistry data for the current fuel cycles for both units. The results of the analysis concluded that each unit is operating with one failed fuel rod.

The first indication of leaking fuel for Unit 1 occurred on November 27, 1993, when elevated Xe-133 concentrations were detected in RCS samples. Following a unit shutdown on February 2, elevated Xe-133 and iodine spiking confirmed that fuel was leaking. The licensee concluded that one fuel rod was leaking and that the failure was a tight defect. A tight defect is a small crack or pin hole through the fuel cladding of the fuel rod that releases fission products after relatively large power changes, due to the increase of internal fuel rod gas pressure. The licensee estimated that the failed rod is located in a second or third burned assembly. There are a total of 109 second and third

burned assemblies in the Unit 1 core. During the next Unit 1 refueling outage, 16 of these assemblies are planned to be reloaded. The licensee is evaluating fuel sipping and core reload redesign to ensure that the leaking fuel assembly is not reloaded.

Reactor coolant chemistry data for Unit 2 indicated that a fuel leak began on November 19. The data indicated that the leaking rod has a tight defect and that the rod is located in a second or third burned assembly. None of these assemblies are planned to be reloaded during the next Unit 2 refueling outage.

The licensee developed a standing order to provide guidance for Unit 1 and 2 operation with fuel defects. The inspector reviewed the standing order and observed that the rate of reactor power increases are restricted above 20% power to minimize the potential for increasing the existing failures. The standing order also provides instructions for obtaining additional RCS samples following power reductions.

The inspector did not identify any concerns during this review of the licensee's actions in response to recent fuel failures.

f. Control Room Enhancements

During this inspection period, the licensee began efforts to enhance the main control room by replacing desktops, carpeting, and furniture. The licensee also began replacement of approximately 16 chart recorders per unit. Historically, the chart recorders in the control room required significant licensee efforts to maintain operability. The new chart recorders are expected to require less maintenance to keep operable. By the end of the inspection period this effort was largely completed.

The inspector noted that the enhancements improved the SRO and RO workstations and improved the reliability and level of information available from control room chart recorders.

No violations or deviations were identified.

3. Surveillance Observation (61726)

Surveillance tests were reviewed by the inspectors to verify procedural and performance adequacy. The completed tests reviewed were examined for necessary test prerequisites, instructions, acceptance criteria, technical content, data collection, independent verification where required, handling of deficiencies noted, and review of completed work. The tests witnessed, in whole or in part, were inspected to determine that approved procedures were available, equipment was calibrated,

prerequisites were met. tests were conducted according to procedure, test results were acceptable and systems restoration was completed.

<u>SURVEILLANCE NO.</u>	<u>TITLE</u>
28820-1	Battery Charger Load Test 1ADC1A
14701-1	Reactor Trip Breakers UV and Shunt Trip Test.
24665-1	Condenser Air Ejector Radiogas Flow 1F12839 ACOT and Channel Calibration
14545-1	Motor Driven Auxiliary FeedWater Pump Monthly Operability Test - A Train
14410-2	Control Rod Operability Test
13502-2	Control Rod Drive and Position Indication System

The inspectors did not identify any problems or concerns during the observation of these surveillance activities.

No violations or deviations were identified.

4. Maintenance Observation (62703)

a. General

Maintenance activities were observed and/or reviewed during the reporting period to verify that work was conducted in accordance with approved procedures, TSs, and applicable industry codes and standards. Activities, procedures, and work orders were examined to verify proper authorization to begin work, provisions for fire, cleanliness, and exposure control, proper return of equipment to service, and that limiting conditions for operation were met.

The inspectors witnessed or reviewed the following maintenance activities:

<u>MWO NOS.</u>	<u>WORK DESCRIPTION</u>
19401681	Troubleshoot 1BA03 Bus Negative Phase Sequence Relay
29303696	Apparent Ground on 125 VDC Bus 2BD1
29400910	Replace 4-way valve on Loop 1 MFIV - 2HV 5227

29400607	Feedwater Heater Instrumentation Verification - 1C Heater
29401043	Suspect Air Inleakage into 2A ESF Chiller

The inspectors did not identify any problems or concerns during the observation of these maintenance activities.

b. Review of MFIV Four Way Hydraulic Valve Failures

On October 29, 1992, Anchor/Darling Valve Company notified GPC of a potential defect (Part 21) in the hydraulic four-way valves supplied with Vogtle MFIVs. That Part 21 notification was reviewed by the inspectors and documented in NRC IR 50-424, 425/93-02. Since the inspector's initial review, there have been two failures of MFIV four-way valves at Vogtle. In both cases, the failed valve was replaced with the unit on-line and the MFIV fully open. Because of these two failures, the inspectors have reviewed the current status of MFIV four-way valves. Each MFIV has redundant hydraulic closure trains with two four-way valves in each closure train, and either train is capable of closing the MFIV.

The first inservice four-way valve failure occurred on December 2, 1993 on Unit 2 MFIV 2HV-5227. One of the four four-way valves was leaking and had shifted position, allowing the contents of the hydraulic accumulator to dump to the hydraulic fluid reservoir. The failed valve had a serial number of 1600. Although the Part 21 applicability was limited to four-way valves with pre-1600 serial numbers, this failure appeared to parallel the symptoms addressed in the Part 21. The failed four-way valve was returned to Anchor/Darling for evaluation. Anchor/Darling determined that the failure was unrelated to the problem described in the Part 21. The root cause of the failure was believed to be overpressurization of the valve body case due to improper isolation of the drain port during testing at the Anchor/Darling facility prior to shipment to Vogtle. Following the overpressurization at Anchor/Darling, which occurred in 1993, the Anchor/Darling test facility was modified to prevent recurrence of the problem. Because this failure has been the only reported inservice failure of this type attributed to the test process, Anchor/Darling did not believe that the failure represented a generic problem.

On December 29, 1993, another four-way valve, serial number 1606, which was known to be functioning correctly, was removed from MFIV 2HV-5227 for evaluation to determine whether the valve failure on December 2 was an isolated case, or if the Part 21 needed to be expanded. The licensee determined from on-site testing that several of the valve bores were outside the vendor's specifications and seemed to exhibit the characteristics of those valves described in the Part 21. The licensee then shipped the

valve to Anchor-Darling for evaluation. Anchor-Darling determined that the valve body bores were out of tolerance but that there was no evidence of gross distortion as described in the Part 21.

The second inservice four-way valve failure occurred on March 25, 1994. Again the failure occurred on MFIV 2HV-5227, but this failure was on a series 1606 four-way valve. The licensee plans to return the failed valve to the vendor for failure analysis. The vendor will then decide what actions should be taken regarding a revision to the original Part 21. The inspectors will continue to monitor the licensee's evaluation and corrective actions regarding MFIV 4-way valve failures.

c. Falsification of Battery Maintenance Data Sheet

On April 3, 1994, at approximately 4:00 a.m., an electrician was dispatched to the on-site nuclear warehouse to take voltage readings, per Procedure 27915-C, General Battery Maintenance, on a spare 1E train "D" battery cell which was on an equalize charge. The battery cell was being maintained in a standby condition for use in the plant should an in-service battery cell fail. Step 4.5.4.5 of Procedure 27915-C directs that the "equalize" potentiometer on the front of the single cell charger be adjusted to 2.39 to 2.41 volts. Step 4.5.4.6 then directs that the "as-left" voltage be recorded on the procedure data sheet. The electrician recorded the "as-found" and "as-left" voltages as 2.54 on the data sheet. Again at 8:00 a.m. on April 3, the same electrician took voltage readings on the same battery and again logged the "as-found" and "as-left" voltages as 2.54. At 9:00 a.m. a second electrician took the voltage readings and also confirmed them to be 2.54 volts. He recognized the voltage discrepancy and initiated action to troubleshoot the problem. The deficient condition was subsequently identified as a disconnected negative sensing lead. The disconnected lead was repaired and the voltage was adjusted to 2.41 volts.

Four days later, on April 7, another electrician, during a review of the MWO package associated with this battery equalize evolution, noted the out-of-tolerance voltage readings for April 3 and advised his supervisor. Later that morning on April 7, the electrician, who recorded the April 3 values, was shown the MWO package containing the out-of-tolerance readings, and while the MWO package was in his possession, he lined-out the out-of-tolerance reading of 2.54 volts, inserted the value of 2.41 volts, and dated his correction as April 3. Subsequent licensee interviews with the electrician indicated that he was aware that the voltages exceeded the procedural guidance and that he knowingly took no action to correct the condition or to inform his supervisor.

The inspector reviewed the MWO and procedure related to this event and discussed the event with Maintenance management. The

inspector concluded that there was no safety significance to this event since the battery cell was not installed in plant equipment and was in a standby condition in the warehouse. The inspector further concluded that the electrician involved initially failed to follow procedure when he failed to take action to correct a voltage reading which was out-of-tolerance. His reading of 2.54 volts was subsequently confirmed to be correct by a second electrician who did take action to correct the discrepancy. The significance of this event occurred on April 7, when the first electrician willfully altered his April 3 data sheet entry to reflect an acceptable voltage reading of 2.41 volts.

This falsification of data event was brought to the inspector's attention by licensee management. Upon discovery of the falsification by the licensee, plant access for the involved electrician was revoked and disciplinary action was taken. The inspector noted that the licensee took prompt corrective actions. Based on this review the inspector considered this to be an isolated event. This item is identified as Unresolved Item 50-424,425/94-09-01, Falsification of Battery Maintenance Data Sheet, pending further NRC management review.

d. Review of Increased Reactor Coolant Pump Vibration Indications

Since the start-up of Unit 2, following refueling outage 2R3 in October 1993, RCP 2 on Unit 2 (RCP 2-2) has experienced relatively high vibration compared to the other Unit 2 RCPs. Vibration measured at the pump shaft of RCP 2-2 has been fairly stable at 10 to 12 mils which compares to pump shaft vibration levels of 2 to 7 mils for the other RCPs.

The inspector reviewed vibration trend data and the licensee's evaluation and investigation of the RCP 2-2 vibration issue with maintenance engineering and Westinghouse personnel. The current RCP 2-2 pump shaft vibration remains satisfactory and continues to operate below the alert levels specified by the pump vendor instruction manual. The vendor instruction manual specifies an alert level of 15 mils and recommends initiating a root cause investigation at this level. Although vibration has not reached the alert level, the licensee has initiated increased monitoring, contacted the pump vendor, and initiated an investigation of the cause.

The licensee's corporate engineering staff and an industry pump vibration consultant have concluded that the most likely causes of the increased vibration may be due to a pump balancing issue or due to the pump operating near its critical speed. The pump vendor initially suspected that the pump impeller was wobbling due to slipping at the shaft keyway. The licensee disagreed with this conclusion based on pump testing data that was obtained on January 19, 1994, when the unit was shutdown. Based on a review of this data, the licensee determined that the impeller was not loose on

the shaft. The licensee is evaluating performing additional pump testing during the next refueling outage, and continues to monitor vibration data to determine which of these suspected causes is the most valid.

The inspector reviewed operating guidance for operators given in annunciator response procedures and the RCP operating procedure. The inspector verified that these procedures require the RCPs to be shutdown when the pump shaft vibration reaches 20 mils, which was consistent with vendor manual instructions.

The inspector observed maintenance engineering personnel perform weekly vibration measurement readings with digital acquisition equipment. The inspector also noted that the onsite vendor representative frequently monitors RCP vibration levels.

The inspector reviewed the balance history for each of Unit 2 RCPs, and noted that RCP 2-1 operates with no balance weights; RCP 2-2 operates with 2467 grams of balance weight distributed among coupling bolts 3,4,5 and 6; RCP 2-3 operates with 1266 grams of weight distributed on bolts 7 and 9; and RCP 2-4 operates with 529 grams of weight distributed on bolts 10 and 11.

The inspector determined that the licensee's efforts to monitor the vibration trend and to investigate the cause of the vibration are adequate. The inspector also observed that the licensee has consulted an industry pump vibration expert and the pump vendor to supplement corporate SCS engineering evaluation of the problem.

One Unresolved item was identified.

5. Follow-up (90712) (92700) (92702)

The Licensee Event Reports and violation listed below were reviewed to determine if the information provided met NRC requirements. The determination included: adequacy of description, verification of TS compliance and regulatory requirements, corrective action taken, existence of potential generic problems, reporting requirements satisfied, and relative safety significance of each event.

a. (Closed) LER 50-425/94-003, Personnel Error Results in Improper Temperature Readings.

The cause of this event was personnel error by a PEO when he failed to measure the temperature in room A008. He mistakenly measured the temperature in two different areas of room A009, rather than take separate measurements in rooms A009 and A008. The PEO was coached and reminded of the importance of attention to detail. Other appropriate personnel were advised of this event during shift briefings and the event will be addressed in operations continuing training.

Based upon the licensee's corrective actions, this item is considered closed.

- b. (Closed) LER 50-424/93-012. Failure to Perform Testing Results in Missed Technical Specification Surveillance.

The inspectors determined in NRC IR 50-424, 425/93-23, that this event was an isolated personnel error by the supervisor that authorized, reviewed and approved the completed test. The inspector verified, by reviewing Operations Reading Book sign off sheets, that all control room operations shifts had reviewed this LER. The inspector also verified that each shift also received a briefing that provided direction to identify and verify the correct train and component to ensure that the surveillance being performed is the surveillance that is specified. The inspector reviewed attendance sheets and sign off sheets for Maintenance and Health Physics/Chemistry Personnel and verified that these departments had reviewed this LER as part of continuing training.

Based on this review of completed corrective actions, this item is closed.

- c. (Closed) VIO 50-424/92-02-02, 10 CFR 50.9 Violation For Failure To Follow Procedure and Subsequent Creation of Data.

This violation was the second of two violations related to the same event. The first violation, 50-424/92-02-01, was closed in IR 50-424, 425/93-21. Because violation 92-02-02 was adequately addressed when violation 92-02-01 was closed, violation 92-02-02 is also considered closed.

No violations or deviations were identified.

6. Exit Meeting

The inspection scope and findings were summarized on April 22, 1994, with those persons indicated in paragraph 1. The inspector described the areas inspected and discussed in detail the inspection findings. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during the inspection.

<u>Item No.</u>	<u>Description and Reference</u>
URI 50-424,425/94-09-01	Falsification of Battery Maintenance Data Sheet

8. Abbreviations

ACOT	- Analog Channel Operational Test
AFW	- Auxiliary Feedwater System
CFR	- Code of Federal Regulations
DC	- Deficiency Card
DG	- Diesel Generator
ESF	- Engineered Safety Feature
GPC	- Georgia Power Company
HDP	- Heater Drain Pump
HP	- Health Physics
hrs	- Hours
I&C	- Instrumentation and Controls
IFI	- Inspector Followup Item
IR	- Inspection Report
ISEG	- Independent Safety Engineering Group
IST	- Inservice Test
LCO	- Limiting Condition for Operation
LER	- Licensee Event Report
MFIV	- Main Feedwater Isolation Valve
MWO	- Maintenance Work Order
NRC	- Nuclear Regulatory Commission
NPF	- Nuclear Power Facility
NSCW	- Nuclear Service Cooling Water System
OT	- Overtime
PEO	- Plant Equipment Operator
RCP	- Reactor Coolant Pump
RCS	- Reactor Coolant System
RO	- Reactor Operator
SAER	- Safety Audit and Engineering Review Group
SCS	- Southern Company Services
SNC	- Southern Nuclear Company
SRO	- Senior Reactor Operator
TS	- Technical Specifications
URI	- Unresolved Item
UV	- Undervoltage
VDC	- Volts direct current
VIO	- Violation
Xe	- Xenon
1R4	- Unit 1 Fourth Refueling Outage
2R3	- Unit 2 Third Refueling Outage

January 10, 1996

Georgia Power Company
ATTN: Mr. C. K. McCoy
Vice President
Vogtle Electric Generating Plant
P. O. Box 1295
Birmingham, AL 35201

SUBJECT: NRC INSPECTION REPORT NOS. 50-424/95-28 AND 50-425/95-28 AND
NOTICE OF VIOLATION

Dear Mr. McCoy:

This refers to the inspection conducted on November 19, 1995 through December 16, 1995 at the Vogtle facility. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

Based on the results of this inspection, the NRC has determined that violations of NRC requirements occurred. These violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the subject inspection report. We are particularly troubled by the violation involving the unsecured designated vehicle in the protected area. This is the fourth time in the last 15 months that you have been cited for similar incidents. Individually, these incidents have been of limited safety significance. However, collectively they represent a failure of licensee management to effectively address a straightforward violation of regulatory requirements.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC

~~50-424/95-28~~ 3PP

Enclosure 2

Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary or safeguards information so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96.511.

Sincerely,

Original signed by
P.H. Skinner
Pierce H. Skinner
Reactor Projects Branch 2
Division of Reactor Projects

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

Enclosures: Notice of Violation
Inspection Report

cc w/encls:
J. D. Woodard
Senior Vice President
Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

J. B. Beasley
General Manager, Plant Vogtle
Georgia Power Company
P. O. Box 1600
Waynesboro, GA 30830

J. A. Bailey
Manager-Licensing
Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

Nancy G. Cowles, Counsel
Office of the Consumer's
Utility Council
84 Peachtree Street, NW, Suite 201
Atlanta, GA 30303-2318

Office of Planning and Budget
Room 615B
270 Washington Street, SW
Atlanta, GA 30334

cc w/encls: (See page 3)

cc w/encls: (Continued)
Office of the County Commissioner
Burke County Commission
Waynesboro, GA 30830

Harold Reheis, Director
Department of Natural Resources
205 Butler Street, SE, Suite 1252
Atlanta, GA 30334

Thomas Hill, Manager
Radioactive Materials Program
Department of Natural Resources
4244 International Parkway
Suite 114
Atlanta, GA 30354

Attorney General
Law Department
132 Judicial Building
Atlanta, GA 30334

Thomas P. Mozingo
Manager of Nuclear Operations
Oglethorpe Power Corporation
2100 E. Exchange Place
Tucker, GA 30085-1349

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Paul, Hastings, Janofsky & Walker
10th Floor
1299 Pennsylvania Avenue
Washington, D. C. 20004-9500

Distribution: (See page 4)

ENCLOSURE 1

NOTICE OF VIOLATION

Georgia Power Company
Vogtle Unit 1 and 2

Docket No. 50-424, 50-425
License No. NPF-68, NPF-81

During the NRC inspection conducted on November 19 through December 16, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violations are listed below.

- A. 10 CFR 50, Appendix B, Criterion VIII, Identification and Control of Materials, Parts, and Components, requires that the traceability of materials installed in safety related components be maintained.

Vogtle Electric Generating Plant Operations Quality Assurance Manual, Section 8.2, Identification and Control of Materials, Parts, and Components; Specific Requirements, requires that measures be established to assure that these materials can be traced to associated documentation such as drawings, specifications, purchase orders, deviation reports, or physical and chemical mill tests.

To accomplish this, Procedure 00262-C, Control of Chemicals/ Fluids, requires that portable/secondary oil containers be annotated with an issue authorization number or material/equipment request number when oil is transferred from the original container.

Contrary to the above, on November 29, 1995, the licensee failed to transfer the issue authorization or material/equipment request number to secondary oil containers stored in the predictive oil laboratory. This oil is added to safety related equipment to replenish oil removed by sampling.

This is a Severity Level IV Violation (Supplement 1).

- B. License Condition 2(E) to License Number NPF-68 issued March 16, 1987 and License Number NPF-81 issued March 31, 1989, requires the licensee fully implement all provisions of the NRC approved "Alvin W. Vogtle Nuclear Plant Physical Security Plan."

Paragraph 5.4.2.4 of the Physical Security Plan requires that designated vehicles inside the protected area not attended by an individual with unescorted access or a security officer as appropriate be secured to prevent movement. Possession of the keys by the authorized individual or security officer or physical restraint of the vehicle accomplishes this objective.

Procedure 00653-C, Protected Area Entry/Exit Control, Step 4.4.8 states that when a designated vehicle is left unattended in the

protected area, the keys shall be kept by an authorized individual.

Contrary to the above, on December 11, 1995, an unattended designated vehicle was identified inside the protected area, with the keys in the ignition and the engine running.

This is a Severity Level IV violation (Supplement III).

Pursuant to the provisions of 10 CFR 2.201, Georgia Power Company is hereby required to submit a written statement of explanation to the U. S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D. C. 20555, with a copy to the Regional Administrator, Region II, and a copy to the NRC Resident Inspector Vogtle Nuclear Plant, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Security or Safeguards Information should be submitted as an enclosure to facilitate withholding it from public disclosure as required by 10 C/F/R 2.790(d) or 10 CFR 73.21.

Dated at Atlanta, Georgia
this 10th day of January 1996



UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W., SUITE 2900
 ATLANTA, GEORGIA 30323-0199

Report Nos.: 50-424/95-28 and 50-425/95-28

Licensee: Georgia Power Company
 P. O. Box 1295
 Birmingham, AL 35201

Docket Nos.: 50-424 and 50-425

License Nos.: NPF-68 and NPF-81

Facility Name: Vogtle 1 and 2

Inspection Conducted: November 19 through December 16, 1995

Inspector: For R. W. Wright 1/10/96
 C. R. Ogle, Senior Resident Inspector Date Signed

For R. W. Wright 1/10/96
 P. C. Hopkins, Resident Inspector Date Signed

For R. W. Wright 1/10/96
 M. T. Widmann, Resident Inspector Date Signed

Approved by: P. H. Skinner 1/10/96
 P. H. Skinner, Chief Date Signed
 Reactor Projects Branch 2
 Division of Reactor Projects

SUMMARY

Scope: This routine inspection entailed inspection in the following areas: plant operations, surveillance, maintenance, onsite engineering, plant support, and follow-up. Backshift inspections were performed on November 20, 24, 26, and 28-30, 1995; and on December 1, 6-7, 9-10, and 12, 1995.

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Results:

Operations:

- In general, the performance in the operations area was satisfactory.
- A deficiency was identified in the establishment of a clearance for maintenance on a radiation monitor. As a result of an inadequate review by clearance and tagging personnel, an inadvertent vent path from containment was established. (paragraph 2.d)

Maintenance:

- The overall performance in the maintenance area was satisfactory.
- A violation was identified in the licensee's control of oil stored in the predictive maintenance laboratory. The observed practice did not maintain traceability of the oil as specified in the licensee's procedures. (paragraph 4.b)
- The licensee identified a missed functional test on the Unit 1 hydrogen recombiners. This is identified as an unresolved item pending a review of the licensee's corrective actions. (paragraph 4.c)
- A strength was noted in the licensee's efforts in controlling maintenance work backlog. During this period, the non-outage corrective maintenance work order backlog was reduced to less than 100 items. (paragraph 4.d)

Engineering:

- The general performance in the engineering area was satisfactory.
- A deficiency was identified in the licensee's implementation of a design change package for the spent fuel pool filters. The review process for this design change was inadequate in that it failed to recognize that an interlock existed between the nitrogen system and the filter system. (paragraph 5.b)
- A non-cited violation was identified regarding licensee identification of non-conservatively established OPΔT setpoints. (paragraph 7.a)

Plant Support:

- The general performance in the plant support area was satisfactory.
- A violation involving an unattended designated vehicle left with the engine running in the protected area was identified. This occurrence was similar to three previous violations identified in Inspection Reports 94-22, 95-06, and 95-24. (paragraph 6.b)
- The inspectors identified a non-cited violation involving two examples of failures to properly label radioactive materials. (paragraph 6.c)
- A non-cited violation was issued for two examples of improperly controlled transient combustibles. (paragraph 6.d)
- The conduct of a recall drill involving a simulated Alert declaration was good. However, a delay in the notification of State and local authorities occurred. (paragraph 6.e)

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *J. Beasley, General Manager Nuclear Plant
- S. Bradley, Reactor Engineering Supervisor
- *W. Burmeister, Manager Engineering Support
- *C. Christiansen, SAER Supervisor
- *R. Dorman, Manager Training and Emergency Preparedness
- J. Gasser, Assistant General Manager Plant Operations
- M. Griffis, Manager Plant Modifications & Maintenance Support
- *K. Holmes, Manager Maintenance
- *D. Huyck, Manager Nuclear Security
- W. Kitchens, Assistant General Manager Plant Support
- I. Kochery, Health Physics Superintendent
- *P. Kochery, Engineering Supervisor Plant Modifications
- *M. Kurtzman, Supervisor HP/Chemistry Training
- R. LeGrand, Manager Health Physics and Chemistry
- *R. Odom, Assistant Performance Team Manager Maintenance
- T. Parton, Health Physics Superintendent
- *T. Polito, Outage Scheduling Supervisor
- *A. Rickman, Senior Engineer, ISEG
- P. Rushton, Manager Operations
- *M. Sheibani, Nuclear Safety and Compliance Supervisor
- M. Slivka, ISEG Supervisor
- *C. Stinespring, Manager Plant Administration
- J. Swartzwelder, Manager Outage and Planning
- *C. Tippins, Nuclear Specialist, NSAC
- R. Waters, Material Supervisor, Plant Administration
- *T. Webb, Senior Engineer, NSAC

Other licensee employees contacted included technicians, supervisors, engineers, operators, maintenance personnel, quality control inspectors, and office personnel.

Oglethorpe Power Company Representative

J. Sharpe, Site Representative

NRC Inspectors

- *C. Ogle, Senior Resident Inspector
- P. Hopkins, Resident Inspector
- *M. Widmann, Resident Inspector
- *P. Skinner, Branch Chief, Region II

*Attended Exit Interview

An alphabetical list of abbreviations and acronyms is located in the last paragraph of the inspection report.

2. Plant Operations (71707)

a. General

The inspection staff reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, TSs, and administrative controls. Control logs, shift supervisors' logs, shift relief records, LCO status logs, night orders, standing orders, and clearance logs were routinely reviewed. Discussions were conducted with plant operations, maintenance, chemistry, health physics, engineering support and technical support personnel. Daily plant status meetings were routinely attended.

Activities within the control room were monitored during shifts and shift changes. Actions observed were conducted as required by the licensee's procedures. The complement of licensed personnel on each shift met or exceeded the minimum required by TS. Direct observations were conducted of control room panels, instrumentation, and recorder traces important to safety. Operating parameters were verified to be within TS limits.

Plant tours were taken during the reporting period on a routine basis. They included, but were not limited to the auxiliary building, control building, electrical equipment rooms, cable spreading rooms, NSCW towers, DG buildings, AFW buildings, MSIV rooms, turbine building and the low voltage switchyard. During plant tours, housekeeping and equipment status were observed.

b. Unit 1 Summary

The unit operated at full power until November 27, when reactor power was reduced to 98% to support moderator temperature coefficient testing. The unit returned to full power later that day. Reactor power was again reduced on December 14, to 98.5% power to conduct maintenance on the level control valve on the sixth stage feedwater heater. Reactor power was returned to full power on December 14 and remained there throughout the rest of the inspection period.

c. Unit 2 Summary

The unit operated at full power until December 2, when power was reduced to 63% to repair a TPCW leak on the isophase bus duct cooler. The unit returned to full power on December 3. On December 15, reactor power was reduced to 98.5% to allow maintenance on the level control valve for the sixth stage feedwater heater. Reactor power was returned to full power later that day and remained there throughout the inspection period.

d. Inadequate Review of Clearance for Maintenance Work

On November 20, 1995, radiation monitor, 2RE-2562, was removed from service for maintenance. A clearance was issued and work authorized to remove and replace the sample pump. When the pump was disconnected from the piping flanges maintenance personnel detected gas escaping from the sample lines. Investigation by operations and maintenance personnel identified that a flowpath had been established from inside to outside containment through the one-inch radiation monitor sample piping. No isolation valves were closed as part of the issued clearance. As a result, the licensee inadvertently entered TS 3.6.1.1., Containment Integrity. Within 1-hour, operators closed the automatic containment isolation valves from the control room isolating the leakage path and thereby exiting the TS action statement.

The inspectors reviewed the associated MWO; the initial and modified clearance boundaries; procedures 00304-C, Equipment Clearance and Tagging, and 29402-C, Work Planning Group Work Request Processing; the DC generated in response to the event; and maintenance personnel statements. The inspectors interviewed appropriate maintenance, operations, and management personnel regarding the licensee's investigation into this issue. Maintenance work package, 29502727, was developed to replace a potentially defective sample pump for 2RE-2562. On November 19, operations prepared and installed clearance 29500543 to isolate the feeder breaker to the sample pump motor. The inspectors were informed during operations interviews that this clearance was initially prepared to de-energize the sample pump motor. However, when maintenance workers sought authorization to commence work on November 20, the scope of work identified on the MWO was to remove and replace the pump. The clearance and tagging supervisor stated that he did not closely review the MWO because he believed he understood the scope of work to be accomplished. The maintenance was authorized and the sample pump was subsequently removed. When the pump was physically removed from the sample system, the inadvertent flowpath from inside to outside containment was established.

Procedure 00304-C, requires that the USS or SSS review the impact of clearances on plant operations and maintain configuration control. The inspectors concluded that an inadequate review of clearance 29500543 was performed by the clearance and tagging supervisor on November 20 for MWO 29502727. This was contrary to the requirements of VEGP 00304-C. However, since the sample pump unit is not safety related, this failure will not be cited, but is identified as a deficiency.

The licensee attributed the failure to adequately establish the clearance for the actual scope of work to cognitive personnel error. Based on their independent inspection effort, the inspectors concurred with the licensee's determination. The

licensee's planned corrective actions include a review of the work package and clearance development approval process and the process of assigning clearances to work orders based on scope of work.

The inspectors observed that although containment integrity was not maintained, the automatic containment isolation valves were operable and would have acted to isolate the flow path if actuated. Furthermore, a review of chemistry permits revealed that a containment sample permit was active and the plant vent radiation monitors were operable at the time the containment vent path was established. Hence, no unmonitored release occurred. In addition, the safety significance was somewhat mitigated due to the relatively minor size of the opening created from inside to outside containment through the one-inch radiation monitor sample pump piping.

No violations or deviations were identified.

3. Surveillance Observation (61726)

General

Surveillance tests were reviewed by the inspectors to verify procedural and performance adequacy. The completed tests were examined for necessary test prerequisites, instructions, acceptance criteria, technical content, data collection, independent verification where required, handling of deficiencies, and review of completed work. The tests witnessed, in whole or in part, were inspected to determine that approved procedures were available, equipment was calibrated, prerequisites were met, tests were conducted according to procedure, test results were acceptable, and system restoration was completed.

The inspectors witnessed or reviewed the following surveillance activities:

<u>SURVEILLANCE NO.</u>	<u>TITLE</u>
14400-1	Control Room Emergency Filtration Actuation Logic Test Train B
14410-1	Control Rod Operability Test
14510-1	Control Room Emergency Filtration System Operability Test
14616-1	SSPS Slave Relay K609 Train A Test Safety Injection
88009-C	Moderator Temperature Coefficient Determination

The inspectors did not identify any problems or concerns during the observation of these surveillance activities.

No violations or deviations were identified.

4. Maintenance Observation (62703)

a. General

Maintenance activities were observed or reviewed during the reporting period to verify that work was conducted in accordance with approved procedures, TSs, and applicable industry codes and standards. Activities, procedures, and work orders were examined to verify proper authorization to begin work, fire hazard provisions, cleanliness, and exposure controls, proper return of equipment to service, and adherence to limiting conditions for operation were met.

The inspectors witnessed or reviewed the following maintenance activities:

<u>MWO NOS.</u>	<u>WORK DESCRIPTION</u>
19500063	MSIV 1HV-3006A Hydraulic Pump Cycling
19502419	DG 1B Fuel Oil Transfer Pump No. 3 and Strainer PM
19503162	MSIV 1HV-3006A Air Regulator Replacement
29502203	CREFS Train B 18 Month PM; Clean/Inspect
29502746	Auxiliary Building Exhaust Fan No. 2 PM

The inspectors did not identify any problems or concerns during the observation of these maintenance activities.

b. Oil Traceability

On November 28, 1995, the inspectors witnessed collection of an oil sample from the turbine for the Unit 2 TDAFW pump. The inspectors questioned the traceability of the replacement oil. The inspectors were advised that an incorrect oil had been added to the turbine. The licensee stated that based on consultation with the responsible vendors, the inadvertent substitution did not impact the operability of the turbine. Technical documentation to support this position was provided by the licensee. On November 29, 1995, the licensee reversed their position, and informed the inspectors that the required oil had been added to the turbine. This revised position was based on statements of the individual who filled the 1-quart oil bottles used to add oil to the turbine lube oil system. This individual recalled filling the bottles with the correct oil, but for one bottle in particular, failed to remove a MER which remained on the bottle from a prior use. (This incorrect MER had led the licensee to question the bottle

contents.) On December 14, 1995, the inspectors were also informed that a chemical analysis performed on residual oil in the bottle confirmed that the correct oil was in the bottle.

As a result of this issue, the inspectors reviewed licensee procedures for the control of lubricants; material identification, control, and issue; and oil sampling. The inspectors also interviewed several individuals involved in the oil sampling program. The inspectors, in addition, witnessed the issue of a container of oil from the warehouse and conducted an inspection of two satellite oil storage areas within the protected area. The inspectors concluded that it is likely that the correct oil was added to the turbine.

During the review by the inspectors two deficiencies with the licensee's control of oil were identified. First, the general condition of the satellite oil storage area in the maintenance building (not the source of the oil for the TDAFW) was markedly below the licensee's usually high standards for cleanliness and housekeeping. Licensee management was informed of this observation. During a tour of this area after the end of the inspection period, the inspectors noted improved levels of cleanliness and housekeeping. Second, the inspectors noted that quart and 4-ounce bottles containing replacement oil stored in the predictive oil lab, were not marked pursuant to licensee procedures so as to maintain the traceability of the oil. Each bottle examined by the inspectors was marked as to the manufacturer's designation but was not labelled as to MER or issue authorization number. The inspectors were informed that the customary practice is to fill these small bottles from containers annotated with a MER. However, the MER is not transferred to the smaller bottles and hence traceability was not maintained. The small bottles are used at a job site to replenish oil removed from equipment by sampling.

Appendix B, Criterion VIII, Identification and Control of Material, Parts, and Components and the licensee's Quality Assurance Policy Manual require that traceability be maintained for components installed in safety related applications. No single site procedure implements all the measures by which this is accomplished. Procedures 00853-C, Material Identification, Control, and Issue; 00262-C, Control of Chemicals/Fluids; and 20411-C, Control of Lubricants, establish requirements to ensure that the necessary traceability is maintained. The inspectors noted that procedure 00262-C specifically requires an Approved Use Category Label annotated with an issue authorization number or MER be affixed to secondary chemical containers. The inspectors concluded that this represents a critical step in maintaining traceability.

The inspectors observed that the oil control practices in the predictive oil lab, did not meet the requirements of procedure 00262-C. This is identified as VIO 50-424,425/95-28-01, Oil Control Practices Contrary To Plant Procedures.

c. Unit 1 Hydrogen Recombiners Missed Functional Test

During licensee QA audit OP09-95/20, it was identified that TS surveillance 14970, Hydrogen Recombiners Functional Test, was not performed prior to Mode 2 entry as required by TS 4.6.4.2, Electric Hydrogen Recombiners, on October 15, 1994.

MWO 19303168 and 19303169 replaced heater cables for Trains A and B hydrogen recombiners during the Unit 1 refueling outage in September 1994. The maintenance was performed to upgrade the cable originally installed in the recombiners. After the cable replacement was performed, surveillance procedure 28835-C, Electric Hydrogen Recombiner Visual and Electrical Checks, was successfully performed on September 25, 1994, for Train A, and on October 1, 1994, for Train B, respectively. This surveillance check consisted of a megger check of power and control cables, as well as, a continuity check of the heater elements. No functional test was performed as part of this surveillance. On October 15, 1994, Unit 1 entered Mode 2. On October 18, 1994, a functional test was performed in accordance with surveillance 14970.

The inspectors reviewed Unit 1 completed surveillances 14970 and 28835-C; Westinghouse letter MED-PCE-13620, Electric Hydrogen Recombiners Heater Wire Change-Out Procedure; heater power and control diagrams; MWOs associated with the heater cable change-out; and DCs generated as a result of the QA audit. The inspectors also interviewed the technician who performed the hydrogen recombiner wiring changes.

From the review, the inspectors concluded that the wiring changes accomplished by MWOs 19303168 and 19303169 were significant enough to require a functional test in accordance with surveillance 14970. The megger and continuity checks performed in accordance with surveillance procedure 28835-C did not provide sufficient assurance of operability given the magnitude of these wiring changes.

A review of Westinghouse's change-out procedure MED-PCE-13620, recommended a functional test to be performed to verify system operability. The letter contained a recommendation to perform a functional test in accordance with applicable sections of the Westinghouse technical manual or existing Vogtle surveillance test procedures. A review of work orders 19303168 and 19303169 identified that no functional test was assigned.

The licensee had not completed their formal review of this issue prior to the end of the inspection period. Pending NRC review of

this effort and any corrective actions, this is identified as URI 50-424/95-28-02, Unit 1 Hydrogen Recombiners Missed Functional Test.

The inspectors reviewed QA audit OP09-95/20 and considered the identification of the missed TS surveillance functional test on the part of the individual auditor to be an excellent finding.

d. Reduction of Non-Outage Corrective Maintenance Work Order Backlog

During the inspection period, the licensee backlog of non-outage corrective work orders was reduced to less than 100. In 1990 this backlog was 983 and in July 1994, the start of the current SALP period, the backlog was 227.

The inspectors noted that this was a significant accomplishment and the result of dedicated licensee efforts focused on reducing the backlog. This is identified as a strength.

One violation and one unresolved item were identified.

5. Onsite Engineering (37551)

a. General

During the inspection period, the inspectors assessed the effectiveness of onsite engineering processes by reviewing engineering evaluations, root cause determinations, modifications, and engineering testing. The inspectors also reviewed DCs to determine whether the licensee was appropriately documenting problems and implementing corrective actions.

b. Oversight of Electrical Interlock During Spent Fuel Pool Filter Design Change Package Review

A design change package to replace the spent fuel pool backflushable filter with a disposable cartridge filter was implemented for Units 1 and 2 during this inspection period. The work included the removal of nitrogen system valving used to backflush the SFP filters. During the post-modification testing, the licensee identified that a portion of an interlock that controls SFP filter inlet and outlet isolation valves, filter vent and drain valves, and the nitrogen system isolation valves was not removed during the DCP work as should have been required by the DCP. The portion of the interlock which was not removed by the DCP, prevented the drain and vent valves on the SFP filter vessel from being opened remotely. However, manual valves to permit draining and venting were available. The other interlocked valves functioned properly.

The inspectors reviewed DCP 94-VAN005, Spent Fuel Pit Backflushable Filter Modification, and applicable drawings. The inspector also interviewed the plant engineer responsible for review of the SFP DCP as well as plant modification and operations management.

The engineering review of the SFP DCP conducted by SCS and PMMS failed to recognize that the interlock existed between the SFP filter system and the backflushable nitrogen system. The licensee attributed the oversight of the interlock to a combination of limited electrical drawings (i.e., vendor schematics and no filter elementary diagrams), and personnel error. The P&IDs associated with the SFP did indicate that an electrical interlock existed between the SFP filter valves and the nitrogen backflushable system. However, the P&ID was not reviewed to develop the electrical wiring modification until after the issue became self-identifying during post-modification testing.

The licensee's corrective actions included a further review of the electrical system schematics, and issuance of a field change request to modify the wiring to resolve the interlock discrepancy.

The inspectors noted that the licensee's post-modification testing program detected the error and prevented the filter from being returned to service. The inspectors also acknowledge that the lack of detailed drawings coupled with the intricacies of the interlock increased the complexities of the design change. Nevertheless, the inspectors concluded that design review process for this DCP was inadequate in that it failed to properly account for the interlock. Since the SFP is not safety related, this inadequacy will not be cited. However, this is identified as a deficiency.

c. Review of Spent Fuel Pool Cooling

Introduction

The inspectors reviewed the adequacy of the original heat load design assumptions for the Spent Fuel Pool System relative to the current operating practice. The inspectors reviewed the FSAR, calculations of SFP Cooling System performance, and historical operating records.

System Description

Each unit has a separate spent fuel pool equipped with racks which provide storage for irradiated spent fuel. Unit 1 has storage locations for 288 assemblies while Unit 2 is equipped with 2098 storage locations. Unit 1 assemblies are transferred to the Unit 2 pool after they have decayed for approximately 15 months in the Unit 1 pool. Each SFP is also provided with two separate redundant cooling loops consisting of a pump, heat exchanger, and

associated piping and valves. A portion of the cooling loop flow can also be diverted through a filter and demineralizer for pool cleanup. The FSAR states that the cooling systems for the two pools are identical.

Design Basis

According to the FSAR, the Unit 2 Spent Fuel Pool Cooling System is evaluated based on the storage of 2098 assemblies. Three different situations for heat removal capability are presented in the FSAR.

Normal refueling - In this case it is assumed that 84 assemblies are transferred to the Unit 2 pool 150 hours after shutdown. This case assumes 2014 assemblies in the pool from earlier core offloads (1006 from Unit 2 and 1008 from Unit 1). With one train of cooling in operation, analysis indicates pool temperature will be maintained below 140°F.

Maximum normal refueling - This case assumes a full core offload of 193 fuel assemblies 120 hours after shutdown. Again 2014 assemblies from previous refuelings are assumed to be in the pool (1006 from Unit 2 and 1008 from Unit 1). With a single train of cooling, the analysis concludes that SFP temperature will be maintained at or below 171.1°F (This analysis conservatively assumes more fuel assemblies than can be stored in the Unit 2 SFP).

Maximum Emergency Core Unload - This case assumes that the entire core is unloaded into the pool 150 hours after shutdown. The pool inventory is assumed to include 84 assemblies from the most recent refueling, with a decay time of 36 days and 1821 assemblies from earlier refuelings (This is assumed to be 897 Unit 2 assemblies and 924 Unit 1 assemblies). With a single train of SFP cooling, the analysis determines that SFP temperature will be maintained below 182°F.

The Unit 1 analyses are similar but use different bounding conditions. The Unit 1 SFP analyses are based on 936 fuel assemblies even though this exceeds the pool loading capacity.

General design - (No special designation for this case is provided in the FSAR.) The general design considers the situation where one-third of the reactor core is unloaded into the SFP 150 hours after shutdown. The SFP inventory is assumed to also contain one-third of a reactor core per year from the annual refueling of the previous 10 years. This is equivalent to eleven-thirds of a core. Using a single train of SFP cooling, the SFP temperature will be maintained below 140°F.

Maximum Normal Refueling - This case is developed assuming a SFP loading of one-third of a core per year for nine years, plus 40 percent of a core from the preceding years refueling, and 40 percent of a core 150 hours after the most recent shutdown. With a single train of SFP cooling, the SFP temperature is analyzed to not exceed 170°F.

Maximum Emergency Core Unload - This case is developed assuming a SFP loading of one-third of a core per year for 10 years and an additional full core loaded into the pool 330 hours after the most recent refueling in which 40 percent of the core was added. With a single train of cooling in operation, the SFP temperature is analyzed to not exceed 170°F.

Refueling Methodology

The inspectors determined based on interviews with plant personnel, that the licensee removes the entire core during refueling. This is also consistent with inspector observations of previous refueling practices. Based on a review of licensee records, the inspectors determined that the licensee has not moved fuel until at least 200 hours after shutdown.

Conclusion

The inspectors concluded that the licensees actual practices for spent fuel movement are bounded by the analyses of the FSAR.

No violations or deviations were identified.

6. Plant Support (71750)

a. General

Plant support activities were observed and reviewed to ensure that licensee programs were implemented in conformance with facility policies and procedures and in compliance with regulatory requirements. Activities reviewed included radiological controls, physical security, emergency preparedness, and fire protection.

b. Designated Vehicle Unsecured Inside the Protected Area

At approximately 8:30 p.m. on December 11, 1995, the licensee's security patrol identified an unattended designated vehicle in the protected area with the keys in the ignition and the engine running. The driver was located and the vehicle was removed from the protected area.

In response to this issue, the inspectors reviewed the Physical Security Plan, applicable security procedures, and vehicle records. The inspectors also interviewed security and operations

management, and the individual responsible for leaving the vehicle unattended. In addition, the inspectors observed the operation of the alarm device installed on the vehicle provided to warn the occupant that the key has been left in the ignition.

The inspectors determined that this incident was the result of inadvertent error on the part of an outside equipment operator. This operator advised the inspectors that he was aware of the requirement to remove the keys from the vehicle but forgot to do so when he exited the vehicle. The inspectors also observed that the vehicle alarm does not warn the occupant if the keys are left in the ignition when the engine is running.

Failure to remove keys from an unattended designated vehicle in the protected area is contrary to the requirements of procedure 00653-C, Protected Area Entry/Exit Control. This is identified as a VIO 50-424,425/95-28-03, Designated Vehicle Left Unattended In Protected Area With Engine Running.

The inspectors noted that this is the sixth incident involving a designated vehicle inappropriately left unattended within the protected area which has been cited in the last 15 months. While the identification of this occurrence by plant security personnel is noteworthy, it does not diminish the fact that it is a repeat violation. The inspectors concluded that licensee management has failed to take sufficient action to prevent repeat violations associated with unattended designated vehicles.

c. Failure to Properly Label Radioactive Materials

On November 22, 1995, during a routine tour of the Unit 1 auxiliary building, the inspectors identified an unattended contaminated laundry bag which was not sealed or labeled with radioactive materials tags. The inspectors waited in the area until HP trained personnel arrived and were informed of the observation. On November 28, 1995, during a routine tour of the Unit 2 auxiliary building, the inspectors identified normal air conditioning fan filters inside a temporary radioactive materials storage area without proper radioactive material tags. The discrepancy was identified to the HP supervisor and SS at the time of discovery. Following confirmation of the inspectors' observations, the contaminated items were properly surveyed and tagged.

As a result of this issue, the inspectors reviewed procedures 00960-C, Control of Radioactive Materials, and 46017-C, Control, Monitoring and Removal of Materials in Radiation Controlled Areas. The inspectors also reviewed a health physics shift briefing detailing these issues. The inspectors interviewed decontamination personnel, the HP technician, and cognizant management regarding the licensee's investigation into both examples of untagged radioactive materials.

The inspectors determined that the laundry bag was left unattended while decontamination personnel were collecting laundry from other auxiliary building areas. The inspectors determined that decontamination and HP personnel were cognizant of the requirements of procedures 00960-C and 46017-C to properly tag, store, and remove radioactive material from inside the RCA. However, the personnel collecting contaminated clothing failed to adhere to the procedure requirements due to their attention being focused on accomplishing the task quickly.

The inspectors determined that the auxiliary building normal air conditioning filters were spot surveyed by the HP technician upon removal from the filter unit on November 2. The spot survey did not identify smearable or fixed contamination. However due to other tasking, the HP technician was unable to continuously monitor the entire maintenance evolution and left the work site. Prior to his departure the technician instructed the maintenance personnel to place the filters in clear plastic bags and store them inside a roped-off temporary radioactive materials storage area as a conservative measure. The HP technician did not return to the filter work area as planned to complete the filter survey due to being distracted by competing activities. A second survey was conducted by HP personnel on November 28 that identified 100 net counts per minute fixed contamination on several filters with zero smearable contamination.

The licensee attributed these incidents to personnel error. The inspectors concurred with the licensee's determination based on their independent inspection effort.

Licensee corrective actions included counseling of the personnel involved on proper surveys and tagging requirements. A shift briefing was also conducted for each HP crew to emphasize the requirements to properly label radioactive materials inside the RCA.

The inspectors concluded that although the contaminated laundry bag identified on November 22 was left unattended for approximately five minutes contrary to licensee procedures, the event was minimized due to the outside of the contaminated bag being subsequently surveyed at less than 0.2 millirem per hour. The inspectors also concluded that the significance of the improperly surveyed filters identified on November 28 was minimized due to the filters being properly contained inside a temporary radioactive materials storage area, and the likelihood of personnel in the area becoming contaminated was remote.

The inspectors concluded that two examples of improperly tagged radioactive materials inside the RCA were contrary to the requirements of procedures 00960-C, and 46017-C. Consistent with Section IV of the NRC Enforcement Policy these failures constitute a violation of minor significance identified as NCV 50-424,425/95-

28-04, Failure to Properly Label Radioactive Materials Inside an RCA.

d. Failure to Obtain Transient Combustible Material Permits

On November 30, 1995, during a routine tour of the Unit 2 auxiliary building, the inspectors identified fire retardant wood scaffolding, a transient combustible material, without the required transient combustible fire loading permit. The discrepancy was identified to a fire protection engineer and following confirmation of the inspectors' observation a combustible permit was issued. The inspectors were informed that a subsequent walkdown by the fire protection engineer in the Unit 2 auxiliary building identified another example of a transient combustible fire load without a proper permit. The second example was also corrected by the fire engineer. The inspectors have identified three other similar examples of undocumented transient combustibles inside the RCA within the last four months. In each case, the discrepancies were resolved by an on-duty fire technician, fire protection engineer, or the responsible maintenance work foreman.

The inspectors reviewed the DC generated in response to this issue. The inspectors also interviewed the foreman responsible for a portion of the scaffold and wood brought into the auxiliary building, and cognizant fire protection personnel regarding the licensee's investigation of the issue.

The inspectors were advised that the transient combustible materials identified on November 30, were brought into the auxiliary building to support separate maintenance work activities. The licensee attributes this issue to a failure to properly implement procedure 92015-C, Use, Control and Storage of Flammable/Combustible Materials, in that the required permits were not obtained. Procedure 92015-C states that if the maximum amount of transient combustible material being brought into a fire protected area exceeds the limits specified in the procedure guidance, a transient combustible permit is required. In both of the cases identified during the inspection report period, the loadings exceeded the procedural limit for a permit being required.

The inspectors noted that a contributing factor to these occurrences may be the process by which a fire permit is obtained. Procedure 92015-C, requires the persons planning to bring materials into a fire zone to perform a calculation to determine if transient combustible limits are exceeded. If the calculation is determined to be below the specified limits no permit is required and the material may be brought into the fire zone. Individual transient combustible loads under procedural limits are not required to be tracked by the fire technician. The inspector determined during the review that it is possible to have several

different fire loads be below procedural limits within a specific fire zone, but have a combined total load that exceeds the procedural requirement. Procedure 92015-C does not address this situation.

As corrective action, the licensee stated their intention to enhance procedure 92015-C to ensure that any transient combustible materials, regardless of quantity, are reviewed and documented by the fire technician to ensure that specified fire loading zones limits are not exceeded.

The inspectors concluded that these two examples of transient combustible materials in the auxiliary building without the proper fire loading permits were contrary to the requirements of procedure 92015-C. However, the safety significance of these observations were minimized due to the availability of fire detection devices located in the areas. Consistent with Section IV of the NRC Enforcement Policy these failures constitute a violation of minor significance identified as NCV 50-424,425/95-28-05, Failure to Obtain Transient Combustible Material Permits.

e. Recall Drill

On the evening of December 12, 1995, the inspectors witnessed an unannounced, after hours recall drill conducted by the licensee. The drill simulated an Alert declaration based on a seismic event and included activation of the TSC and OSC. The inspectors also attended an exercise controller's critique held the following day.

Overall, the conduct of the drill was good. The TSC and OSC were activated within specified timeframes. While notification to the NRC Operations Center was timely, the licensee failed to notify all appropriate State and local authorities within 15-minutes of the Alert declaration. This notification took almost 25-minutes and involved some coaching on the part of an exercise controller. Both control room communicator performance and difficulties in establishing communications with certain local authorities were involved in this delay. This issue was captured during the licensee's critique for corrective action. The inspectors will monitor licensee performance in this area during future drills.

One violation and two non-cited violations were identified.

7. Follow-up (92902)

The following items were reviewed using licensee reports, inspections, record reviews, and discussions with licensee personnel, as appropriate:

a. (Closed) URI 50-424,425/95-24-04 OPΔT Non-Conservative Setpoints.

IR 95-24 documents the inspectors' initial review of non-conservative OPΔT setpoints identified by the licensee in early

October 1995. The improperly established setpoints were attributed to calculational errors in the software program used to generate the setpoints. Pending an inspector review of the licensee's formal evaluation of the setpoint errors, the issue was documented as URI 50-424,425/95-24-04.

The inspectors have reviewed the licensee's evaluation as well as their proposed corrective actions. The licensee determined that the root cause of the event was an inaccurate assumption made during the development of the software algorithms regarding the upper limit of the plants operating Tavg value.

The licensee identified several long term corrective actions in response to this issue. These included a revised testing philosophy to challenge the Tavg penalty generator; management oversight for future projects of this nature; training to enhance individual performance of design verification and validation; and an independent formal review of the OPΔT and OTΔT calculational methods.

The inspectors concluded that the improperly established OPΔT setpoint represented a failure to maintain system design and was contrary to the requirements of 10 CFR 50 Appendix B Criterion III, Design Control. Consistent with Section VII of the NRC Enforcement Policy, this licensee identified and corrected violation is identified as NCV 50-424,425/95-28-06, OPΔT Setpoints Established Incorrectly.

Based on the inspector's review of licensee actions, this item is closed.

- b. (Closed) URI 50-424,425/94-09-01, Falsification of Battery Maintenance Data Sheet.

Inspection Report 50-424,425/94-09 documents the inspector's review of a falsification event which occurred in April 1994. The event involved an alteration of an out-of-tolerance reading by an electrician on a battery surveillance data sheet approximately four days after the reading was taken. The inspectors concluded that there was no safety significance to this event since the battery was in a standby condition in the warehouse.

The NRC has completed its review of this issue.

This item is closed.

One non-cited violation was identified.

8. Exit Meeting

The inspection scope and findings were summarized on December 19, with those persons indicated in paragraph 1. The inspector described the areas inspected and discussed in detail the inspection findings. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during the inspection.

<u>Item No.</u>	<u>Status</u>	<u>Description and Reference</u>
VIO 50-424,425/ 95-28-01	Open	Oil Control Practices Contrary To Plant Procedures (paragraph 4.b)
URI 50-424/ 95-28-02	Open	Unit 1 Hydrogen Recombiners Missed Functional Test (paragraph 4.c)
VIO 50-424,425/ 95-28-03	Open	Designated Vehicle Left Unattended In Protected Area With Engine Running (paragraph 6.b)
NCV 50-424,425/ 95-28-04	Closed	Failure to Properly Label Radioactive Materials Inside an RCA (paragraph 6.c)
NCV 50-424,425/ 95-28-05	Closed	Failure to Obtain Transient Combustible Material Permits (paragraph 6.d)
NCV 50-424,425/ 95-28-06	Closed	OPΔT Setpoints Established Incorrectly (paragraph 7.a)
URI 50-424,425/ 95-24-04	Closed	OPΔT Non-Conservative Setpoints (paragraph 7.a)
URI 50-424,425/ 94-09-01	Closed	Falsification of Battery Maintenance Data Sheet (paragraph 7.b)

Two cited and three non-cited violations were identified.

9. Abbreviations

AFW	- Auxiliary Feedwater System
BTU	- British Thermal Unit
CFR	- Code of Federal Regulations
CREFS	- Control Room Emergency Filtration System
DC	- Deficiency Card
DCP	- Design Change Package
DG	- Diesel Generator
FSAR	- Final Safety Analysis Report
HP	- Health Physics
IR	- Inspection Report

ISEG	- Independent Safety Engineering Group
LCO	- Limiting Condition for Operation
MER	- Material/Equipment Request
MSIV	- Main Steam Isolation Valve
MWO	- Maintenance Work Order
NCV	- Non-Cited Violation
NPF	- Nuclear Power Facility
NRC	- Nuclear Regulatory Commission
NSAC	- Nuclear Safety and Compliance
NSCW	- Nuclear Service Cooling Water System
NUREG	- Nuclear Regulations
OPΔT	- Over Power Differential Temperature
OSC	- Operations Support Center
OTΔT	- Over Temperature Differential Temperature
PDR	- Public Document Room
P&ID	- Piping & Instrumentation Drawings
PM	- Preventive Maintenance
PMMS	- Plant Modifications and Maintenance Support
QA	- Quality Assurance
RCA	- Radiation Controlled Area
SAER	- Safety Audit And Engineering Review
SALP	- Systematic Assessment of Licensee Performance
SCS	- Southern Company Services
SFP	- Spent Fuel Pool
SSPS	- Solid State Protection System
SS	- Shift Superintendent
SSS	- Support Shift Supervisor
TAVG	- Average Temperature
TDAFW	- Turbine Driven Auxiliary Feedwater
TPCW	- Turbine Plant Cooling Water
TS	- Technical Specifications
TSC	- Technical Support Center
URI	- Unresolved Item
USS	- Unit Shift Supervisor
VIO	- Violation

Nuclear Regulatory Commission, Document Control Desk, Washington, DC 20555, two copies to the appropriate Regional Office, and one copy to the appropriate NRC Resident Inspector if one has been assigned to the site of the facility.

- (i) Emergency plan pursuant to § 50.34;
- (ii) Change to an emergency plan pursuant to § 50.54(q);
- (iii) Emergency implementing procedures pursuant to Appendix E.V of this part.

(6) *Updated FSAR.* An updated Final Safety Analysis Report (FSAR) or replacement pages, pursuant to § 50.71(e) must be submitted as follows: the signed original and 10 copies to the Nuclear Regulatory Commission, Document Control Desk, Washington, DC 20555, one copy to the appropriate Regional Office, and one copy to the appropriate NRC Resident Inspector if one has been assigned to the site of the facility.

(7) *Quality assurance related submittals.* (i) A change to the Safety Analysis Report quality assurance program description pursuant to § 50.54(a)(3) or § 50.55(f)(3), or a change to a licensee's NRC-accepted quality assurance topical report pursuant to § 50.54(a)(3) or § 50.55(f)(3), must be submitted as follows: the signed original to the Nuclear Regulatory Commission, Document Control Desk, Washington, DC 20555, one copy to the appropriate Regional Office, and one copy to the appropriate NRC Resident Inspector if one has been assigned to the site of the facility.

(ii) A change to an NRC-accepted quality assurance topical report from nonlicensees (i.e., architect/engineers, NSSS suppliers, fuel suppliers, constructors, etc.) must be submitted as follows: one signed original to the Nuclear Regulatory Commission, Document Control Desk, Washington, DC 20555.

(c) *Form of communications.* All copies submitted to meet the requirements set forth in paragraph (b) of this section must be typewritten, printed or otherwise reproduced in permanent form on unglazed paper. Exceptions to these requirements may be granted for the submittal of micrographic, photographic, or electronic forms. Prior to making any submittal in other than paper form, the applicant or licensee must contact the Information and Records Management Branch, Nuclear Regulatory Commission, Washington, DC 20555, telephone (301) 415-7230, to obtain specifications, copy requirements, and prior approval.

(d) *Delivery of communications.* Written communications may be delivered to the Document Control Desk at 11555 Rockville Pike, Rockville, Maryland between the hours of 8:15 a.m. and 4:00 p.m. Eastern Time. If a submittal due date falls on Saturday, Sunday, or Federal holiday, the next Federal working day becomes the official due date.

(e) *Regulation governing submission.* Licensees and applicants submitting correspondence, reports, and other written communications pursuant to the regulations of this part are requested but not required to cite whenever practical, in the upper right corner of the first page of the submittal, the specific regulation or other basis, requiring submission.

(f) *Conflicting requirements.* The communications requirements contained in this section and §§ 50.12, 50.30, 50.36, 50.36a, 50.44, 50.48, 50.54, 50.55, 50.55a, 50.59, 50.62, 50.71, 50.73, 50.82, 50.90, and 50.91 supersede and replace all existing requirements in any license conditions or technical specifications in effect on January 5, 1987. Exceptions to these requirements must be approved by the Information and Records Management Branch, Nuclear Regulatory Commission, Washington, DC 20555, Telephone (301) 415-7230.

§ 50.5 Deliberate misconduct.

(a) Any licensee or any employee of a licensee; and any contractor (including a supplier or consultant), subcontractor, or any employee of a contractor or subcontractor, of any licensee, who knowingly provides to any licensee, contractor, or subcontractor, components, equipment, materials, or other goods or services, that relate to a licensee's activities subject to this part; may not:

(1) Engage in deliberate misconduct that causes or, but for detection, would have caused, a licensee to be in violation of any rule, regulation, or order, or any term, condition, or limitation of any license, issued by the Commission, or

(2) Deliberately submit to the NRC, a licensee, or a licensee's contractor or subcontractor, information that the person submitting the information knows to be incomplete or inaccurate in some respect material to the NRC.

(b) A person who violates paragraph (a)(1) or (a)(2) of this section may be subject to enforcement action in accordance with the procedures in 10 CFR part 2, subpart B.

(c) For purposes of paragraph (a)(1) of this section, deliberate misconduct by a person means an intentional act or omission that the person knows:

(1) Would cause a licensee to be in violation of any rule, regulation, or order, or any term, condition, or limitation, of any license issued by the Commission, or

(2) Constitutes a violation of a requirement, procedure, instruction, contract, purchase order or policy of a licensee, contractor, or subcontractor.

§ 50.7 Employee protection.

(a) Discrimination by a Commission licensee, an applicant for a Commission license, or a contractor or subcontractor of a Commission licensee or applicant against an employee for engaging in certain protected activities is prohibited. Discrimination includes discharge and other actions that relate to compensation, terms, conditions, or privileges of employment. The protected activities are established in section 211 of the Energy Reorganization Act of 1974, as amended, and in general are related to the administration or enforcement of a requirement imposed under the Atomic Energy Act or the Energy Reorganization Act.

(1) The protected activities include but are not limited to:

(i) Providing the Commission or his or her employer information about alleged violations of either of the statutes named in paragraph (a) introductory text of the section or possible violations of requirements imposed under either of those statutes;

(ii) Refusing to engage in any practice made unlawful under either of the statutes named in paragraph (a) introductory text or under these requirements if the employee has identified the alleged illegality to the employer;

(iii) Requesting the Commission to institute action against his or her employer for the administration or enforcement of these requirements;

(iv) Testifying in any Commission proceeding, or before Congress, or at any Federal or State proceeding regarding any provision (or proposed provision) of either of the statutes named in paragraph (a) introductory text.

(v) Assisting or participating in, or is about to assist or participate in, these activities.

51 FR 40303

50 FR 24549

53 FR 6137

52 FR 31601

60 FR 24549

56 FR 40664

56 FR 40664

58 FR 52406