UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
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ATLANTA, GEORGIA 30303-8931

February 26, 2001

Southern Nuclear Operating Company, Inc.
ATTN: Mr. J. B. Beasley, Jr., Vice President
P. O. Box 1295
Birmingham, AL 35201-1295

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT NOS. 50-424/01-02 AND 50-425/01-02

Dear Mr. Beasley:

On January 26, 2001, the NRC completed an inspection at your Vogtle Electric Generating Plant reactor facilities. The enclosed report documents the inspection findings which were discussed on January 26, 2001**,** with Mr. J. Gasser and other members of your staff.

The inspection examined the area of problem identification and resolution as related to compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and representative records, observed activities, and interviewed personnel.

No findings of significance were identified during the inspection. The inspection team concluded that overall implementation of your corrective action program was effective. Problems were generally properly identified, evaluated, and resolved. A very low threshold for entering problems in the program was observed. However, efforts taken as part of a management priority to reduce configuration control issues have not been focused or coordinated in the corrective action program and have not resulted in a reduction in the number of issues. Minor deficiencies were found regarding classification and evaluation for some low-level condition reports. Inspectors noted that issues from self-assessments were not routinely entered into the corrective action program. This was also observed on a previous inspection.

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Sincerely,

/RA/
Stephen J. Cahill, Chief
Reactor Projects Branch 2
Division of Reactor Projects

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

Enclosure : (See page 2)

Enclosure: NRC Inspection Report 50-424/01-02 and 50-425/01-02

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PUBLIC DOCUMENT (circle one): YES

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.	50-424 and 50-425
License No.	NPF-68 and NPF-81
Report No:	50-424/01-02 and 50-425/01-02
Licensee:	Southern Nuclear Operating Company, Inc. (SNC)
Facility:	Vogtle Electric Generating Plant Units 1 and 2
Location:	7821 River Road Waynesboro, GA 30830
Dates:	January 16 through 26, 2001
Inspectors:	C. Patterson (Team Lead), Senior Resident Inspector, Turkey Point Nuclear Plant P. VanDoorn, Senior Reactor Inspector, Region II T. Morrissey, Vogtle Resident Inspector
Approved by:	Stephen J. Cahill, Chief Reactor Projects Branch 2 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000424-01-02, IR 05000425-01-02, on January 16-26, 2001, Southern Nuclear Operating Company; Vogtle Electric Generating Plant, Units 1 and 2, annual baseline inspection of Problem Identification and Resolution.

The inspection of the licensee's corrective action program (CAP) was conducted by a senior resident inspector, a senior reactor inspector, and a resident inspector. The inspection focused on CAP performance in the period since the previous CAP inspection in March 2000. No significant findings were identified.

Identification and Resolution of Problems

Overall, the licensee's CAP was effective at identifying, evaluating, and correcting problems. The threshold for entering problems into the CAP was low, resulting in a large number of Condition Reports (CRs). Problems entered into the CAP were adequately evaluated and appropriate actions were taken to resolve the problem. One exception was noted concerning the resolution of human performance errors associated with configuration control of components. Although the problem had been previously identified by the licensee as a management priority, the number of instances had remained elevated since the previous NRC team inspection of the CAP in March 2000. The problem was not captured in a single overall CAP trend CR. Therefore, a comprehensive analysis of the scope of the problem and a comprehensive corrective action plan was not developed. Although additional and appropriate corrective actions were taken by the licensee, they were not coordinated or tracked by the CAP.

Some instances of incorrect classification, evaluation, and documentation of low-level CRs were noted. System engineers were found to use the CAP effectively to address equipment issues. Quality Assurance organization audits were effective in identifying issues but licensee self-assessments were inconsistent in scope and format. Self-assessment findings were not always entered into the CAP which was also noted on the previous NRC inspection of corrective action. A safety conscious work environment was found where employees felt free to raise safety issues in CRs or the employee concerns program.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope:

The inspectors reviewed issues that were documented in NRC inspection reports and entered in the licensee's corrective action program (CAP) since the last performance of an NRC CAP team inspection in March 2000 (IR 50-424,425/2000-02). The inspectors discussed problem identification and resolution (PI&R) observations from the baseline NRC inspection program with the resident inspectors. The inspectors reviewed condition reports (CR's) for safety significant systems and discussed them with the system engineer to determine whether problems were effectively identified and evaluated. The systems were Emergency Diesel Generator, Residual Heat Removal, Rod Control, and Auxiliary Feedwater. A walkdown of each system was conducted with the system engineer. The inspectors verified that problems in CRs were properly evaluated using the Maintenance Rule when appropriate. Maintenance work orders for the last six months were reviewed to verify proper classification of deficiencies as either work orders or CRs.

The inspectors reviewed thirteen licensee operating experience (OE) items to determine if they were appropriately evaluated for applicability and if identified problems were entered into the CAP.

During the inspection period, several ongoing plant activities were reviewed: several plan of the day meetings and a Plant Review Board (PRB) meeting on January 19, 2001, were attended; operating logs and the Major Problem Status Report (December 2000) were reviewed; and issues were discussed with plant employees. Several equipment problems discussed during the plan of the day meetings were selected by the inspectors to verify that the issues had been entered into the CAP if necessary.

The inspectors reviewed self-assessment reports, audit reports, internal assessment reports, Human Performance Review Board data, and minutes of the PRB and Safety Review Board (SRB) meetings (listed in the attached List of Documents Reviewed) to determine if oversight activities were effective and if self-identified issues were appropriately entered into the CAP.

(2) Issues and Findings:

The licensee's program for identification of problems was effective. Plant equipment problems, operating experience, and other problems were entered into the CAP. The threshold for entering issues was low and employees were encouraged to enter items. Over 2000 CRs were issued in 2000.

Quality Assurance (QA) group audits were generally effective in identifying issues. Audits of the CAP were focused primarily on licensee procedural compliance versus evaluating the adequacy of root causes, the quality of problem descriptions, or the thoroughness of corrective actions. For example, some audits were focused on only confirming corrective actions were implemented. The PRB and SRB reviewed a large number of CRs, but the reviews did not result in much critical feedback on CR effectiveness or adherence to CAP and management expectations. Inspectors found a recent licensee initiative to establish Human Performance Review Boards was providing valuable feedback for the selected human performance related CRs.

Self-assessments (SAs) were performed on most departments, but some assessments were narrowly focused. Examples included SAs for maintenance dated July 14, 2000; and operations dated July 2000. An SA of the CAP was not performed in the period inspected. The SA program guidance was inconsistent regarding methodology, documentation format, description of issues, and broadness of reviews performed. The previous NRC CAP inspection (IR 50-424, 425/2000-02) documented that some issues from SAs were not entered into the CAP. The inspectors made similar observations again in that minor findings from SAs, audits, and internal assessment observations were sometimes not entered into the CAP. Additionally, the licensee had initiated CR-2001000109 in response to an internal audit finding that actions items had not been entered in the CAP from a November 2000 maintenance rule (A4) SA.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The inspectors reviewed the licensee's quarterly trend reports to determine whether identified trends were placed in the CAP. The inspectors also reviewed the Major Problem Status Report (December 2000) and selected completed CR's to determine whether the conditions identified had been resolved. The licensee classified CRs on safety significance ranging from Severity Level (SL) 1 (high significance) through SL 5 (little or no significance). All SL 3 and above CRs required a formal root cause determination, while SL 4 and 5 CRs could have a root cause determination if directed by management. During the inspection period, no SL 1 CR's and two SL 2 CR's for plant trips were issued. The inspectors reviewed the SL 2 CR's, selected SL 3 and 4 CR's, and several SL 5 CR's. All SL 4 and 5 CR's with a root cause determination were reviewed and root cause preparers for all CRs were verified to ensure they had completed root cause training. A sample of voided CR's was also reviewed to verify they were voided for appropriate reasons such as a duplicate CR.

(2) Issues and Findings:

The licensee was generally effective in the use of trending, problem status reports, and SL classification of CRs to prioritize and evaluate issues. CRs associated with plant trips were notably stringent and effective trending was noted with foreign materials exclusion (FME) issues. Inspectors identified several examples (CRs 200000066, 0388, and 1493) where the root cause preparer was not on the list of trained individuals. Although the procedure required that someone "qualified" perform the root cause

evaluation, it did not define qualification. Since the noted CR evaluations were thorough, this was considered a minor deficiency.

The inspectors had a negative observation related to the prioritization and evaluation of low SL CRs. Several discrepancies were found within the CRs that were sampled. Two SL 5 CRs (2000000188 and 2015) should have been classified as SL 4. SL 5 CRs are for issues identified and corrected at the time of discovery and are used for tracking and trending only. However, appropriate corrective actions were conducted for each, minimizing the impact of these mis-classifications. Three SL 4 CRs (2000000237, 322, and 700) only fixed the immediate physical problem and did not address the cause of the problem or justify why it was not addressed. Although licensee management stated that their expectation was for SL 4 CRs to address the cause of the problem, some licensee personnel did not think that the apparent cause was required to be identified for SL 4 issues and, therefore, was not expected to be addressed. The licensee's CAP guidance does not require apparent cause evaluations so this was considered an inconsistency in implementation and an ineffective use of lower level issues for trending and analysis to initiate preventive actions. Inspectors also found a SL 3 CR (2000001563), regarding a weak procedure which had contributed to a plant event, did not identify corrective actions addressing why the procedure was originally weak.

c. Effectiveness of Corrective Actions

(1) Inspection Scope:

The inspectors reviewed a number of root cause evaluations, the backlog of open items and actions items, and selected CRs to determine if appropriate corrective actions were assigned and implemented. The inspectors attended a Human Performance Review Board that reviewed a human performance error. The inspectors were also briefed by the licensee of an on-going audit of the CAP.

Vogtle human performance issues have resulted in configuration control problems. Since these issues can be safety-significant, the inspectors reviewed 24 related CRs, trends, and selected corrective actions to evaluate effectiveness.

(2) Issues and Findings:

In general, corrective actions were effective. System engineers were knowledgeable of equipment issues and effectively used the CAP to deal with equipment issues. The effectiveness of corrective actions was monitored and the backlog of issues manageable. The inspectors found the Human Performance Review Board initiative to be effective. A number of these boards had been performed to attempt to change behavior of first line supervisors in order to prevent human performance issues.

The inspectors found that the corrective actions associated with CR 2000000066, which documented a continuing trend in the area of FME, were effective and appropriately focused to reduce the number of FME issues. The root cause analysis utilized a multi-disciplined team approach to develop corrective actions.

Licensee trends indicated that the number of human performance induced equipment configuration problems has been elevated since the fourth quarter of 1998 and continued to be elevated in the year 2000. Problems have continued to occur, including several during the inspection. Addressing configuration control problems was a management priority contained in their Major Problem Status Report. Consequently, entering associated problems into the CAP was an emphasized expectation and likely accounted for some of the elevated numbers. Although a CR was occasionally upgraded to a SL 3 from SL 4 based on short term trends, an overall trend CR had not been initiated to drive a full and comprehensive analysis of the issues. Two SL 3 CRs, initiated due to short term trends, both concluded that no trend existed and therefore took no additional corrective actions beyond fixing the specific issue. On six of nine associated SL 3 CRs reviewed, the only corrective action was counseling of individuals. Although licensee management had initiated some appropriate corrective actions in 2000, such as an out-of-position log and Human Performance Review Boards, they were not coordinated or tracked by the CAP. The licensee stated that an analysis had been recently performed of problems involving the Operations department, but this was also not tracked or documented within the CAP. The licensee had not determined which departments were involved with the occurrences of the first three quarters of 2000 or performed reviews of other departments, although they were developing these numbers per department near the end of the inspection.

Licensee management had prioritized this issue as a significant problem. While some good initiatives had been implemented, the licensee had not yet achieved a significant reduction to a level commensurate with independently established standards. The human performance problem was not captured in a single overall CAP trend CR. Therefore, a comprehensive analysis of the scope of the problem and a comprehensive corrective action plan was not developed. During the inspection, the licensee initiated CR 2001000135 to analyze the problems and indicated that a full analysis would be performed.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope:

The inspectors questioned licensee employees during interviews to determine whether any conditions existed that would cause employees to be reluctant to raise safety issues. The inspectors also reviewed the employee concerns program (ECP) in detail. The inspector reviewed an audit of the ECP which included random interviews of employees regarding their willingness to use the ECP if not satisfied with the CAP. The inspectors reviewed the ECP procedure and summary of concerns. The ECP supervisor was interviewed and the visibility of the program was discussed.

(2) Issues and Findings:

No findings of significance were identified. The inspectors determined that the licensee had established and maintained a safety conscious work environment as evidenced by the number of CRs written, a visible ECP, and the results of the NRC independent interviews. In the licensee audit, employees indicated they would use the ECP if an issue could not be resolved with their supervisors. All employees knew who the ECP

coordinator was and this was noted as a significant improvement from the last audit. Employees indicated there was an open environment in which they felt free to raise issues.

4OA5 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on January 26, 2001. The licensee acknowledged the findings presented. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

W. Bargeron, Manager Operations
R. Brown, Manager, Training and Emergency Preparedness
W. Burmeister, Manager Engineering Support
G. Frederick, Plant Operations Assistant General Manager
J. Gasser, Nuclear Plant General Manager
K. Holmes, Manager Maintenance
P. Rushton, Plant Support Assistant General Manager

NRC
L. Reyes, Regional Administrator Region II
S. Cahill, Branch Chief Region II

LIST OF DOCUMENTS REVIEWED

Licensee Procedures:

00150-C	Condition Reporting and Tracking System, Rev 30
80014-C	Handling of Condition Reports for Deficient Conditions, Rev 17
80016-C	Trend Identification and Reporting, Rev 3
00040-C	Self Assessment Program, Rev 3
00414-C	Operating Experience Program, Rev 13
VSAER-WP-03	Safety Audit and Engineering Review Field Audits, Rev 15
VSAER-WP-05	Annual SAER Department Assessment, Rev 6
00058-C	Root Cause Determination, Rev 13
00409-C	Action Item, Open Item, and Commitment Tracking, Rev 15
VNS-AP-16	Condition Reporting and Tracking System, Rev 0
SNOC	Concerns Program Procedure, Rev 4

Operating Experience:

Information Notice (IN)	
88-023	"Potential for Gas Binding of HPSI pumps during a Loss-of-Coolant Accident," Supplements 1 - 5
IN 98-02	"Nuclear Power Plant Cold Weather Problems and Protective Measures"
IN 98-11	"Cracking of Reactor Vessel Internal Baffle Former Bolts in Foreign Plants"
IN 98-21	"Potential Deficiency of Electrical Cable/Connection Systems"
IN 98-31	"Fire Protection System Design Deficiencies and Common-Mode Flooding of ECCS Rooms at WNP-2"
IN 99-14	"Unanticipated Reactor Water Draindown at Quad Cities Unit 2, Arkansas Nuclear One Unit 2, and Fitzpatrick"
IN 99-21	"Recent Plant Events Caused by Human Performance Errors"
SOER 99-1	"Loss of Grid"
SER 1-0	"Significant Reactor Coolant System Leakage Resulting from RHR Piping Failure
SEN 211	"Mispositioned Valve Causes Inadvertent Draindown of the RCS as Shutdown Cooling is Placed in Service"
SER 98-01	"Unplanned Personnel Radiation Dose"
SEN 195	"Unplanned Entry into Reduced Inventory Conditions During Refueling Cavity Draindown"
SEN 210	"Reactor Scram Caused by Rapid Injection of Cold Feedwater"

Condition Reports:

2000002309	Unit 1 Reactor Tripped During Surveillance
2000000933	Unit 1 Manual Reactor Trip Due to MSIV Closure
2000000267	SAER Audit Finding Report - Training Not Attended
2000000388	Error in OTDT Set point Calculation
2000000684	CR for Trending - Refrigerant Records
2000001493	Reporting of Changes in Peak Clad Temperature Calculation
2000000016	Rod Control Firing Card Failure

2000000299	Rod Control Bank Step
2000000555	Rod Control ARO Position
2000000663	Rod Control Auto Step
2000000690	Rod Control Auto Step
2000000752	Rod Control Auto Step
2000000783	Rod Control Auto Step
2000000859	Rod Control Auto Step
2000001104	Rod Control Auto Step
2000001200	Rod Control Auto Step
2000001252	Rod Control Auto Step
2000001689	Rod Control Procedure Not Sent to Document Control
2000002206	Rod Positioning
2000002294	Rod Bank Lo Limit Alarm Not Received
2000000833	Voided
2000001096	Voided
2000000764	Voided
2000000671	Voided
2000002351	Voided
2000001859	Voided
2000001665	Voided
2000001319	Voided
2000002143	Test
2000000988	Test
2000000151	CR Not Written
2000002017	Defective Zone Alarm
2000002196	LER Corrective Action Not Implemented On Time
2000002010	CR Overdue
2000002012	CR Overdue
2000001386	Recurring Problem with Discharge Flange
2000001399	Recurring Leakage Problem on Seal Injection Filters
2000001868	CR Missing From Database
2000000384	Numbers Discrepancies Breaker Labels
2000000584	Power to Annunciator System Inverter Failed
2000000306	Repeated Pipe Failures on TDAFW Steam Drain
2000000353	Sheared Roll Pins on Valve Reach Rod
2000000162	EDG 2B Link Pin Bushing Damage
2000000237	EDG 2A Turbo Charger Nozzle Ring
2000000243	EDG 2A Control Air Fitting Failure
2000000322	EDG 1A Jacket Water Temperature Alarm Improper Actuation
2000000700	EDG 2A Fuel Rack Bell Crank Arm Anti-Rotation Pin Missing
2000000882	EDG 2A Start Admission Valve Leak
2000000888	EDG 2A Start Air Admission Block Valves Leaking
2000001359	EDG 2A Fuel Oil Strainer Delta P High
2000001360	EDG 2A Start Air Valve Leaks
2000001486	EDG 1B Crankcase Pressure Indication Manometer Low on Fluid
2000001487	EDG 1B Logic Probe Failure During Testing
2000001488	EDG 1B Crank Case Pressure High Due to Oil in Water

2000001563	Technical Specification 3.0.3, Entry for Unit 1 Safety Injection
2000001679	Operations Error Load to Missed Fire Watch
2000000063	Document potential trend for Clearance-related Occurrences as identified in Vogtle Quarterly Trend Report 3Q99
2000000065	Document potential trend for Failed Surveillance or Acceptance Criteria as identified in Vogtle Quarterly Trend Report 3Q99
2000000066	Document potential trend for Foreign Materials Exclusion as identified in Vogtle Quarterly Trend Report 3Q99
2000001409	Potential developing trend for occurrences associated with “purchase order not complied with “ event code
2000000307	TDAFW pump did not meet acceptance criteria
2000000308	Review of TDAFW pump operability test performed on 1/22/00 found turbine speed recorded to be incorrect
2000000309	Review of TDAFW pump operability test performed on 1/27/00 found required discharge pressure to be less than acceptance criteria
2000000366	18 month unavailability for Unit 1 AFW train C exceeded Maintenance Rule criteria.
2000001007	TDAFW pump operability test performed out of sequence
2000001881	TDAFW turbine failed overspeed test
2000002016	TDAFW turbine sticking governor valve
2000001833	Replaced MDAFW pump A mechanical seal gland ring did not have proper documentation
2000001134	Train B AFW pumphouse fan trip on thermal overload not documented as required
2000001123	Train B AFW pumphouse fan tripped on thermal overload
2000002015	TDAFW injection near miss
2000001402	Air bubbles discovered during 2B RHR discharge venting
2000001413	RHR hot leg injection relief discovered to have plug in bonnet leak off port
2000001449	RHR containment sump PASS sample valve failed to stay closed during performance of slave relay test
2000001569	RHR B miniflow valve did not auto close as expected
2000001883	RHR pump room drains left open contrary to drawing
2000001683	RHR suction relief discovered to have plug in bonnet leak off port
2000002286	RHR elementary diagram lists incorrect contact and valve position for an RHR valve
2000000156	CR initiated in response to review of San Onofre inspection report regarding licence operator required on-shift under instruction requirements
2000000188	CR initiated in response to review of a federal register notice involving annual respirator fit tests
2000000259	CR initiated in response to review of a Beaver Valley LER on the subject of RCS dose equivalent iodine
2000000735	CR initiated in response to review of NRC IN 2000-07 on the subject of SCBA cylinders
2000001112	Procedure that contained actions in response to GL88-14 was deleted
2001000091	Work plan to replace Fuses not Correct
2001000094	OE issue was closed with action still pending
2001000109	Self assessment action items not assigned

2001000135 Testing of Configuration Control Problems

Configuration Control Issues CRs:

CR 2000000028	CR 2000000063	CR 2000000168
CR 2000000357	CR 2000000413	CR 2000000552
CR 2000000717	CR 2000000760	CR 2000000762
CR 2000000791	CR 2000000804	CR 2000000978
CR 2000001029	CR 2000001228	CR 2000001448
CR 2000001460	CR 2000001637	CR 2000001854
CR 2000002040	CR 2000002132	CR 2000002132
CR 2000002174	CR 2000002215	CR 2000002215
CR 2000002251		

Maintenance Work Orders:

Maintenance Work Orders for RHR, AFW, and Rod Control, since July, 2000

Licensee Audits:

Audit of Corrective Action Programs, VSAER-2000-077
Audit of Corrective Action Programs, OP21-00/14
Audit of Corrective Action Programs, VSAER-2000-016
Audit of 1R9 Refueling Outage Activities, VSAER-2000-095
Audit of Surveillance Program/Technical Specification Compliance, VSAER-2000-084, 9/25/00
Audit of Environmental Monitoring and Environmental Technical Specifications,
Audit of Health Physics and Radiation Protection, VSAER-2000-085
Audit of Plant Chemistry and Environmental Monitoring - VSAER-2000-039
Audit of Radioactive Waste Control, VSAER-2000-044
Audit of Equipment Qualification, VSAER-2000-055
Audit of Fuel Handling and Special Nuclear Material Control, VSAER-2000-065
Audit of Fire Protection Program, VSAER-2000-068

Self-Assessments:

Minutes - SRB Major Meeting 00-01
Minutes - SRB Major Meeting 00-03
Minutes - SRB Major Meeting 00-05
Minutes - SRB Major Meeting 00-10
Plant Review Board Minutes 2000-1 through 20 and 54 thru 69
Operations Fall 2000 Self Assessment
Operations Department Self Assessment - July, 2000
Maintenance Self Assessment - July 14, 2000
10 CFR 50.65(a)(4) Self Assessment - November 6-8, 2000
Maintenance Rule Periodic Assessment - May, 2000
Design Control Self Assessment - April, 2000
Review of Flow Accelerated Corrosion Program - September 27, 2000

Internal Assessment Report for September, 2000
Internal Assessment Report for October, 2000
Internal Assessment Report for November, 2000
Human Performance Review Board Data
Operations Self Assessment - July 30, 1999
Maintenance Self Assessment - February, 1999
Health Physics Self Assessment Observation/Assessment Forms - February 2000 and May 2000
Chemistry Self Assessment Observation/Assessment Forms - 2000
Human Performance Leading Indicators - November and December, 2000
Not Improving, NSAC judgement

Independent Safety Engineering Group monthly reports - January 2000 - December 2000

Vogtle Quarterly Trend Reports

-November, December 1999 and January 2000
-February, March and April 2000
-May, June and July 2000
-August, September and October 2000

Vogtle Major Problems Status Report - December 22, 2000

Previously Identified NRC Concerns

NCV (50-424/00-02-01), Failure to promptly identify and correct degraded TDAFW pump flow conditions (CR's 2000000307, 309 and 366)