Arizona Nuclear Power Project
P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

July 7, 1986
ANPP-00015-JGH/TDS/96.03

Mr. John B. Martin, Regional Administrator
U.S. Nuclear Regulatory Commission
Region V
1450 Maria Lane, Suite 210
Walnut Creek, CA 94596-5368

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 2
Docket No STN 50-529 (License NPF-51)

Notice of Violation: 50-529/86-17-02

File: 86-001-493

Reference: Letter from A. E. Chaffee (NRC) to E. E. Van Brunt, Jr. (ANPP), dated June 13, 1986, NRC Inspection Reports 50-528/86-16, 50-529/86-17 and 50-530/86-11.

Dear Mr. Martin:

This letter is provided in response to the inspection conducted by Messrs. R. Zimmerman, C. Bosted, G. Fiorelli and J. Ball of the NRC Staff on April 14 through May 26, 1986. Based on the results of the inspection, one (1) violation of NRC requirements was identified (failure to follow procedure during containment air lock seal leak test). The violation is discussed in Appendix A of the referenced letter. The violation and ANPP's response is provided in Attachment A. The response to the concern of general procedural adherence as discussed in the referenced letter is provided in Attachment B.

Very truly yours,

JGHaynes

J. G. Haynes
Vice President
Nuclear Production

JGH/TDS/kj

Attachments

cc: E. E. Van Brunt Jr. (w/attachment)
L. F. Miller (w/attachment)
R. P. Zimmerman (w/attachment)
E. A. Licitria (w/attachment)
A. C. Gehr (w/o attachment)

IE-01

bcc: R. M. Butler (all w/ attachments)
J. R. Bynum
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LCTS Coordinator

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ATTACHMENT A

NOTICE OF VIOLATION

Arizona Nuclear Power Project
Post Office Box 52034
Phoenix, Arizona 85072-2034

Docket No. 50-529
License No. NPF-51

Technical Specification 6.8.1.c requires that written procedures be established and implemented for surveillance and test activities of safety-related equipment.

PVNGS Manual Procedure 73ST-9CL03, Containment Airlock Seal Leak Test, Revision 1 (through procedure change notice number 3), effective February 7, 1986, paragraph 10.0, Contingencies, states that when the inner door fails the seal leak test and requires repair, the outer door shall remain closed until repair and retest have been satisfactorily completed.

Contrary to the above, on April 11, 1986, the Unit 2 140' containment airlock inner door failed a seal leak test performed using procedure 73ST-9CL03, and the outer door was opened prior to satisfactory repair and retest of the inner door.

ANPP's RESPONSE TO VIOLATION

I. THE CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

As an immediate corrective action the engineers involved were counseled on the importance of procedural adherence and ANPP's policy concerning deviations from that position. Additionally, the Technical Support Department Manager issued a memorandum to all personnel in the department addressing the importance of preventing personnel errors during the performance of assigned tasks and reiterating the consequences of committing errors through negligence. The procedure, which was being utilized during the airlock seal leak test, has been revised to clarify the differences between Unit I and Unit II's Technical Specifications. An evaluation of the overall effectiveness of these measures is discussed in Attachment B.

II. THE CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER ITEMS OF NONCOMPLIANCE

An evaluation was conducted to determine the root cause of the identified deficiency. Based upon the results of the evaluation it was determined that the event was caused by a conscious decision made by the responsible personnel to violate the established procedural controls. Their decision was based on a known difference between Unit I and Unit II's Technical Specifications. The difference, as explained in the inspection report, permits the operable door to be opened for a cumulative time not to exceed one hour per year in Unit II. The procedure being used during this activity, 73ST-9CL03 "Containment Airlock Seal Leak Test", was written to

address the requirements of Unit I's Technical Specifications and does not provide the option to open the operable door. The responsible personnel were aware that performing the tasks in the manner that they did, had no safety impact and did not violate Unit II's Technical Specification 3.6.1.3. They were also aware that their actions were contrary to the requirements of the approved procedure. Therefore, based on ANPP Management's continued attention to issues such as procedural adherence, a broad scope plan has been developed. This plan is discussed in Attachment B.

III. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on April 11, 1986 when the Containment Airlock Door was successfully tested and closed.

ATTACHMENT B

In response to the general issue discussed in the referenced letter, an evaluation was conducted to address not only the specific incidents identified but the generic question of procedural adherence. The inspection report transmittal letter states that the potential for a more general problem exists based on two previous concerns of procedural noncompliance identified in 1985. The specific incidents described were attributed to willfull violations of procedural controls, committed by knowledgeable individuals without ANPP Management's knowledge. The incidents cited, when evaluated in the overall context of procedural adherence, appear to be isolated cases which could only be addressed as they were on a case by case basis.

However, during the course of the evaluation, potential areas of weakness in procedural adherence were identified. These areas have been isolated to individual departments and do not appear to represent a generic concern. ANPP Management's continued concern in this area is demonstrated by the implementation of various corrective measures whenever a potential problem such as this was identified.

Since 1983, ANPP Management has implemented various programs and initiated changes to existing programs to reduce both personnel errors and procedural violations. These efforts have included:

a. Establishment of a "Quality Improvement Report" (QIR) program in the I&C Maintenance area. This program was designed to investigate various incidents, determine the cause and develop the necessary corrective action plan. This program was implemented in I&C Maintenance initially because of

specific concerns identified that appeared unique to that area.

b. Expansion of the QIR program to include all areas of the Maintenance Department.

c. Modifying the existing administrative controls which specify how approved procedures may be revised or changed. This was done to expedite the process and enable the user to easily modify an existing procedure whenever an error was discovered or a potential enhancement was identified.

d. Establishment of the "Operations Department Experience Report" (ODER) program. This program was designed to achieve the same objectives as the QIR program.

In conjunction with the specific programs described above additional generic actions were taken. These included:

a. The production of a video tape by the Executive Vice President in which he stressed the criticality of procedural adherence. This video was required to be viewed by all PVNGS personnel and is currently being used during the new employee indoctrination.

b. The topic of procedure adherence was repeatedly used as a topic in the "Quality Talks" program.

c. Including the topic of "Procedural Adherence" in the "Site Access Training" program (SAT).

As described above various approaches had been taken in the past to address not only the generic issue of procedural adherence but to specifically address identified weaknesses and concerns. The individual successes of these programs varied. However, the implementation of the QIR and accelerated disciplinary programs in the I&C Maintenance area proved effective. Based upon the success achieved the decision

area proved effective. Based upon the success achieved the decision was made to utilize this approach to address the recently identified concerns. The basic program is being expanded to include all individuals reporting to the Plant Manager. The initial implementation of this program was begun on July 7, 1986, when the Plant Manager issued a memorandum to all PVNGS personnel stressing the necessity to reduce personnel errors and to comply with all station procedures. The memorandum also emphasized the potential for administering accelerated disciplinary action for any individual who, through willfull intent or negligence, commits an error or procedural violation. The Compliance Manager has been assigned the responsibility to develop the remaining portions of the program which includes:

a. Expansion of the existing QIR program philosophy to encompass all departments reporting to the Plant Manager. This approach will ensure that a comprehensive review is conducted for all incidents effecting the department, that the root cause is identified and that effective corrective actions are initiated.

b. Establishment of a committee, consisting of the Plant Manager and his direct reports, to review incidents and interview personnel found to have willfully or through negligence committed an error or procedural violation. This committee will evaluate the incidents on a case by case basis and recommend appropriate disciplinary actions.

ANPP Management believes that full implementation of this comprehensive program, expected by October 1, 1986, will successfully control and reduce both personnel errors and procedural violations.