

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

In the Matter of	)	
	)	Docket No. 50-424
GEORGIA POWER COMPANY	)	License No. NPF-68
(Vogtle)	)	EA 91-141

ORDER IMPOSING CIVIL MONETARY PENALTY

I

Georgia Power Company (Licensee) is the holder of Operating License No. NPF-68 issued by the Nuclear Regulatory Commission (NRC or Commission) on March 16, 1987. The license authorizes the Licensee to operate Vogtle Electric Generating Plant Unit 1 in accordance with the conditions specified therein.

II

An investigation of the Licensee's activities was completed on March 19, 1991 by the Nuclear Regulatory Commission. The results of this investigation indicated that the Licensee had not conducted its activities in full compliance with NRC requirements. A written Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was served upon the Licensee by letter dated December 31, 1991. The Notice states the nature of the violations, the provisions of the NRC's requirements that the Licensee violated, and the amount of the civil penalty proposed for the violations. The Licensee responded to the Notice by letters dated January 30 and February 3, 1992. In its responses, the Licensee denied the violations, disagreed with the

severity level, and requested complete mitigation of the proposed civil penalty action.

### III

After consideration of the Licensee's responses and the statements of fact, explanation, and argument for mitigation contained therein, the NRC Staff has determined, as set forth in the Appendix to this Order, that Violations A, B, C.1, and D occurred as stated. With regard to Violation C.2, the NRC Staff agrees with the Licensee that the wrong revision of VEGP Procedure 10000-C was referenced in the Notice. However, as discussed in the Appendix to this Order, the NRC Staff has concluded that, the Licensee's action, when viewed against the correct revision of the procedure, still constitutes a violation. Therefore, the proposed penalty designated in the Notice should be imposed.

### IV

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205, IT IS HEREBY ORDERED THAT:

The Licensee pay a civil penalty in the amount of \$100,000 within 30 days of the date of this Order, by check, draft,

money order, or electronic transfer, payable to the Treasurer of the United States and mailed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555.

## V

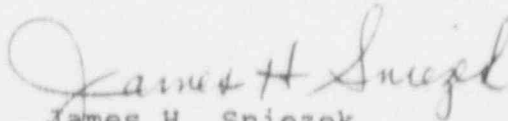
The Licensee may request a hearing within 30 days of the date of this Order. A request for a hearing should be clearly marked as a "Request for an Enforcement Hearing" and shall be addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555. Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address and to the Regional Administrator, NRC Region II, 101 Marietta Street, N.W., Atlanta, Georgia 30323.

If a hearing is requested, the Commission will issue an Order designating the time and place of the hearing. If the Licensee fails to request a hearing within 30 days of the date of this Order, the provisions of this Order shall be effective without further proceedings. If payment has not been made by that time, the matter may be referred to the Attorney General for collection.

In the event the Licensee requests a hearing as provided above, the issues to be considered at such hearing shall be:

- (a) whether the Licensee was in violation of the Commission's requirements as set forth in the Notice as modified in Section III above, and
- (b) whether, on the basis of such violations, this Order should be sustained.

FOR THE NUCLEAR REGULATORY COMMISSION



James H. Sniezek  
Deputy Executive Director  
for Nuclear Reactor Regulation,  
Regional Operations, and Research

Dated at Rockville, Maryland  
this 12<sup>th</sup> day of June 1992

## APPENDIX

### EVALUATIONS AND CONCLUSION

On December 31, 1991, a Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was issued to Georgia Power Company (GPC) for violations identified by the Nuclear Regulatory Commission (NRC) Staff during an investigation. GPC responded to the Notice in correspondence dated January 30, 1992 and February 3, 1992. GPC denies the violations occurred and also considers the civil penalty to be unwarranted. The NRC Staff's evaluation and conclusions regarding GPC's responses are presented below.

#### Restatement of Violation A

- A. Technical Specification (TS) 3.4.1.4.2 (1988 edition) required that two residual heat removal (RHR) trains shall be OPERABLE and at least one RHR train shall be in operation. Reactor Makeup Water Storage Tank (RMWST) discharge valves (1208-U4-175, 1208-U4-176, 1208-U4-177, and 1208-U4-183) shall be closed and secured in position whenever the plant is in Mode 5 with reactor coolant loops not filled. Action c. of TS 3.4.1.4.2 required that with the RMWST valves not closed and secured in position, immediately close and secure them in position.

Contrary to the above, on October 12 and 13, 1988, with Unit 1 in Mode 5, loops not filled, RMWST valves 1208-U4-176 and 1208-U4-177 were opened in order to add chemicals to the reactor coolant system.

#### Summary of Licensee's Response to Violation A

GPC denies Violation A based on its position that the decision to voluntarily enter the Limiting Conditions for Operation (LCO) of TS 3.4.1.4.2 (1988 edition) was consistent with the language of the TS as well as the established practice and NRC guidance available at the time. In addition, GPC contends that since an entry into the specific TS LCO was not prohibited, no violation occurred. GPC also contends that the term "immediate" as applied to this TS is open to interpretation.

#### NRC Evaluation of Licensee's Response to Violation A

The language which GPC contends sanctioned its voluntary entry into TS LCO can be found in a section from the Inspection and Enforcement (I&E) Manual, [Note: This manual is now titled NRC Inspection Manual], Chapter 9900, STS (Standard Technical Specifications) Section 3.0, Voluntary Entry Into Action

Statements, with an issue date of January 1, 1982 (Exhibit 24).<sup>1</sup> In this guidance, NRC Staff states that "The NRC endorses Voluntary Entry into the Action Statement Conditions and has structured the TS to permit the licensee to exercise judgment within the latitude permitted by the Action Statement language". TS 3.4.1.4.2 action statement does not contain any latitude. Action c. of that TS can only be reasonably read to address the situation where the valves are found either not closed or unsecured and requires in those circumstances that the valves immediately be closed and secured. Interpreting the TS to allow intentional opening of valves that were closed and tagged to perform an evolution is directly contrary to the stated requirement of the TS.

In choosing the NRC Staff's guidance it cites, the licensee selectively picked guidance that supports its position and did not address guidance that did not support its position. Another section of the same I&E chapter referred to by the licensee, discusses in detail an interpretation of locked or otherwise secured components. In part, that guidance dated October 1, 1977, states that the locking into a prescribed position of a manually operated valve should be accomplished using a key or combination lock or other acceptable means to preclude the manipulation from the prescribed position. This guidance also states that the use of a tag or similar device on a valve handwheel does not meet the requirements for a locked valve in a fluid system important to safety. Clearly, if tags in lieu of a locking device on a closed valve would not suffice to meet a requirement that mandates the valve be closed and secured in position, then an individual actually opening the valve (exactly opposite to the required position) under some undocumented administrative control, as occurred in the case at issue, is clearly unacceptable.

The GPC statement that since "Such an entry was not prohibited by TS, no violation occurred", is not supported. As discussed above, the TS clearly prohibited the licensee's action in this case. A document containing guidance in this area is the Technical Specification Improvement Program Highlights, dated August 1987 (Exhibit 27) which the licensee again attempts to selectively use to support its argument. In the section entitled "Voluntary Entry into Technical Specification Action Statements", a specific comment is made to address the entry into TS 3.0.3 (standard version) by licensees. The guidance states that "since such actions remove the last echelon of defense against deleterious events, NRR (Nuclear Reactor Regulation) has alerted

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<sup>1</sup> All exhibits referenced are contained in Appendix I of GPC response to the NRC June 3, 1991 Demand for Information.

Regional Administrators that voluntary use of specification 3.0.3 is unacceptable as an operating convenience in lieu of other courses of action."

With regard to the Technical Specification in this case and the above referenced guidance, three points need to be made. First, if anything, the use of the term "immediate" in the Action for TS 3.4.1.4.2 should have reinforced the importance of following the TS requirement, which in this case was to have the valves closed and secured in position.

Second, the licensee supports its position that entry into the Action is not prohibited by relying on the TS basis. The TS requirement and not its basis establishes the TS requirement with which the licensee must comply. In this case, the requirement prohibits the opening of the valves in Mode 5, loops not filled. Notwithstanding the language of the TS basis, the language of the Final Safety Analysis Report (FSAR), sections 15.4.6.2.1 and 15.4.6.2.2, did not support the Operations Manager's decision.

Finally, consistent with the above referenced guidance, the licensee did not extensively consider other possible courses of action before opening the valves in Mode 5, loops not filled. Given that a question of Technical Specification applicability had been raised by a senior reactor operator and that the situation did not involve an evolution that needed to be accomplished immediately in order to maintain plant safety, the plant conditions could have been altered, for example by refilling the RCS loops, so that opening of the valves would unquestionably have been allowed.

GPC discusses the term "immediate" and reaches the conclusion that the time associated with this term is open to interpretation. GPC has stated that NRC Staff internal correspondence dated May 1977 (Exhibit 29) states that the NRC Staff would have to rely on the technical judgment of the NRC inspection staff on a case-by-case basis to determine the appropriate time interval before an "immediate" action had to be taken. In addition, GPC cites another NRC Staff internal memorandum (Attachment 4 to its response) in which Region II requested NRR to review the policy of entering action statements that do not contain allowed outage times (AOT) and the meaning of the word "immediately" as contained in specifications. GPC contends in its analysis that NRC Staff has imposed a definition of "immediate" as not permitting any time interval before the required action must be taken in this enforcement action.

Arguments about the term "immediate" have no relevance in this case. Interpretation of that term would only become necessary if it were concluded that in the situation at issue the licensee could have properly entered Action c. of T.S. 3.4.1.4.2.

However, in Mode 5, loops not filled, entering Action c. by intentionally opening the RMWET valves is in direct violation of the TS requirement. The NRC Staff readily acknowledges that the TS basis states that the requirement is included to preclude an uncontrolled boron dilution. However, the TS requirement achieves that by prohibiting all injections through the valves in Mode 5, loops not filled. While the requirement may have been more stringent than necessary, the licensee is bound by the requirement and not the basis. As was subsequently done by GPC, the TS requirement could have been changed through the amendment process by providing additional analysis, supported by the TS basis, to allow opening the valves with proper controls under those plant conditions.

GPC claimed that the Sequoyah plant staff used the same logic as did the Vogtle Electric Generating Plant (VEGP) staff when they chose to voluntarily enter an LCO which contained a required immediate action (Exhibit 31). The licensee states that the NRC Staff's present position is an example of inconsistency in the application of the regulatory process. However, interpretations concerning the term "immediate" are not relevant due to the clear language of the Vogtle TS. Nevertheless, a detailed review of the Sequoyah event has been conducted by NRC Staff. That event is detailed in Licensee Event Report (LER) 50-328/91-03 dated April 10, 1991 and NRC Inspection Report Nos. 50-327/91-06 and 50-328/91-06 dated April 25, 1991. A summary of the review of the inspection report and LER is included below:

- Areas of similarity between the event at VEGP and the event at Sequoyah are as follows:
  - a. Neither evolution was performed using an approved procedure.
  - b. Senior level operations managers were involved in the initial decision to enter the TS action statement.
  - c. The evolutions were conducted using verbal directions from the control room.
  - d. The evolutions were only discussed with operations personnel at the time actions were initiated.
  
- Areas of dissimilarity between the Sequoyah and Vogtle event are as follows:
  - a. The Technical Specifications for Sequoyah (TS 3.5.1.1 and the related surveillances T.S. 4.5.1.1.1.d.1 and 2) are worded differently from the Vogtle TS. Specifically, there are two differences that are germane to discussion of the October 1988 Vogtle event.



First, Sequoyah's TS 4.5.1.1.1.d does allow for the licensee to periodically close the valves, in the applicable mode, in order to perform surveillance activities. This is in direct contrast with the Vogtle TS which contains no provisions for opening the RMWST valves, in the applicable mode. Second, should the action for Sequoyah TS 3.5.1.1 be entered, in addition to requiring the isolation valve to be immediately reopened, it provides a specific amount of time within which a plant shutdown must be initiated (1 hour). Again, this contrasts with the Vogtle TS which contains no specific action time limit.

- b. At Sequoyah, while placing the plant outside the design basis, the valve was manipulated as an operating evolution in response to a potential safety concern. Identifying plant leakage as in-leakage into a cold leg accumulator allowed the problem to be addressed and maintained a safety system in an operable status. At Vogtle the manipulations were not to maintain a safety system in an operable condition and could have been made at a time when the TS did not preclude operation of the valves.
- c. The event at Sequoyah was investigated and reviewed in detail by the licensee resulting in a LER. At Vogtle, the decision to manipulate the valves was only reviewed within the Operations Department, was not investigated until long after the event, and a report was not submitted.
- d. The Sequoyah personnel who investigated this event recognized that the actions they had taken resulted in placing the plant in a condition outside the design basis. At Vogtle, the event was not recognized as a condition outside the design basis even though a question about the evolution was raised by a senior reactor operator and an analysis did not exist to address a dilution event for the specific plant conditions.
- e. The root cause of this event at Sequoyah was determined to be solely personnel error which resulted in a failure to return a circuit breaker to its specified position. The licensee received a Notice of Violation associated with this problem. The Vogtle event resulted in multiple violations, when considered collectively, indicate a significant breakdown in managerial and administrative controls of licensed activities in a number of inter-related areas.

Based on this review, the NRC Staff has concluded that the Sequoyah event, while similar in several minor respects to the Vogtle event, was based on a different set of circumstances from the event at VEGP and different requirements and therefore does not reflect any inconsistency in the NRC Staff's application of the regulatory process.

#### Restatement of Violation B

- B. 50.73(a)(2)(ii)(B) requires licensees to submit a Licensee Event Report (LER) within 30 days after the discovery of any event or condition that resulted in the nuclear power plant being in a condition outside the design basis of the plant.

Contrary to the above, on or about November 17, 1989, the Plant Review Board (PRB) determined the opening of the RMWST valves specified in TS 3.4.1.4.2 was not reportable and, consequently, an LER was not submitted within 30 days, even though opening the valves on October 12, and 13, 1988 had placed the plant in a condition outside of the design basis. Opening the valves constituted a condition outside the plant design basis because at the time the valves were opened an analysis for a boron dilution accident through the valves did not exist.

#### Summary of Licensee's Response to Violation B

GPC denies this violation based on its contention that opening the RMWST discharge valves specified in TS 3.4.1.4.2 did not place the plant in a condition outside the design basis. GPC contends that the TS Bases for TS 3.4.1.4.2 state that the subject valves are closed to prevent an uncontrolled boron dilution event. Since the evolution was administratively controlled the licensee argues that the manner in which the controls were applied precluded an uncontrolled boron dilution event.

GPC further states that 10 CFR 50.2 defines design basis as "information which identifies the specific functions to be performed by a structure, system, or component of a facility, and the specific values or ranges of values chosen for controlling parameters as reference bounds for design." In addition, GPC contends that the physical design of the chemical addition portion of the chemical and volume control system is such that the chemical addition evolution of October 1988 did not exceed the acceptance criteria specified in the Standard Review Plan (SRP). In its discussion of the SRP, GPC cites Section 15.4.6 which specifies time limits associated with operator actions to mitigate an unplanned dilution event.

GPC also argues that 10 CFR 50.73(a)(2)(ii) treats conditions

outside the design basis of the plant and unanalyzed conditions that significantly compromise plant safety as two separate and distinct criteria for reportability. The licensee asserts that if an unanalyzed condition necessarily places that plant outside the design basis there is no need for two different criteria.

GPC provides an analysis performed in November 1989 (November 14, 1989) by Westinghouse (Exhibit 21) that it argues supports its position that the plant was not placed in a condition outside the design basis.

#### NRC Evaluation of Licensee's Response to Violation B

The NRC Staff also relies on the definition of design basis contained in 10 CFR 50.2, which includes additional clarifications not provided in the excerpt cited by GPC. Again, the licensee is selectively choosing excerpts from the referenced document to support its position. The language that was omitted states (with regard to "values chosen for controlling parameters as reference bounds for design") "These values may be (1) restraints derived from generally accepted "state of the art" practices for achieving functional goals, or (2) requirements derived from analysis (based on calculation and/or experiments) of the effects of a postulated accident for which a structure, system, or component must meet its functional goals."

As discussed in the FSAR, the specific RMWST valves were to be closed and secured in position in order to prevent uncontrolled dilution events in Mode 5, loops not filled. That configuration (RMWST valves closed and secured in position) is the one that the NRC Staff reviewed and accepted in granting the plant a license. Consistent with 10 CFR 50.2, that configuration achieved the functional goal of preventing an uncontrolled dilution event and therefore defines, in part, the system design basis. Because at the time the valves were opened in October 1988, no analysis had been performed to support that condition the plant was placed in a condition outside the design basis as defined in 10 CFR 50.2. The licensee's attempts to now rely on selected words of 10 CFR 50.2 to justify its position are completely contrary to the fact that at the time of licensing, a dilution event through the RMWST valves was specifically excluded from the plant design basis. (See section 15.4.6.2.1.1 of the FSAR).

The NRC Staff does not dispute the fact that the subsequent Westinghouse analysis provides support for changing the TS requirement and allowing administrative control of the valves. However, as stated above, the analysis did not exist at the time the valves were opened. Additionally, the administrative control of the maximum time the valves would be open, that the licensee attempts to take credit for, was not clearly specified. At least one of the plant equipment operators involved in the October 1988

event did not recall that there was any prohibition on how long the valves could be open. In fact, his recollection was consistent with the then existing chemical addition procedures, which specified minimum rather than maximum flush times to ensure all chemicals were added. More fundamental is the fact that the TS requirement prohibited opening the valves regardless of what the analysis might have been able to support.

GPC states that "VEGP recognizes, as did the PRB in 1989, that the use of the flow path in question was not currently analyzed in the Final Safety Analysis Report (FSAR). However, this condition did not significantly compromise plant safety and does not equate to a condition outside the design basis of the plant, and therefore was not reportable." The PRB could not reach such a conclusion without first performing an analysis in accordance with the requirements of 10 CFR 50.59 because the FSAR required the valves to be closed and secured in position. Since the NRC Staff review indicates that PRB did not obtain information to support this conclusion until mid-November 1989, the manipulation of the RMWST valves on October 12 and 13, 1988 met the criteria for reportability pursuant to 50.73(a)(2)(ii)(B). Even if the PRB had immediately obtained the Westinghouse analysis in August 1989, when questions about the October 1988 event were raised again, the correct determination would have been that the event was reportable as the plant had been outside its design basis, as identified in 10 CFR 50.2, when the valves were opened in October 1988.

With regard to the licensee's specific arguments concerning reportability under 50.73(a)(2)(ii)(B), the NRC Staff makes the following summary points:

1. The NRC Staff's position regarding the reportability of this event is supported by the discussion on pages 6 and 7 of this Appendix that, by the definition of 10 CFR 50.2, opening the RMWST valves in Mode 5, loops not filled, placed the plant in a condition outside the design basis.
2. As the NRC Staff cited the licensee for failing to report the plant being in a condition outside the plant design basis, discussion of the applicability of 50.73(a)(2)(ii)(A) and its relationship to 50.73(a)(2)(ii)(B) are not relevant. Further, a discussion of whether plant safety was significantly compromised, in the context of supporting a reportability determination, would only be necessary if a citation had been made under 50.73(a)(2)(ii)(A).
3. GPC introduced a Sequoyah LER to support its position with respect to Violation A. Apart from the NRC Staff's position regarding the Sequoyah event discussed above, GPC's arguments ignore the fact that the Sequoyah event was

reported under 50.73(a)(2)(ii). Specifically, in the Sequoyah LER report it was concluded that the event was a condition that was outside the design basis of the plant (See LER 50-328/91-003 page 7 of 11, Analysis of Event).

#### Restatement of Violation C

- C. Technical Specification 6.7.1 requires written procedures shall be established, implemented, and maintained covering the activities recommended by Appendix A of Regulatory Guide (RG) 1.33, Revision 2, February 1978. Section 2 of Appendix A of RG 1.33, recommends procedures for general plant operation.

The following procedures, in part, implement TS 6.7.1.

1. Vogtle Electric Generating Plant (VEGP) Operations Procedure Number 12006-C, Unit Cooldown to Cold Shutdown, in use on October 12 and 13, 1988, stated in Section D4.2.14 that valves 1-1208-U4-175, 1-1208-U4-176, 1-1208-U4-177, 1-1208-U4-181, 1-1208-U4-183, and others be closed, locked and tagged in Mode 5, loops not filled.
2. VEGP Procedure 10000-C, Conduct of Operations, Section 2.10.2 in use October 12 and 13, 1988, stated that the Unit Superintendent (US) is responsible to ensure plant operations are conducted in accordance with Technical Specifications and approved procedures.

Contrary to the above:

1. On October 12 and 13, 1988, licensed personnel failed to implement the requirements of procedure number 12006-C in that valves 1-1208-U4-176, -177 and -181, which were required to be closed, locked and tagged, were opened in Mode 5, loops not filled.
2. On October 12 and 13, 1988, the US did not ensure that plant operations were conducted in accordance with Technical Specifications in that valves 1-1208-U4-176 and -177 were opened in Mode 5, loops not filled, with the express knowledge of the US.

#### Summary of Licensee's Response to Violation C

GPC denies this violation based on its position that since there was no violation of TS 3.4.1.4.2 in October 1988, this violation could not have occurred. GPC, in response to the first example, states that the procedure identified in Violation C only placed administrative controls on these valves and subsequent control of

these valves was allowed by VEGP Procedure No. 00304-C, Equipment Clearance and Tagging, dated May 23, 1988, (Exhibit 16). GPC contends that the purpose of the administrative controls was to prevent an uncontrolled dilution and that it fulfilled that intent. GPC also points out that the NRC Staff incorrectly cited the applicable section of Procedure No. 10000-C from the revision in use in October 1988 and also identified the incorrect operations staff position.

#### NRC Evaluation of Licensee's Response to Violation C

The NRC Staff, in its review of this action, concluded that since the TS restriction was the only action taken to prevent this dilution accident, an accident scenario which had been specifically excluded from analysis in Chapter 15 of the FSAR, the procedural requirement of Procedure No. 12006-C was, in turn, the only procedural requirement available to preclude placing the plant outside its design basis. Sections 15.4.6.2.1 and 15.4.6.2.2 of Chapter 15, specify that the RMWST are valves to be locked closed in the refueling mode and in cold shutdown when the loops are drained. The action specified in these sections was to prevent any dilution during these conditions and not just uncontrolled dilution. Notwithstanding the words of the TS basis, the licensee failed to perform an adequate analysis to address the language of the FSAR and even failed to properly control the evolution that was improperly approved.

With regard to the use of administrative controls, the licensee had in place procedural requirements such that if a procedure could not be followed as written, then either a temporary or permanent change is required to be made to the procedure in question. A review of VEGP Procedure No. 00304-C, addresses equipment clearance and tagging. The purpose of this procedure was to address clearance processes associated with maintenance, testing or inspection. Since there was no discussion of tagging associated with operational controls for evolutions in progress, the use of Procedure No. 00304-C for that purpose was not appropriate. Further, even if the NRC Staff accepts that Procedure No. 00304-C could have been used to modify the requirements of Procedure No. 12006-C without a 10 CFR 50.59 analysis, the procedure was not permanently or temporarily modified to allow such a use. In summary, the licensee had no basis to allow administrative control of the RMWST valves when they were opened in October 1988.

The NRC Staff acknowledges that the incorrect revision of Procedure No. 10000-C was referenced in the violation. However, after review of the applicable revision, dated October 3, 1988, it was concluded that while the position titles changed, the substantive requirements did not and, therefore, notwithstanding the incorrect reference, the responsible individual did not carry

out his assigned duties. That leads to the licensee's second argument, which is that Procedure No. 10000-C is an organizational procedure which establishes broad areas of responsibility and that the mere occurrence of a TS violation does not establish that a violation of Procedure No. 10000-C occurred. The case at hand is not one of those situations. In this case, the evolution which resulted in the TS violation, and violation of Procedure No. 10000-C, was an evolution occurring with specific On-Shift Operations Supervisor (OSOS) approval despite the fact that questions had been raised about the evolution's appropriateness. Additionally, the detail in which the functions of personnel delineated in Procedure No. 10000-C are defined, argue against the broadness advocated by the licensee. Specifically, Section 2.4.c requires that the OSOS ensure that operations are conducted in accordance with Technical Specifications and approved procedures and Section 2.4.1 requires that temporary procedure changes are properly administered. The OSOS should have recognized that contrary to Section 2.4.c, the evolution could not be accomplished (see Violation D) in accordance with existing procedures and, as required by Section 2.4.1, the temporary change procedure was not properly implemented when Procedure No. 12006-C, as written, was not followed.

The NRC Staff does not agree with the interpretation made by GPC with regard to the broadness of the descriptions provided by Procedure No. 10000-C. If the procedure was really intended to be only broad guidance, there would be no need for it to contain the detailed defining functions that it does. A violation of a procedure occurs when the requirements set forth in the procedure are not performed as the procedure delineates and that was the situation in this case. However, because the NRC Staff agrees with GPC that the wrong revision of Procedure No. 10000-C was cited in Violation C.2, NRC records will be amended to reference the correct procedure revision and corresponding applicable steps.

#### Restatement of Violation D

- D. 10 CFR 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures or drawings. VEGP Procedure No. 13007-1, VCT Gas Control and RCS Chemical Addition, Section 4.7, Procedure No. 35110-C, Chemistry Control of the Reactor Coolant System, Section 4.7 provide the instructions on chemical additions to the Reactor Coolant System.

Contrary to the above, on October 12, and 13, 1988, VEGP

Procedure Nos. 13007-1 and 35110-C were inadequate in that these procedures did not contain provisions for adding chemicals to the reactor coolant system in Mode 5, loops not filled. Specifically, the procedures specify such conditions as having a reactor coolant pump running which is not possible in Mode 5, loops not filled.

#### Summary of Licensee's Response to Violation D

GPC denies this violation based on the position that the procedures were adequate to perform the evolution that was being conducted.

GPC states that the NRC Staff erred in limiting its view to only a portion of Procedure No. 13007-1. GPC contends that there is a hierarchy of procedures applicable to the evolution of October 1988, and that the sum total of all these procedures addressed the evolution of adding chemicals in Mode 5 and ensured proper mixing. GPC states that Procedures Nos. 13007-C and 35110-C addressed the specific task of adding chemicals and not the configuration control aspects of the evolution. In addition, GPC points out that Procedure No. 49006-C, Health Physics and Chemistry Department Outage Activities Implementing Procedures, (Exhibit 40) accomplishes the required configuration control. GPC also acknowledges a weakness in the development of this procedure which failed to identify a potential TS conflict; yet GPC believes that the procedure was adequate for the chemical addition evolution.

#### NRC Evaluation of Licensee's Response to Violation D

The NRC Staff has reviewed the licensee's arguments and the procedures referenced. The NRC Staff finds a number of inconsistencies in the licensee's arguments. First, it is not clear how Procedure No. 49006-C, which is solely a Health Physics and Chemistry Department Procedure, can accomplish the required configuration controls, which are within the purview of the Operations Department. While Procedure No. 49006-C addresses what the plant conditions need to be to perform certain chemical procedures, it does not detail how to attain those conditions. That problem leads to the second point. It is inconsistent for the licensee to require very detailed step-by-step operations procedures, with very specific prerequisites and precautions, for chemical additions at power and in certain routine shutdown conditions, but then argue that chemical additions in a very infrequent and abnormal shutdown condition such as Mode 5, loops not filled, require only general guidance. Finally, GPC states that the NRC Staff erred in limiting its view to only Procedures 13007-1 and 35110-C. However, starting on Page 77, for example, of the GPC enforcement conference transcript, it is clear that it was only those procedures and not Procedure No. 49006-C which



were relied on by the operators in October 1988. This is not surprising given that, as discussed above, Procedure No. 49006-C only applied to Health Physics and Chemistry Department personnel. In summary, the NRC Staff concludes that the procedures for adding chemicals in Mode 5, loops not filled, were inadequate.

#### Summary of Licensee's Answer To A Notice of Violation

In answer to the Notice, GPC denies that a violation occurred based on the information it provided which has been addressed above and its conclusion that the positions taken by the NRC Staff are based on a new interpretation of the TS at issue. GPC also contends that the cited violations reflect an unwarranted retroactive application of a new position. GPC also considers the NRC Staff citation of four separate examples associated with a single event to reflect a cascading of one principle violation into multiple violations. In addition, GPC has stated that the PRB reviewed this event in 1989 and determined that it did not involve a condition that significantly compromised plant safety or that it was outside the design basis of the plant.

GPC in its response goes on to state that this enforcement action is not the type of straightforward, clear action designed to address the actual safety significance of a particular violation envisioned by the NRC's Enforcement Policy. GPC considers that this action involves a legitimate difference of professional opinion in interpreting regulations and also considers that an industry-wide advisory addressing the issue of action statements in TS containing the term "immediate" would be more beneficial than this enforcement action.

In its request for reconsideration of the severity level which accompanies its response to cited violations, GPC disagrees with the NRC Staff assignment of a Severity Level III to this enforcement action. This is based on GPC's contention that this issue did not have safety significance and that the NRC Staff subsequently approved a TS change to allow chemical addition evolutions of the type involved in this enforcement action. GPC also contends that the NRC Staff assignment of the severity level based on a significant breakdown in managerial and administrative controls is not appropriate. As discussed above, GPC is of the view that the PRB actions were appropriate and that the "command and control" of operational activities was maintained by the shift crew and plant management. Based on this information, GPC states that the fashioning of a Severity Level III problem is inconsistent with the safety significance of this event and the Enforcement Policy's guidance which requires the staff to identify the relative safety importance of each violation as the "first step in the enforcement process". GPC further requests the NRC Staff to reconsider its factual underpinnings for

reaching any conclusion regarding broad-based regulatory deficiencies.

In its discussion associated with managerial and administrative controls, GPC acknowledges that inadequate planning and procedures and inadequate training and guidance contributed to the failure of licensed operators to recognize a TS compliance issue in October 1988. Also acknowledged were weaknesses in the procedure for outage chemistry activities and the FSAR in this area. However, GPC did not agree that it has far-ranging management problems. It considers this as an event of very limited scope.

In discussing the PRB's review and conclusions relative to the event in October 1988, GPC concluded that the PRB's review was reasonable, balanced and sufficiently thorough. Further, GPC points out that the PRB unanimously concluded that the decision to open the valves in order to add chemicals was correct. GPC further states the PRB at the time it considered this matter, knew and understood that a condition not analyzed in the FSAR associated with this chemical addition occurred in October 1988. As previously discussed with respect to Violation B, GPC's position is that the PRB decision is a simple reportability disagreement rather than a management problem.

GPC's response also addresses the command and control of the operations staff with respect to the activities that occurred in October 1988. GPC states that the shift crew worked as a team to diligently and continuously monitor the various changes in operation parameters and appropriately delegated specific tasks to qualified individuals. It concludes that since this was a preplanned activity and scheduled to be accomplished at this time, there was no loss of command and control. GPC acknowledges the extreme importance of ensuring compliance with TS and its obligation to comply regardless of whether NRC Staff guidance is available. It is GPC's view that even if the NRC Staff disagrees with its position that a TS violation did not occur in this case, the violation would not rise to the level of a Severity level III violation. GPC indicates that in March of 1991, licensed personnel at TVA's Sequoyah plant used the same logic and the enforcement action taken in that case was inconsistent with the action taken in the instant case with GPC. (See discussion above in section entitled NRC Evaluation of Licensee's Response to Violation A).

GPC has also requested in its correspondence that the NRC Staff reconsider the escalation applied to the base civil penalty for untimely long-term corrective action and NRC identification of the violation. This request is based on the following factors: (1) Since GPC determined that no violation occurred, no long-term corrective actions were required, and (2) The PRB, recognizing

that future questions would be raised whenever this activity was to be performed, initiated a proposal to change the TS for clarification purposes before the next scheduled outage. Based on this action, GPC concludes that the action taken was timely. GPC also requests reconsideration of the escalation factor associated with identification based on the position that since it did not conclude that a violation occurred, the identification factor should not be used to escalate the base civil penalty. GPC's position in this regard is that licensees are penalized for opinions differing from those of the NRC Staff.

In addition to the above issues, the licensee's response of February 3, 1992 asserts that the NRC Staff failed to determine whether a violation occurred before referring the matter to the Office of Investigations (OI) and that the proposed large fine was apparently based more on the level of NRC Staff resources devoted to the matter rather than on safety significance. GPC's final position, based on the information provided above, is that the violations did not occur and that a civil penalty is inappropriate in this case.

#### NRC Evaluation of Licensee's Request for Reconsideration of Severity Level and Mitigation

The NRC Staff has reviewed GPC's response in detail and has also reviewed the bases upon which the staff concluded that taken collectively these violations represent a significant regulatory concern. The individual violations have previously been discussed in this Appendix. The NRC Staff is not relying on the cascading effect of one principal violation, in that numerous violations occurred representing a lack of adequate "command and control." Although the NRC Staff concludes that violation of the TS requirement is important by itself, taken collectively the violations represent a significant regulatory concern. As stated in the cover letter to the Notice of Violation and Proposed Imposition of Civil Penalty, these violations indicate a significant breakdown in managerial and administrative controls of licensed activities. This case not only involved inadequate actions and faulty decisions during the event by individual senior licensed operators in management positions, but included the Plant Review Board which subsequently performed an inadequate review, consequently confirmed the reasonableness of a flawed Technical Specification interpretation and did not recommend reporting the matter. Therefore, even though a direct compromise of plant safety did not occur, the NRC Staff is well within the guidance of the Enforcement Policy in aggregating these violations into a Severity Level III problem.

The NRC Staff has also reviewed the licensee's request for reconsideration of the escalation of the civil penalty. With regard to the escalation for identification, the NRC Staff

maintains that the questions raised by GPC staff about the appropriateness of the evolution and the concerns about the evolution, that resurfaced in August 1989 and were improperly dispositioned by the PRB in November 1989, gave GPC adequate opportunities to identify this violation.

With respect to escalation for corrective action, contrary to GPC's assertion, the concerns about PRB activities were not the only NRC Staff concerns which have not been addressed as part of the licensee's corrective actions. Procedures which were clearly inadequate for chemical addition in Mode 5, loops not filled, were not temporarily corrected when used, as required by the existing temporary change mechanism, and were not subsequently updated to resolve the problems. In summary, the NRC Staff concludes 100 percent escalation of the civil penalty was appropriate for NRC identification and inadequate corrective actions.

While the NRC Staff finds them in no way to be germane to the action, two additional issues were raised in the licensee's February 3, 1992 letter. In that letter, the licensee contends the NRC Staff issued a civil penalty to recover staff costs and initiated an investigation without first concluding there was a violation. GPC apparently draws its conclusion that the NRC Staff failed to determine whether a violation occurred before referring the matter to the Office of Investigations (OI), from internal NRC correspondence requesting an interpretation of the TS in question. While it is true that both the request for the interpretation and the reply occurred after OI involvement, review of only that internal correspondence would present an incomplete picture. The request simply memorialized the basis for the written position that had been taken by NRC Region II prior to referral of the issue to OI. With regard to the GPC assertion that the proposed fine was apparently based more on the level of staff resources devoted to the matter rather than on the safety significance of the events, that assertion is again without foundation. All civil penalties collected, no matter how large or small, are deposited in the U.S. Treasury with the NRC Staff receiving no direct benefit. That being the case, the NRC Staff not only did not but could not use a civil penalty to offset staff costs. As discussed extensively throughout this Appendix the NRC Staff maintains that the severity level of the problem is supported by the events that occurred at Vogtle which are the subject of this action. Further, having properly arrived at the severity level, the NRC Staff maintains the escalation and mitigation factors of the Enforcement Policy were properly assessed and appropriate to the circumstances. In summary, the NRC Staff finds the two additional issues raised by the licensee to be unsupported by the facts and completely unrelated to the significant issues in this action which are, adequate control of

on-shift activities and thorough review of matters potentially impacting plant safety.

NRC Conclusion

The NRC Staff has concluded that GPC has not provided adequate basis for the assertion that the violations should be withdrawn or that the civil penalty is inappropriate. Consequently, the NRC Staff concludes that the proposed civil penalty in the amount of \$100,000 should be imposed.

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