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

NOV 25 1991

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

Georgia Power Company
ATTN: Mr. W. G. Hairston, III
Senior Vice President -
Nuclear Operations
P. O. Box 1295
Birmingham, AL 35201

Gentlemen:

SUBJECT: SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE
(NRC INSPECTION REPORT NOS. 50-424/91-25 AND 50-425/91-25)

The NRC Systematic Assessment of Licensee Performance (SALP) has been completed for your Vogtle facility. The facility was evaluated for the period of October 1, 1990 through September 28, 1991. The results of the evaluation are documented in the enclosed Initial SALP Report. This report will be discussed with you at a public meeting to be held at the Vogtle facility in Waynesboro, Georgia, on December 4, 1991, at 10:00 a.m.

The performance of your Vogtle facility was evaluated in the functional areas of Plant Operations, Radiological Controls, Maintenance/Surveillance, Emergency Preparedness, Security, Engineering/Technical Support, and Safety Assessment/Quality Verification.

Overall, performance at your Vogtle facility has improved. Radiological Controls continued to exhibit superior performance. Plant Operations was characterized by good judgement and conservative decisions in operating the plant. A reduction was noted in the number of plant trips attributed to Maintenance activities. Vogtle's increased management attention has resulted in improvements in Emergency Preparedness and Security. Your commitment to self-assessment programs, and Engineering/Technical Support were also evident.

Your challenge is to continue the improved performance in these areas, while maintaining the other areas at a high level of performance.

Any comments you have concerning our evaluation of the performance of your Vogtle facility should be submitted to this office within 30 days following the date of our meeting. These comments will be considered in the development of the Final SALP Report. Your comments and a summary of our meeting will be issued as an appendix to the Final SALP Report.

Should you have any questions concerning this letter, we will be glad to discuss them with you.

Sincerely,

Stewart D. Ebneter

Stewart D. Ebneter
Regional Administrator

Enclosure:
Initial SALP Report - Vogtle

cc w/encl:
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(cc w/encl cont'd - see page 3)

ENCLOSURE

INITIAL SALP REPORT

U. S. NUCLEAR REGULATORY COMMISSION
REGION II

SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE
INSPECTION REPORT NUMBERS
50-424/91-25 AND 50-425/91-25

GEORGIA POWER COMPANY

VOGTLE, UNITS 1 AND 2

OCTOBER 1, 1990 THROUGH SEPTEMBER 28, 1991

I. INTRODUCTION

The Systematic Assessment of Licensee Performance (SALP) program is an integrated NRC staff effort to collect available observations and d ta on a period c basis and to evaluate licensee | erformance on the basis of this information. The program is supplemental to normal regulatory processes used to ensure compliance with NRC rules and regulations. It is intended to be sufficiently diagnostic to provide rational basis for allocation of NRC resources and to provide meaningful feedback to the licensee's management regarding the NRC's assessment of their facility's performance in each functional area.

An NRC SALP Board, composed of the staff members listed below, met on November 8, 1991, to review the observations and data on performance, and to assess licensee performance in accordance with the guidance in NRC Manual Chapter NRC-0516, "Systematic Assessment of Licensee Performance". The Board's findings and recommendations were forwarded to the NRC Regional Administrator for approval and issuance.

This report is the NRC's assessment of the licensee's safety performance at the Vogtle Units 1 and 2 for the period October 1, 1990 through September 28, 1991.

The SALP Board for Vogtle was composed of:

E. W. Merschoff, Acting Director, Division of Reactor Projects (DRP), Region II (RII) (Chairperson)
S. D. Rubin, Acting Deputy Director, Division of Reactor Safety, RII
B. S. Mallett, Deputy Director, Division of Radiation Safety and Safeguards, RII
A. R. Herdt, Chief, Reactor Projects Branch 3, DRP, RII
G. C. Lainas, Assistant Director, Division of Reactor Projects-I/II, Office of Nuclear Reactor Regulation (NRR)
D. S. Hood, Project Manager, Project Directorate II-3, NRR
B. R. Bonser, Senior Resident Inspector, Vogtle, DRP, RII

Attendees at SALP Board Meeting:

P. H. Skinner, Chief, Project Section 3B, DRP, RII
S. E. Sparks, Project Engineer, Project Section 3B, DRP, RII
R. D. Starkey, Resident Inspector, Vogtle, DRP, RII
G. R. Wiseman, Reactor Engineer, Technical Support Staff, DRP, RII

II. SUMMARY OF RESULTS

During this assessment period, Vogtle was operated in a safe and conservative manner. Both units experienced a reduction in reactor trips from the previous assessment period. Operator performance during plant transients and major evolutions continued to be a strength. Management

Notwithstanding the generally improving performance of Operations, there were several instances of inadequate procedure implementation, personnel error, and inattention to detail during normal operational activities. Examples included a lack of control board awareness by an RO during a safety injection system fill and vent operation; hanging and independently verifying a clearance on a Nuclear Service Cooling Water (NSCW) pump on the wrong unit; unplanned start of an emergency diesel generator (EDG); failure to dilute a liquid effluent release; failure to ensure proper safety injection system alignment prior to running a surveillance test; and failure to verify closure of an NSCW pump discharge valve during a functional test. Management has taken corrective actions to address procedural compliance deficiencies.

Appearance and preservation of the plant has improved over this period through a broad painting and preservation program. Improvements in the control of valve leakage were noted. However, several relatively inaccessible valve rooms had not received the same level of attention. The labeling program has also improved through the use of temporary label tags. Replacement of Unit 1 plastic and temporary tags with metal tags is scheduled for 1992. During NRC system walkdowns, few labeling discrepancies were noted.

Operation's interface with other site departments has also improved. This has been accomplished, in part, by the rotation of managers with operations experience to other departments. Other Operations personnel have also been rotated to other departments.

Communication between the NRC and licensee management has been an area of concern. This area has continued to improve, as evidenced by licensee management interface with the resident inspectors on potential regulatory issues and maintenance problems.

The fire protection program was satisfactorily implemented. The use of a Fire Protection Technician assigned to each operational shift was a program strength. This relieved control room operators of fire protection duties. Comprehensive procedures have been developed to implement the fire protection program. The fire brigade was well trained and equipped. The TS required fire protection program audits performed by the licensee were comprehensive and thorough. Surveillance of the fire protection system was acceptable, although some tests were being performed without calibrated instruments. Maintenance of the fire protection features and systems was adequate, however, adequate

G. Safety Assessment/Quality Verification

1. Analysis

This functional area addressed the licensee implementation of safety policies, activities related to licensee amendments, exemptions and relief requests, responses to Generic Letters, Bulletins, Information Notices, resolution of safety issues (10 CFR 50.59 reviews), safety review committee activities, and the use of feedback from self-assessment programs and activities. It included the effectiveness of the licensee's quality verification function in identifying and correcting substandard or anomalous performance, in identifying precursors of potential problems, and in monitoring the overall performance of the plant.

Management involvement was evident in the handling of licensing actions, NRC staff requests, and licensee commitments. Management was usually well aware of the status and details of such items, whether completed or pending, and assured that commitments were completed in a timely manner.

Management generally kept the NRC informed of its ongoing and planned activities affecting matters under active NRC review. An exception occurred when the licensee filed corrections to its Emergency Core Cooling System analyses during final phases of the NRC's review of the associated amendment request to use VANTAGE-5 reload fuel.

The licensee requested meetings when appropriate to inform the NRC of appropriate developments, such as the transition of the SNC organization. The licensee was well prepared during meetings with the NRC. Periodic "interface" meetings were effectively used to keep NRC informed of progress on licensing actions and of the licensee's various initiatives. The licensee also provided ample technical support for its positions during an NRR site audit regarding bypassing the high jacket water temperature trip for the EDGs. This contributed to timely resolution of technical concerns on this issue.

The licensee's proposals and responses to the NRC were generally clear, timely, and technically sound. The licensee carefully assessed the impact of Generic Letters and Bulletins upon the plant and provided appropriate responses. However, NRC approval of the licensee's response to Generic Letter 90-03 was delayed because the licensee's exception to one of the requirements was not clearly explained and required further information. In addition, a request to discontinue engineering reviews of structural tilt for large structures was lacking an adequate technical basis.

Requests for license amendments were generally of high quality and permitted NRC approval without the need for further additional information. Examples of such responses included requests for TS changes regarding surveillance of snubbers, membership of the Plant Review Board, pressure-temperature limitations for reactor coolant system heatup and cooldown, and limited use of a new fuel cladding. The licensee's 10 CFR 50.59 reviews were also thorough.

Management involvement was apparent in the licensee's responses to numerous issues raised in a 10 CFR 2.206 petition. The replies were timely and responsive. The licensee was also observed to be responsive to the Atomic Safety and Licensing Board during prehearing activities associated with amendments on bypassing the high jacket water temperature trip for EDGs, and on proposed amendments affecting the frequency of EDG testing.

The licensee normally exhibited a thorough understanding of the regulations and NRC policies. However, one exception was noted this assessment period involving a limited understanding of the regulations. The licensee submitted a written request for an NRR waiver of compliance without also requesting an emergency TS change. The request was associated with a TS requirement on the heater capacity for the Piping Penetration Area Filtration and Exhaust System.

Licensee Event Reports (LERs) were timely and adequately described relevant aspects of the event, including corrective actions and actions to prevent recurrence.

The licensee had sufficient staff both at the plant and at the corporate office to support licensing activities. This was exhibited by timely and thorough responses throughout the assessment period.

Management has continued to support and improve plant organizations and programs which identify and assess problems, and provide a mechanism for their resolution. These organizations and programs included the Safety Audit and Engineering Review (SAER) group, the Independent Safety Engineering Group (ISEG), the Deficiency Card (DC) program, the open item/commitment tracking system, the event investigation and root cause determination programs, and the human factors evaluation program. The Plant Review Board (PRB) was also effective in reviewing matters related to nuclear safety.

The SAER group was effective in the identification of deficiencies and followup of corrective actions. Examples included a deficiency in the method of performing TS HVAC heater dissipation surveillances, improper approval of overtime, distribution and control problems with control room drawings, and Fitness for Duty program deficiencies. Management has taken timely and effective corrective action in response to SAER findings.

ISEG was also effective in identifying and/or resolving safety significant issues. Examples included a review of miswiring events occurring during maintenance, and an investigation of open sliding links. ISEG members frequently participated and lead event investigations. ISEG members have also been trained in and perform human factors evaluations.

The licensee's event investigation program was identified as a strength. The process was effective in assessing problems, determining root causes, and recommending corrective actions. One specific area which had been a weakness in the past was the investigations into EDG problems. This period, when several problems with the EDG voltage regulation and excitation system occurred, the licensee was aggressive in pursuing the causes of the problems and taking corrective action.

The licensee's Deficiency Card program was also effective in identifying, evaluating, reporting and dispositioning problems. Deficiencies were reviewed for reportability, evaluated, and corrective actions taken in a timely manner. Deficiency cards were also reviewed by the Plant Review Board for safety concerns. This process resulted in several licensee identified violations.

One weakness was identified with implementation of a safety evaluation into operating procedures. The licensee failed to completely incorporate the specified actions in a safety evaluation for minimization of potential main feedwater water hammer after a design change to remove differential temperature indication and alarms.

Management decisions regarding safety were considered conservative. As discussed in Section IV.A, plant management made decisions to shutdown the units, although not required by regulations. Licensee decisions on TS interpretations were found to be safe and conservative. Plant management also improved the TS clarification program. Previously, TS clarifications had been performed by the Operations manager with no other review. These clarifications now receive additional review by the Technical Support manager.

An NRC team inspection conducted an evaluation of corrective actions taken to address weaknesses noted during a previous Emergency Operating Procedure (EOP) Inspection. The team found that an extensive effort had been applied to revising the EOPs and the Abnormal Operating Procedures. The corrective actions were thorough and corrected the previous weaknesses. The approach towards addressing labeling discrepancies was technically sound and thorough in most cases. The EOPs were found to adequately mitigate the consequences of a broad range of accidents and multiple equipment failures.

No violations were cited.

2. Performance Rating

Category: 2

3. Recommendations

None

V. SUPPORTING DATA AND SUMMARIES

A. Licensee Activities

The third refueling outage for Unit 1 began September 14, 1991, and is scheduled through November 5, 1991 (52 days). Major activities include RTD bypass manifold removal, steam generator level tap modifications, and EDG 60 month inspection.

The licensee completed the first refueling outage for Unit 2 and returned to critical status on November 9, 1990. The outage was delayed due to data interface problems with the fuel handling machine and difficulties with the retaining ring on the main generator.

B. Direct Inspection and Review Activities

In addition to the routine inspections performed at the Vogtle facility by the NRC staff, special inspections were conducted as follows:

February 11-15, February 25 - March 1, and March 11-15, 1991, Maintenance Team Inspection

May 15, 1991, Emergency Preparedness Exercise Evaluation