

Georgia Power Company
40 Inverness Center Parkway
Post Office Box 1295
Birmingham, Alabama 35201
Telephone 205 877-7127

C. K. McCoy
Vice President, Nuclear
Vogtle Project



November 16, 1992

ELV-05015

Docket No. 50-424

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
REPLY TO A NOTICE OF VIOLATION

Pursuant to 10 CFR 2.201, Georgia Power Company (GPC) submits the enclosed response to the violations identified in Inspection Reports 50-424/92-20 and 50-425/92-20 concerning the inspection conducted by Mr. B. R. Bonser during the period of August 23 - September 26, 1992.

Sincerely,

C.K.M. G
C. K. McCoy

CKM/NJS/gmb

Enclosure

xc: Georgia Power Company
Mr. W. B. Shipman
Mr. M. Sheibani
NORMS

U. S. Nuclear Regulatory Commission
Mr. S. D. Ebnetter, Regional Administrator
Mr. D. S. Hood, Licensing Project Manager, NRR
Mr. B. R. Bonser, Senior Resident Inspector, Vogtle

190062
9211190218 921116
PDR ADDCK 05000424
G PDR

TEC 11

ENCLOSURE

VOGTLE ELECTRIC GENERATING PLANT - UNIT 1
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424/92-20 AND 50-425/92-20

The following is a transcription of the violations as cited in the Notice of Violation (NOV):

- "A. Technical Specification 6.7.1a requires that written procedures be established, implemented, and maintained covering activities delineated in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Rev 2, February 1978, delineates the types of safety-related activities that should be covered by written procedures.

Procedure 12003-C, Reactor Startup, step 4.2.9 requires the Rod Bank Selector Switch to be in Manual, step 4.2.12 requires that rod withdrawal during reactor startup stop every 50 steps to check for proper bank tip-to-tip distance (115 steps).

Contrary to the above, on September 16, 1992, during a Unit 1 reactor startup the reactor operator failed to select Manual and selected Control Bank A (CBA) on the Rod Bank Selector switch, and withdrew CBA to 174 steps before it was recognized that proper bank tip-to-tip distance had not been checked at 150 steps on CBA.

This is a severity level IV violation (Supplement 1).

- B. Technical Specification 6.7.1a requires that written procedures be established, implemented, and maintained covering activities delineated in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Rev 2, February 1978, delineates the types of safety-related activities that should be covered by written procedures.

Procedure 00950-C, Personnel Dosimetry Program, step 8.1.4 states prior to entering a radiation controlled area (RCA), the individual will select and wear a whole body direct reading dosimeter (DRD). The DRD will be worn for the duration of the entry and, then, returned to Health Physics (HP).

Procedure 00930-C, Radiation and Contamination Control, step 5.2.2 requires a radiation work permit (RWP) for any entry into an RCA. Step 5.4.2 requires a full whole body frisk to be performed by all personnel when exiting the RCA access control point or at other areas designated by HP.

Contrary to the above, between June and September 11, 1992, security personnel entered the Unit 1 refueling water

ENCLOSURE (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNIT 1
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424/92-2G AND 425/92-20

storage tank (RWST) valve gallery, a posted RCA, without first logging onto the appropriate RWP, without obtaining a whole body DRD, and without performing a whole body frisk upon exit.

This is a severity level IV violation (Supplement IV).

- C. Technical Specification 6.11.1, High Radiation Area, requires each high radiation area, as defined in 10 CFR 20, in which the intensity of radiation is greater than 100 mR/h but less than 1000 mR/h at 45 cm (18 inches) from the radiation source or from any surface which the radiation penetrates shall be barricaded and conspicuously posted as a high radiation area and entrance thereto shall be controlled by requiring issuance of a radiation work permit (RWP).

Procedure 43003-C, Establishing and Posting Controlled Areas and High Radiation Area Access Control, Step 3.4.3, provides instructions to barricade each high radiation area in lieu of control devices, alarm signals, or continuous attendance of a HP technician.

1. Contrary to the above, on September 15, 1992, a posted high radiation area in the Unit 1 Auxiliary Building Room D78 was found not to contain the appropriate barricade.
2. Contrary to the above, on September 23, 1992, a posted high radiation area in the Unit 1 Auxiliary Building Room A09 was found to be improperly barricaded.

This is a severity level IV violation (Supplement IV)."

RESPONSE TO VIOLATION A

Admission or Denial of the Violation

The violation occurred as stated in the notice of violation.

Reason for the Violation

This violation occurred as a result of the reactor operator's (RO) failure to follow the appropriate procedural steps for positioning the rod bank selector switch and his failure to verify the appropriate rod sequencing during control rod withdrawal. Contributing to this event was the failure of the RO to perform self-verification of the rod bank selector switch position. Also contributing to this event was the failure of the unit shift supervisor (USS) to ensure proper control rod sequencing during control rod withdrawal.

Immediately prior to the event, the operating crew had been

ENCLOSURE (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNIT 1
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424/92-20 AND 425/92-20

thoroughly briefed by the manager of operations. The briefing stressed attention to detail, procedure adherence, and discussions of lessons learned from the industry reactor startup experience. During the event there was good communication among the operating crew with "repeatbacks." There were no unusual distractions or alarms during the event, and there was no feeling of urgency to complete the startup.

This event occurred with the plant subcritical and did not result in any core operating limits being exceeded. However, GPC management has given this procedure violation serious consideration. This is due to the fundamental requirement that operators exercise verbatim procedure compliance and be constantly aware of important operating parameters, especially those associated with reactivity changes and infrequently performed evolutions.

Corrective Steps Which Have Been Taken and the Results Achieved

- Control bank A rods were immediately reinserted to "0" steps at 2336, September 16, 1992, a deficiency card (1-92-165) was generated to document the event, and plant management was notified.
- After plant management reviewed the event and discussed it with the shift crew, reactor startup was recommenced at 0421, September 17, 1992, and the reactor was taken critical at 0548, September 17, 1992, without further problems.
- The role of the reactor engineer has been strengthened to emphasize independent review of reactivity parameters during startups and special reactivity evolutions.
- Management expectations regarding self-verification have been reemphasized to the RO. Appropriate levels of positive discipline have also been administered to the RO and the USS.

Corrective Steps Which Will Be Taken to Avoid Further Violations

No further action is warranted at this time.

Date When Full Compliance Will Be Achieved

Full compliance was achieved when the control bank A rods were reinserted to "0" steps at 2336 on September 16, 1992.

ENCLOSURE (CONTINUEE)

VOGTLE ELECTRIC GENERATING PLANT - UNIT 1
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424/92-20 AND 425/92-20

RESPONSE TO VIOLATION B

Admission or Denial of the Violation

The violation occurred as stated in the notice of violation.

Reason for the Violation

This violation occurred as a result of personnel failing to follow the appropriate procedures for entering/exiting a radiation controlled area (RCA).

Contributing to this was the fact that personnel entering the area were unsure of the RCA boundary. Some personnel thought the yellow and magenta rope, the boundary of the contaminated area, was the boundary for the RCA and did not consider the door where the posting was installed as the boundary for the RCA.

The RCA postings for the RWST valve galleries for both units on various occasions have been located inside the room and on the door. These changing conditions contributed to personnel confusion regarding entry into the areas.

Additionally, less than adequate communications took place prior to area entry. The primary reason for the lack of communication appears to be the fact that conditions in the area had not changed for a period of time, and personnel assumed that previous requirements for entry into the area were still in effect.

Corrective Steps Which Have Been Taken and the Results Achieved

- A broadness investigation was performed to determine if other departments had entered the RWST valve galleries improperly during the period of June through August 1992. It was found that in addition to Security, improper entries were also made by individuals in other departments to a much lesser extent.
- Briefings covering the review of postings and entry/exit requirements were held for Security, Operations, Maintenance, Training, Independent Safety Engineering Group (JSEG), and contractor personnel by the Health Physics (HP) staff.
- Health Physics personnel performed dose assessments to determine if any dose limits had been exceeded. No individual exceeded any dose limit. The maximum calculated annual dose a single individual could have received performing this surveillance is 40 mrem/year/unit (80 mrem/year for both units). This calculation assumes the same individual performing the surveillance for a year.

ENCLOSURE (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNIT 1 REPLY TO A NOTICE OF VIOLATION NRC INSPECTION REPORTS 50-424/92-20 AND 425/92-20

- General Employee Training handbook/lesson plans have been updated to include entry/exit requirements for outside RCAs.
- Health Physics also reviewed previous surveys and verified contamination was not tracked outside the posted areas.
- Health Physics personnel management conducted shift briefings to discuss this event, review the lessons learned, and emphasized the importance of closed loop communications with the radiation workers.

Corrective Steps Which Will Be Taken to Avoid Further Violations

No further action is warranted at this time.

Date When Full Compliance Will Be Achieved

Full compliance was achieved September 10, 1992, at which time the HP superintendent initiated followup surveys of the RWST, had dose assessments performed, and informed Security management of the access requirements for the RWST valve galleries. Additionally, a survey of access during the first 2 weeks of October 1992 into the RWST valve galleries was conducted. The posted entry requirements for this area were complied with by all personnel for this period.

RESPONSE TO VIOLATION C

Admission or Denial of the Violation

The violation occurred as stated in the notice of violation.

Reason for the Violation

The violation occurred as a result of an HP technician's failure to follow the appropriate procedures that specify instructions for barricading high radiation areas (room D78) or for ensuring doors to high radiation areas were closed (room A09).

The primary cause for the improper barricade in room D78, a posted high radiation area, was the HP technician's failure to verify that the barricade requirements were met when the door to room D79 was unlocked. The only entrance to room D78 is via room D79 which is not a radiation area. The entrance into room D78 is through a labyrinth at the back of room D79. There is no door or locking mechanism at the entry to room D78. There is, however, a lockable door at the entrance to room D79. In order to prevent inadvertent access into the high radiation area of room D78, the cage door at the entrance to room D79 was maintained locked. Operations and other personnel frequently require access to room D79. Since this room was locked, the worker was required to go

ENCLOSURE (CONTINUED)

**VOGTLE ELECTRIC GENERATING PLANT - UNIT 1
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424/92-20 AND 425/92-20**

to the HP control point to sign out the key and return it after the entry. On August 4, 1992, a contract HP technician was given the assignment to unlock the door at room D79 so the key sign-out would no longer be required for entry. At the time the door to room D79 was unlocked, the entry to room D78 was conspicuously posted "High Radiation Area, Notify HP Prior to Entry." Since the contractor HP technician is no longer on site, it was not possible to verify the existence of the required barricade in room D78. This room may have been in this condition until September 15, 1992.

The main reason for the improper barricading of the posted high radiation area in room A09 in the auxiliary building on September 23, 1992, was an HP technician's failure to self-check that the door was closed and locked when he exited the work area. The HP technician was dispatched to unlock room A09 so that contract electricians could perform their assigned tasks. The HP technician, after unlocking the door, remained in the area to assist the workers with removal of their protective clothing. When the job was completed, the two electricians and HP technician left the area with the door open. At approximately 1213, the resident NRC inspector was briefed for a routine entry into room A09. He found the cage door completely open on arrival. He also noted the door did not contain any automatic closure mechanism. The door was closed and the barricade restored. Door A09 was left open and unattended for a maximum of 1 hour and 15 minutes.

Corrective Steps Which Have Been Taken and the Results Achieved

- The entrance to room D78 was immediately barricaded by placing a swing gate at the entrance.
- The door to room A09 was closed and locked upon discovery.
 - All HP foremen and technicians were briefed on the procedural requirements for high radiation areas and their responsibility for ensuring these controls are in place.
 - Appropriate levels of positive discipline were administered to the responsible HP technician.
 - An automatic door closure mechanism has been added to the door leading into room A09.

Corrective Steps Which Will Be Taken to Avoid Further Violations

- All high radiation areas are being checked daily to ensure appropriate barricades are in place. This will continue through November 20, 1992, at which time the frequency of the checks will be reevaluated.

ENCLOSURE (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNIT 1
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-24/92-20 AND 425/92-20

Date When Full Compliance Will Be Achieved

Full compliance was achieved when the barricade was placed at the entrance to room D78 on September 15, 1992, and the barricade (closed door) was restored to room A09 on September 23, 1992.