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April 22, 1982



J. T. Beckham, Jr.
Vice President and General Manager
Nuclear Generation

U. S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Washington, D. C. 20555

REFERENCE:
Docket No. 50-321
License No. DPR-57
EA 82-18

ATTENTION: Mr. Richard C. DeYoung, Director

GENTLEMEN:

Georgia Power Company (GPC) is submitting this response to the Notice of Violation and Proposed Imposition of Civil Penalties dated March 29, 1982. GPC has reviewed the alleged violations and hereby responds in accordance with 10 CFR 2.201.

At the outset, GPC wishes to emphasize that although six violations are cited, they arise out of one general circumstance which involved the use of substandard vendor supplied valve diaphragms in the high pressure coolant injection (HPCI) system. Each acknowledged violation was basically procedural in nature and occurred either as a direct result of the lack of actual awareness of the fact that deficient diaphragms were used or lack of appreciation of the effect of such diaphragms on HPCI operability, or as related consequences of these causes.

Furthermore, any violations by GPC were clearly not willful. As the NRC special inspection report states, the first substandard diaphragm to be installed was a part of a complete valve assembly replacement with the identical part number having been ordered according to design specifications. Subsequent deficient replacement diaphragms were also obtained from the valve manufacturer. While it is true that G.E. Service Information Letter (SIL) was received at the plant site a few days before the first substandard diaphragm was installed, the NRC recognizes in the inspection report that a month passed before the information in the SIL came to the attention of responsible licensee personnel. This is perhaps understandable, since the relative importance of the SIL was not highlighted or otherwise mentioned within the SIL and the significant information of concern herein was indistinctly placed in the body of the last paragraph of the SIL. Also, the NRC did not describe the diaphragm problem in any official NRC correspondence, such as in an Inspection and Enforcement Bulletin or Notice. Consequently, it not only took some time for GPC to become aware of the diaphragm information, but some additional time to become fully aware of the ramifications of such deficient diaphragms.

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We further note that a base civil penalty of \$40,000 was increased by 25% because we "could reasonably have been expected to have taken effective preventive measures." No specific reasons were given why the step-up mechanism was applied beyond that statement. Since the basic violation was a case of not having taken effective preventive measures, we fail to see the basis for increasing the penalty for the same reason.

VIOLATION A

Technical Specification 6.5.1.6.d states that the PRB shall be responsible for review of all proposed changes or modifications to unit systems or equipment that affect nuclear safety.

Contrary to the above, between August 7 and September 14, 1981, the licensee made facility changes without prior NRC approval or without having conducted an evaluation as required. Use of valve diaphragms in the HPCI system which did not meet design specifications constituted a facility change.

RESPONSE TO VIOLATION A

1. Admission or denial of the alleged violation:

The violation did occur, except that the period of the violation ended on September 11, 1981. However, as discussed in paragraph 2, this violation was directly related to the lack of information that would have been available had a deviation report been prepared as cited in Violation B.

2. Reasons the violation occurred:

The violation occurred because it was not recognized that use of replacement valve diaphragms required a Design Change Request or a written safety evaluation to support utilization of the substitute component. This also resulted because a deviation report was not prepared for the substitute valve diaphragm as explained in the response to Violation B.

3. Corrective steps that have been taken and the results achieved:

On September 11, 1981, the Plant Review Board (PRB) and Safety Review Board (SRB) met in joint session to perform a retrospective 10 CFR 50.59 safety evaluation concerning the use of a substitute diaphragm (100-cycle, oil-compatible) in the control valve and determined that use of this diaphragm did not constitute an unreviewed safety question, nor did it require a change to the Technical Specifications. Design change request (DCR) 81-176 was written to document this change on September 14, 1981.

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RESPONSE TO VIOLATION A (Continued)

4. Corrective steps that will be taken to avoid further violations:

To prevent recurrence, non-licensed employee training for the site engineering staff was performed on October 30, 1981. This training centered on the HPCI oil diaphragm events and re-emphasized the 10 CFR 50.59 requirements as set forth in the existing design change request procedure, HNP-809. Additionally, similar training will be provided to members of the Plant Review Board by May 1, 1982.

We believe that these actions are sufficient to ensure that evaluations of all changes or modifications to unit systems or equipment that affect nuclear safety are performed as required by 10 CFR 50.59 and Unit 1 Technical Specification 6.5.1.6.d.

5. Date when full compliance will be achieved:

Compliance with these requirements was achieved on September 11, 1981.

VIOLATION B

10 CFR 50, Appendix B, Criteria V and XVI, as implemented by the licensee's accepted QA program, final safety analysis report (FSAR) Sections D.9.5 and D.9.16, respectively, require the licensee to establish and implement measures for ensuring that deviations are promptly identified and corrected.

Contrary to the above, the licensee did not implement an established measure for ensuring that deviations were promptly identified and corrected. Although HNP-425, "Deviation Report," an established measure, requires the licensee to initiate a deviation report at the time it discovers a condition in the plant that may degrade a safety system, the licensee did not initiate deviation reports upon discovery of failures of a valve diaphragm in the HPCI system, a condition that degraded a safety system, on July 21 and August 11, 1981.

RESPONSE TO VIOLATION B

1. Admission or denial of the alleged violation:

The violation did occur, but due to lack of appreciation of the importance of the valve diaphragm rather than as intentional avoidance of writing a deviation report by the licensee. Deviation reports were written for all valve diaphragm failures once plant staff had actual awareness of the effect of diaphragm failures on HPCI operability.

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RESPONSE TO VIOLATION B (Continued)

2. Reasons the violation occurred:

Thus, the violation occurred because the valve diaphragm failures were not recognized as deviations as defined in plant procedure HNP-425, "Deviation Report". The initial failure to issue a deviation report resulted from the fact that the control valve diaphragm was not determined to be a component that directly affected HPCI system operability.

3. Corrective steps that have been taken and the results achieved:

A deviation report was written on August 17, 1981, for the event occurring on August 11, 1981. This deviation report along with the deviation report for the event occurring on August 18, 1981, was addressed in LER 50-321/1981-088. Also, the sequence of events beginning on July 21, 1981, through the event of August 18, 1981, was included in this LER. Deviation reports were written for all other diaphragm failures that occurred after August 17, 1981. The subject component was replaced on September 17, 1981 with a part that met purchase specifications.

4. Corrective steps that will be taken to avoid further violations:

To prevent recurrence, plant management guidance to plant department heads, Operations and Maintenance supervisors and Operations and Maintenance foremen was given related to restoration of safety systems. Additionally, by June 1, 1982, non-licensed employee training for all employees who would have occasion to write deviation reports will be provided. The training will emphasize: a) deviation reports and the requirements set forth in plant procedure HNP-425; b) restoration of safety systems following maintenance; and c) operability of safety systems. We believe that this action is sufficient to ensure that deviation reports are written when required and are issued in a timely manner.

5. Date when full compliance will be achieved:

Full compliance was achieved on August 17, 1981.

VIOLATION C

Technical Specification 6.9.1.9.b requires the licensee to submit a written report to the NRC within 30 days of its discovery of a condition that leads to operation in a degraded mode.

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VIOLATION C (Continued)

Technical Specification 6.9.1.8.e requires the licensee to report to the NRC the failure or malfunction of one or more components that prevents or could prevent, by itself, the fulfillment of the functional requirements of a system used to cope with accidents analyzed in the safety analysis report (SAR). This report must be submitted within 24 hours, and a followup written report must be submitted within 14 days.

Technical Specification 6.9.1.8.i requires the licensee to report to the NRC performance of a system that requires corrective measures to prevent operation in a manner less conservative than assumed in the SAR. It requires the licensee to submit a report within 24 hours of the event, and a written followup report within 14 days.

Contrary to the above, the licensee did not report to the NRC within 30 days of its discovery, on July 21, 1981, that the HPCI system was inoperable, a condition that led to operation in a degraded mode. On July 21, August 11, and August 18, 1981, the licensee did not report to the NRC within 24 hours the failure of a valve diaphragm that could prevent by itself the fulfillment of the functional requirements of the HPCI system, a system used to cope with accidents analyzed in the SAR. On August 12, 1981 the licensee did not report to the NRC within 24 hours its established procedure for biweekly replacement of HPCI valve diaphragms, a corrective measure intended to prevent operation in a manner less conservative than assumed in the SAR.

RESPONSE TO VIOLATION C

1. Admission or denial of the alleged violation:

The violation did occur; although, the July 21 failure was not reported as a result of the lack of a deviation report as cited in Violation B, and the August 11 and August 18 failures were reported under Technical Specification 6.9.1.9.b rather than 6.9.1.8.e.

2. Reasons the violation occurred:

The violation occurred as a result of the following:

- a. A deviation report was not initiated for the event on July 21, 1981, as discussed in the response to Violation B. In this situation, a deviation report would have served as the predecessor to a Licensee Event Report (LER). Consequently, the appropriate report to the NRC, an LER, was not made.

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RESPONSE TO VIOLATION C (Continued)

- b. The plant staff did not determine that Technical Specification 6.9.1.8.e (24-hour reporting) was applicable for the events on August 11 and August 18, 1981, but instead reported these events per Technical Specification 6.9.1.9.b (30-day reporting; reference LER 50-321/1981-088).
- c. The failure to report to the NRC within 24 hours the establishment of a procedure for biweekly replacement of HPCI valve diaphragms occurred because Technical Specification 6.9.1.8.i was not determined to be applicable.

3. Corrective steps that have been taken and the results achieved:

A deviation report was written on August 17, 1981, for the event occurring on August 11, 1981. This deviation report along with the deviation report for the event occurring on August 18, 1981, was addressed in LER 50-321/1981-088. Also, the sequence of events beginning on July 21, 1981, through the event of August 18, 1981, was included in this LER.

4. Corrective steps that will be taken to avoid further violations:

To prevent recurrence, training was held on NRC reporting requirements for plant personnel holding senior reactor operator (SRO) licenses, SRB members and certain members of the management staff. This training was completed on December 9, 1981. We believe that this action is sufficient to ensure compliance with the identification of reporting requirements for special events and reportable occurrences.

5. Date when full compliance will be achieved:

Compliance was achieved on September 17, 1981, when the subject component was replaced with a part that met purchase specifications.

VIOLATION D

When the HPCI system is inoperable, Technical Specification 4.5.D.2 requires, among other things, that the automatic depressurization system (ADS) actuation logic and reactor core isolation cooling (RCIC) system be demonstrated immediately to be operable. This specification also requires the RCIC system and ADS logic to be demonstrated operable daily thereafter, until the HPCI system is returned to normal operation.

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VIOLATION D (Continued)

Contrary to the above, on August 7, 1981, when the HPCI system was inoperable, the licensee did not demonstrate immediately the operability of the RCIC system and the ADS logic. In addition, between August 7 and 22, 1981, the licensee did not demonstrate daily that the RCIC system and ADS logic were operable.

RESPONSE TO VIOLATION D

1. Admission or denial of the alleged violation:

The violation did occur except that the period of violation ended on August 18, 1981. However, this violation was directly related to procedural failure to conduct a safety evaluation as cited in Violation A and the procedural failure to initiate a deviation report as cited in Violation B.

2. Reasons the violation occurred:

The violation occurred as a result of the plant staff having failed to determine that HPCI was inoperable on August 7, 1981. Such a determination would require the RCIC system and ADS logic to be immediately demonstrated to be operable. Similarly, the HPCI system was considered to be operable during the time frames of August 7 to August 11, 1981, and August 12 to August 18, 1981. Consequently, the RCIC system and ADS logic were not demonstrated to be operable on a daily basis during this time. The reason for a discrepancy as to the dates that the RCIC system and ADS logic were required to be demonstrated to be operable is that the diaphragm was not discovered to be not oil-compatible until after the rupture of the diaphragm which occurred on August 11, 1981. The plant staff became aware on August 7, 1981, of GE SIL # 358, which warned that certain valve diaphragms may have a reduced life, but the staff did not recognize that the diaphragm in use was unacceptable. Following the event on August 11, 1981, the plant staff determined that the diaphragm in use was not oil-compatible and instituted a procedure, based on the expected service life of the not oil-compatible diaphragm, to replace the diaphragm bi-weekly until diaphragms meeting the original design criteria became available.

3. Corrective steps that have been taken and the results achieved:

Following the diaphragm failure on August 18, 1981, the RCIC system and the ADS logic were immediately demonstrated to be operable and were demonstrated to be operable daily thereafter until the HPCI system was returned to normal operation with an oil-compatible diaphragm which was installed on August 22, 1981.

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RESPONSE TO VIOLATION D (Continued)

4. Corrective steps that will be taken to avoid further violations

To prevent recurrence, plant management guidance to plant department heads, Operations and Maintenance supervisors and Operations and Maintenance foremen was given related to restoration of safety systems. Additionally, by June 1, 1982, non-licensed employee training for all employees who would have occasion to write deviation reports will be provided. The training will emphasize: a) deviation reports and the requirements set forth in plant procedure HNP-425; b) restoration of safety systems following maintenance; and c) operability of safety systems. In addition, a plant tracking system was instituted in September, 1981, whereby Plant Management logs incoming correspondence requiring action; this includes among other items, Service Information Letters. We believe that this action is sufficient to ensure that safety-related systems are not declared operable until all necessary prerequisites are met.

5. Date when full compliance will be achieved:

Full compliance was achieved on August 18, 1981.

VIOLATION E

10 CFR 50, Appendix B, Criteria V and XVI, and the licensee's QA program, specifically FSAR Section D.4.1, require the licensee to establish and implement procedures to ensure that conditions adverse to quality are promptly identified and corrected.

Contrary to the above, on and after August 18, 1981 the licensee did not implement procedure QA-05-13, a procedure established to ensure that conditions adverse to quality are promptly identified and corrected. Although paragraph A.3.c of the procedure required the QA Site Supervisor to report (through the QA Field Supervisor to the Manager of QA) findings for which the site QA group and site management reach a corrective action impasse and findings that require immediate action because of a safety concern, the QA Site Supervisor did not report such findings. On August 18, 1981, the QA Site Supervisor and site management (PRB) reached a corrective action impasse with respect to the QA Site Supervisor's recommendation that the HPCI system be declared inoperable until such time as valve diaphragms that met design specifications could be installed. This finding should have been reported by the QA Site Supervisor to the Manager of QA as called for by procedure QA-05-13. In addition, this finding should have been reported, as it constituted a safety concern and required immediate action.

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RESPONSE TO VIOLATION E

1. Admission or denial of the alleged violation:

The violation is not denied. However, the response in item 2 clarifies some misunderstandings the NRC has with respect to the occurrence of a clear impasse.

2. Reasons the violation occurred:

The Quality Assurance Site Supervisor discussed the valve diaphragm replacement with the Plant Review Board on August 18, 1981. The occurrence of a clear impasse is questionable. The QA Site Supervisor received, in the PRB meeting and subsequent discussions, what he felt to be an appropriate response to his concerns and did not believe a reportable impasse had occurred. Also, a report was not made of findings that require immediate action because of a safety concern due to the fact that the QA Site Supervisor did not believe such findings to constitute a safety concern.

3. Corrective steps that have been taken and the results achieved:

Corrective actions and actions which have been or will be taken to prevent recurrence of this violation are described in item 4 of this response.

4. Corrective steps which will be taken:

To strengthen the QA program, the following steps have been or will be taken:

- a. The Quality Assurance Site Supervisor was instructed on October 29, 1981, by the Quality Assurance Field Supervisor and the Quality Assurance Manager that they should be informed immediately of any impasse reached between the QASS and Plant Management. Such information may be transmitted by a phone call, but will be followed-up in writing;
- b. Procedure QA-05-13 will be revised by June 1, 1982, to clarify reporting requirements;
- c. Procedure QA-05-13 will be revised by June 1, 1982, to provide guidance and a formal method for reporting items that may require more timely action by plant management than that required by an Audit report.

5. Date when full compliance will be achieved:

Full compliance was achieved on October 29, 1981.

VIOLATION F

Technical Specification 6.5.1.8 requires the PRB to maintain for each meeting written minutes, documenting results of its activities. Technical specification 6.5.1.6.e requires the PRB to investigate all violations of Technical Specifications. Technical Specification 6.5.1.7.b requires the PRB to render decisions in writing with regard to whether or not items considered under 6.5.1.6 constitute unreviewed safety questions.

Contrary to the above, the PRB minutes of its meeting on August 18, 1981, did not document that the QA Site Supervisor appeared before the PRB and stated that the HPCI system should be declared inoperable because of the diaphragm problems. This was, in substance, an allegation of violation of the operability requirements of Technical Specification 3.5.D. The minutes did not document the PRB decision regarding whether or not the use of substandard diaphragms in the HPCI system constituted an unreviewed safety question and whether or not the operability requirements of Technical Specification 3.5.D were being met.

RESPONSE TO VIOLATION F

1. Admission or denial of the alleged violation:

The violation did occur; however, had a design change request (DCR) or a safety evaluation been performed as cited in Violation A, the HPCI valve diaphragm failure would have been identified in the minutes of the August 18 PRB meeting.

2. Reasons the violation occurred:

The Quality Assurance Site Supervisor (QASS), as a member of the PRB, participated in PRB meeting discussions on August 18, 1981. The violation occurred because the PRB did not consider the referenced diaphragm replacement to place the HPCI system in a degraded mode of operation or to require a determination of whether or not this replacement constituted an unreviewed safety question, and therefore did not document the discussion.

3. Corrective steps that have been taken and the results achieved:

Corrective actions and actions which have been or will be taken to prevent recurrence of this violation are described in item 4 of this response.

4. Corrective steps that will be taken to avoid further violations:

To prevent recurrence, PRB minutes # 81-185, dated October 29, 1981, documents that all PRB members are expected to clearly identify any safety related concerns for resolution prior to adjournment of the meeting. Discussion of such concerns are now to be recorded in the PRB minutes. HNP-6, "Plant Review Board," an

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RESPONSE TO VIOLATION F (Continued)

established measure, provides a process for resolution of any required investigation or follow-up. Refer to part 4 of the response for Violation A for action to ensure evaluations are performed if a change constitutes an unreviewed safety question. We believe that these actions are sufficient to ensure that the PRB minutes reflect any personal concerns voiced in the PRB meeting(s) and also to ensure that all changes requiring an evaluation are reviewed as necessary.

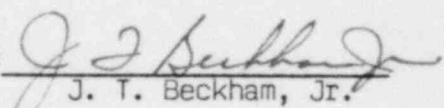
5. Date when full compliance will be achieved:

Full compliance was achieved on October 29, 1981.

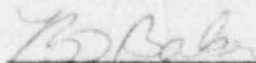
Georgia Power Company shares the Commission's concerns as elaborated in your March 29, 1982, Notice of Violation and Proposed Imposition of Civil Penalties. We have taken this opportunity to clarify the record regarding the six items listed, in addition to detailing the corrective actions taken to assure compliance and those actions which have been or will be taken to prevent future recurrence. Plant management has been given a better understanding of the issues involved and we believe, through corrective actions described herein, that the necessary actions have been taken to resolve those issues. Accordingly, Georgia Power Company does not protest the proposed imposition of civil penalty under 10 CFR 2.205. Therefore, please find enclosed payment in the sum of \$50,000.00.

J. T. Beckham, Jr. states that he is Vice President of Georgia Power Company and is authorized to execute this oath on behalf of Georgia Power Company, and that to the best of his knowledge and belief the facts set forth in this letter are true.

GEORGIA POWER COMPANY

By: 
J. T. Beckham, Jr.

Sworn to and subscribed before me this 22nd day of April, 1982



Notary Public

LTG/mb Notary Public, Georgia, State at Large
Enclosure My Commission Expires Sept. 20, 1983

xc: H. C. Nix
R. F. Rogers, III
J. P. O'Reilly (NRC-Region II)

BILL FOR COLLECTION

Bill No. _____

Nuclear Regulatory Commission

Date April 27, 1982

(Department or Establishment and Bureau or Office)

Washington, DC 20555

(Address)

PAYER:

Georgia Power Company
P.O. Box 4545
Atlanta, GA 30302

*This bill should be returned by the
payer with his remittance.
SEE INSTRUCTIONS BELOW.*

Date	DESCRIPTION	Quantity	Unit Price		Amount
			Cost	Per	
4/27/82	Full payment in reference to civil penalty for Docket No. 50-321, EA 82-18.				\$50,000.00
AMOUNT DUE THIS BILL.					\$ 50,000.00

This is not a receipt

INSTRUCTIONS

Tender of payment of the above bill may be made in cash, United States postal money order, express money order, bank draft, or check, to the office indicated. Such tender, when in any other form than cash, should be drawn to the order of the Department or Establishment and Bureau or Office indicated above.

Receipts will be issued in all cases where "cash" is received, and only upon request when remittance is in any other form. If tender of payment of this bill is other than cash or United States postal money order, the receipt shall not become an acquittance until such tender has been cleared and the amount received by the Department or Establishment and Bureau or Office indicated above.


Failure to receive a receipt for cash payment should be promptly reported by the payer to the chief administrative officer of the bureau or agency mentioned above.

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Georgia Power Company
Post Office Box 4545
Atlanta, Georgia 30302
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Georgia Power 

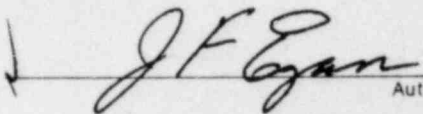
Date
4/20/82

CHECK NUMBER
057104
Amount

Pay *****50.000* and 00/100 Dollars *****50.000.00

to
the
order
of
TREASURER OF THE UNITED STATES
WASHINGTON, DC


Authorized Signature


Authorized Signature

The Citizens and Southern National Bank Atlanta, Georgia

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