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102-01549-WFC/TDS/TRB

December 21, 1989 DEC 28 AID: 12

WILLIAM F. CONWAY
EXECUTIVE VICE PRESIDENT
NUCLEAR

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

Reference: Letter from A. E. Chaffee, Deputy Director, Division of Reactor
Safety and Projects, NRC to W. F. Conway, Executive Vice President
Nuclear, Arizona Public Service, dated November 21, 1989

Dear Sir:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Units 1, 2, and 3
Docket No. STN 50-528 (License No. NPF-41)
STN 50-529 (License No. NPF-51)
STN 50-530 (License No. NPF-74)
Reply to Notice of Violations - 50-529/89-43-02, 50-529/89-43-01,
50-528/89-43-02 and 50-529/89-43-03
File: 89-070-026

This letter is provided in response to the inspection conducted by Messrs. D. Coe, T. Polich, J. Ringwald and J. Sloan from September 11 through October 15, 1989. Based on the results of the inspection, four (4) violations of NRC requirements were identified. The violations are discussed in Appendix A of the referenced letter. A restatement of the violations and PVNGS's responses are provided in Appendix A and Attachment 1, respectively, to this letter. Attachment 2 contains a list of items discussed within the inspection report which APS believes require clarification. The items in Attachment 2 were also discussed with the NRC resident staff.

The referenced letter states that APS's management expectation for plant activities to proceed only with careful attention to detail in accordance with procedural requirements and not in the face of uncertainty, has yet to be fully ingrained into the Palo Verde organization. The letter lists five (5) examples where more thoughtful and methodical work practices and better supervisory oversight could have avoided problems and requests our evaluation of the underlying reasons for the events.

PVNGS management has evaluated the specific examples and concurs with the NRC's assessment that management expectations have not yet been fully ingrained throughout our organization. The cause of this may vary for each specific example however, as pointed out at the December 1, 1989, NRC/APS management meeting, the culture and attitudes which have existed for some time are changing.

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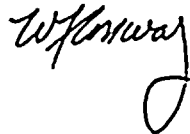


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Should you have any questions regarding this response, please contact me.

Very truly yours,



WFC/TDS/TRB/kj

Attachments

cc: J. B. Martin
T. J. Polich
T. L. Chan

E. E. Van Brunt
A. C. Gehr
J. R. Newman



APPENDIX A

NOTICE OF VIOLATION

Arizona Nuclear Power Project
Palo Verde Units 1, 2 and 3

Docket Numbers 50-528, 50-529 and 50-530
License Numbers NPF-41, NPF-51 and NPF-74

During an NRC inspection conducted from September 11 through October 15, 1989, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1989), the violations are listed below:

A. Technical Specification 6.8.1 states, in part: "Written procedures shall be established, implemented, and maintained covering... the recommendations in Appendix A for Regulatory Guide 1.33, Revision 2, February, 1978..." (RG 1.33).

1. RG 1.33, paragraph 2, "General Plant Operating Procedures", recommends procedures for "Hot Standby to Minimum Load (Nuclear Startup)."

RG 1.33 is implemented in part by ANPP Unit 2 procedure 42OP-2ZZ03, "Reactor Startup," which includes two steps in 4.3.7.4, "At the Startup and Control Channel Drawer". One of these steps, step 4.3.7.4.2, directs the operator to shift the HV meter from Start Up to Control.

Contrary to the above, on September 22, 1989, a Unit 2 licensed Control Room Operator did not switch the HV meter from Startup to Control and a licensed Assistant Shift Supervisor signed this step off as complete when it had not been performed.

2. RG 1.33, paragraph 9, "Procedures for Performing Maintenance", recommends procedures for "Maintenance that can affect the performance of safety-related equipment..."

RG 1.33 is implemented in part by ANPP Work Order 381401 to adjust the Blowdown Ring of Main Steam Code Safety Valve SGE-P5V-0556. Step 4.5A directed the mechanic to "Insert gauge OP 2040, 0.133 inch end..." to check the position of the upper blowdown ring.

Contrary to the above, on September 15, 1989, the mechanic used gauge OP2041 and logged gauge OP2041 in the work order as the gauge used.



APPENDIX A

(CONTINUED)

- B. Technical Specification 6.5.1.6(c) states: "The Plant Review Board (PRB) shall be responsible for: Investigation of all violations of the Technical Specifications (T/S) including the preparation and forwarding of reports covering evaluation and recommendations to prevent recurrence to the Nuclear Safety Group (NSG)." 6.5.1.7(a) states: "The PRB shall: Render determinations in writing with regard to whether or not each item considered under Specification 6.5.1.6(c) above constitutes an unreviewed safety question."

Contrary to the above, from January 1, 1989 to September 1989, five Licensee Event Reports (LERs) of T/S violations were issued by the licensee, none of which received a PRB written evaluation. Thus, for none of these violations did the licensee determine in writing whether the violations constituted unreviewed safety questions, and the licensee failed to send to the NSG written evaluations and recommendations to prevent recurrence.

- C. 10 CFR 50.74 states, in part: "Each licensee shall notify the Commission in accordance with 10 CFR 50.4 within 30 days of the following in regard to a licensed operator or senior operator.

(c) Disability or illness..."

Contrary to the above, a licensed operator was removed from duties and denied access to the protected area of the reactor facilities on July 6, 1989, because of a medical disability. This was not reported to NRC until September 15, 1989



ATTACHMENT 1

REPLY TO NOTICE OF VIOLATION 50-529/89-43-02

A.1.I REASON FOR VIOLATION

During performance of a reactor startup on September 22, 1989, the control room received the "High CPS (counts per second)" annunciator as expected. In accordance with procedure, the Reactor Operator (RO) verified overlap between the Startup Channels and turned off the high voltage to the Startup Channels by selecting the Control Channel in the control room.

The Assistant Shift Supervisor, in accordance with procedure, directed another RO to the local Startup and Control Channel drawer to remove the High Voltage Permissive and to shift the indication to the Control Channel meter. The RO acknowledged the direction and left the control room to perform the required actions, but did not take a copy of the procedure with him. The RO removed the High Voltage Permissive but did not shift the Control Channel meter for indication. When the RO returned to the control room, the Assistant Shift Supervisor asked him if the required steps had been performed. The RO responded affirmatively and the Assistant Shift Supervisor signed off both procedure steps.



This violation is attributable to personnel error, i.e. failure of the RO to follow approved procedures.

A.1.II

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

As immediate corrective action, the Shift Supervisor, when notified of this occurrence, shifted the indication meter to the control channels. Additionally, the Shift Supervisor counseled the RO and Assistant Shift Supervisor involved.

Unit 2 operating crews have been briefed on this event and have received instruction that they may sign off only procedure steps which they have performed.

The Unit 1, 2, and 3 Operations Managers issued a memorandum to Shift Supervisors and Assistant Shift Supervisors reiterating management's expectations concerning the use of procedures.

APS management has also reviewed and revised the guidance within Administrative Procedure 40AC-90P02, "Conduct of Shift Operations" regarding the use of procedures to make clear the management policy that procedures shall be used and followed exactly as written. This review and resulting actions are documented in a letter from J. N. Bailey, APS to J. B. Martin, NRC dated November 17, 1989.



The Vice President, Nuclear Production has issued a memorandum to PVNGS supervisors requiring each supervisor to discuss with his employees the appropriate procedural controls in their areas of responsibility and ensure that their employees understand the importance of proper procedural usage, controls, and compliance.

A.1.III CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

APS believes that the actions taken above should minimize the likelihood of recurrent violations. APS management will continue to stress its expectations in this area and will evaluate each occurrence, if any, of failure to follow procedures to ensure actions taken in each case are sufficient.

A.1.IV DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on September 22, 1989, when the Shift Supervisor shifted the indication meter to the control channels.



ATTACHMENT 1

(CONTINUED)

A.2.I. APS denies the violation occurred.

REASON FOR DENIAL OF VIOLATION

Prior to performance of the maintenance task, the work order had been changed to require the use of gauge OP2041. Step 4.5A of work order #00381399 stated "Insert gauge OP2040, 0.113" end of the gauge up against the bottom of the upper ring...". Upon review of the work order and Engineering Evaluation Request (EER) 89-SG-281, it was determined by the Work Group Supervisor, Engineering, and Quality Control that the gauge that should be used at step 4.5A is OP2041 and not OP2040.

Step 3.6.3 of procedure 30DP-9WP02, Work Planning, states, in part:

"Nonscope/nonintent changes, additional work instructions, for any work package initially reviewed by Quality Control that are recommended by field personnel may be approved by the WGS or Planner and shall receive a quality control review for inspection points insertion. All changes of this type shall be documented in the work package."



Procedure 30DP-9WP02 defines Intent Change as:

"Exists when the change alters the Work Order Package objectives."

Procedure 30DP-9WP02 defines Scope Change as:

"When the work required involves work on equipment other than what is defined in the original work order instructions."

Since the change of gauges was a nonintent/nonscope change, the work group supervisor was authorized to change the work order. The work group supervisor and quality control inspector changed the work order and initialled the change in accordance with procedural requirements prior to step 4.5A being performed. Step 4.5A was then performed using gauge OP2041 as required by the changed work order.

Based on the above, the work order steps were performed as specified by the change, the change was properly made in accordance with procedural requirements and no violation of PVNGS procedures occurred.



ATTACHMENT 1

(CONTINUED)

REPLY TO NOTICE OF VIOLATION 50-528/89-43-02

B.I. REASON FOR VIOLATION

The violation resulted from a misinterpretation of the Technical Specifications by the former PRB chairman which resulted in the NSD receiving information on Technical Specification violations and their causes by distribution of associated Licensee Event Reports (LERs) and LER trending reports, and not from written PRB evaluations of the individual LERs.

Each completed Licensee Event Report (LER) is distributed to each Plant Review Board (PRB) member and to the Nuclear Safety Department (NSD) for their review. Contained within each LER, as required by 10CFR50.73, are conclusions regarding safety significance and actions to prevent recurrence.

Additionally, a LER monthly trend report is distributed to the PRB and NSD. Within the trend report, Technical Specification violations are specifically denoted along with a listing of the applicable LERs. Thus, APS provides, in writing, evaluations concerning safety significance and actions to prevent recurrence.



The PRB believed that its review of the monthly Licensee Event Report (LER) trend information, concurrent with individual PRB member review of LERs, was fulfilled to meet the requirement of Technical Specification (T.S.) 6.5.1.6.c. This review, when documented in PRB meeting minutes, was also believed sufficient to meet the requirement of T.S. 6.5.1.7.a to render a determination in writing with regard to whether or not the T.S. violations constituted an unreviewed safety question. Since the NSD received the LERs, the LER trend reports and the PRB meeting minutes, the PRB believed the T.S. requirements had been fully met.

B.II. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

To ensure that violations of Technical Specifications are properly reviewed, the PRB practices have been changed to require PRB review of LERs rather than just the monthly LER trend report. Further, a compilation of those T.S. violations that are not reportable as LERs will be provided to the PRB on a monthly basis by the Compliance Department. The conclusions resulting from this review will be documented in meeting minutes. Should additional comments or corrective actions be deemed necessary, these will be documented in PRB meeting minutes which are reviewed routinely by the Nuclear Safety Department.



B.III. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The PRB will review the 1989 Technical Specification violations (reportable and non reportable) during meetings scheduled for December, 1989 and January, 1990. Documentation of that review will be in accordance with the method discussed above.

B.IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance will be achieved by January 31, 1990, upon completion of PRB review of the 1989 Technical Specification violations.



ATTACHMENT 1

(CONTINUED)

REPLY TO NOTICE OF VIOLATION 50-529/89-43-03

C.I. REASON FOR VIOLATION

At the time of the event the Nuclear Licensing Department was in the process of developing a procedure to identify and describe incapacitation of a licensed operator resulting from disability or illness including notification of the NRC. The procedures were not in place as of the date of the event which is the subject of the violation and timely notification was not made.

C.II CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Nuclear Administrative and Technical Manual procedure 93GB-OLC09, "Incapacitation of Licensed Operators," became effective on October 3, 1989, and incorporates the reporting requirements of 10 CFR 50.74(c) and 10 CFR 55.25 into the PVNGS Operator licensing program.

C.III CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Implementation of Nuclear Administrative and Technical Manual procedure 93GB-OLC09 should ensure no further violations of the cited regulation. Therefore, no further corrective action for this specific



violation are planned. As an additional activity however, a systematic review of 10 CFR Part 55 and 10 CFR 50.74 has been performed to identify all additional requirements for licensee notifications and submittals related to Operators' Licenses. Procedures to ensure controls exist for all notifications required by 10 CFR Part 55 and 10 CFR 50.74 will be developed.

The Vice President, Nuclear Production; Manager, Nuclear Licensing; Operations Managers; Senior Nurse, Palo Verde Medical Department; Manager, Nuclear Training; and Licensed Operators have been sent a copy of procedure 93GB-OLC09 with their respective responsibilities and procedural requirements highlighted.

C.IV DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on September 15, 1989, upon submittal of notification of incapacitation of a licensed operator.

Procedures to ensure controls exist for all notifications required by 10 CFR Part 55 and 10 CFR 50.74 are scheduled to be completed by March 31, 1990.



ATTACHMENT 2

To ensure that future references to Inspection Report 89-43 do not rely on inaccurate statements in the report, APS would like to point out the following corrections:

1. Appendix A, Item A.2 states that Work Order (W.O.) 381401 was used to adjust valve SGE-PSV-0556. W.O. 381399 is for valve SGE-PSV-0556 and is the W.O. discussed in Paragraph 11 of the Inspection Report. A discussion with the NRC resident inspector confirmed that W.O. 381399 was the W.O. in question.
2. Appendix A, Item A.2 states that the mechanic performed the work. This is incorrect. The vendor performed the work as required by Step 1.1A of the work order.
3. Paragraph 11 of the Inspection Report states that "gauge OP2040 does not have a 0.113 inch end, it is constructed with a .058" tip and a 0.171" step." This is incorrect. Gauge OP2040 has a .058" tip and a 0.113" step with a total thickness of 0.171." It should be noted that either gauge 2040 or 2041 can perform the ring clearance measurement (0.113" + or - .020") required by the work order.
4. Paragraph 11 of the Inspection Report states that "The work order was very specific in requiring particular tools for the mechanics to measure the ring clearances but made no mention of which tool the



Quality Control (QC) Inspector was to use..." This is incorrect. The work order specifically states that "QC holdpoint/verify the gauge portion of upper ring acceptable per Step 4.5A and EER 89-SG-281." This holdpoint requires the QC inspector to perform the identical inspection that the vendor performed per Step 4.5A. Additionally, EER 89-SG-281 states that gauge EM-3195 is to be used to verify the clearance. The QC inspector used EM-3195 as documented in the work order.

5. Paragraph 11 of the Inspection Report states that mechanics used a slugging wrench and then a sledge hammer to loosen a stuck plug. This is incorrect. A light ballpeen hammer was used. This practice is acceptable in cases where a bolt or plug is stuck or exhibits signs of corrosion.



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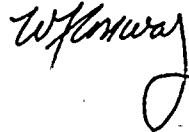


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ATTACHMENT 1

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REASON FOR VIOLATION

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This violation is attributable to personnel error, i.e. failure of the RO to follow approved procedures.

A.1.II CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

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ATTACHMENT 1

(CONTINUED)

REPLY TO NOTICE OF VIOLATION 50-528/89-43-02

B.I. REASON FOR VIOLATION

The violation resulted from a misinterpretation of the Technical Specifications by the former PRB chairman which resulted in the NSD receiving information on Technical Specification violations and their causes by distribution of associated Licensee Event Reports (LERs) and LER trending reports, and not from written PRB evaluations of the individual LERs.

Each completed Licensee Event Report (LER) is distributed to each Plant Review Board (PRB) member and to the Nuclear Safety Department (NSD) for their review. Contained within each LER, as required by 10CFR50.73, are conclusions regarding safety significance and actions to prevent recurrence.

Additionally, a LER monthly trend report is distributed to the PRB and NSD. Within the trend report, Technical Specification violations are specifically denoted along with a listing of the applicable LERs. Thus, APS provides, in writing, evaluations concerning safety significance and actions to prevent recurrence.



The PRB believed that its review of the monthly Licensee Event Report (LER) trend information, concurrent with individual PRB member review of LERs, was fulfilled to meet the requirement of Technical Specification (T.S.) 6.5.1.6.c. This review, when documented in PRB meeting minutes, was also believed sufficient to meet the requirement of T.S. 6.5.1.7.a to render a determination in writing with regard to whether or not the T.S. violations constituted an unreviewed safety question. Since the NSD received the LERs, the LER trend reports and the PRB meeting minutes, the PRB believed the T.S. requirements had been fully met.

B.II. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

To ensure that violations of Technical Specifications are properly reviewed, the PRB practices have been changed to require PRB review of LERs rather than just the monthly LER trend report. Further, a compilation of those T.S. violations that are not reportable as LERs will be provided to the PRB on a monthly basis by the Compliance Department. The conclusions resulting from this review will be documented in meeting minutes. Should additional comments or corrective actions be deemed necessary, these will be documented in PRB meeting minutes which are reviewed routinely by the Nuclear Safety Department.



B.III. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The PRB will review the 1989 Technical Specification violations (reportable and non reportable) during meetings scheduled for December, 1989 and January, 1990. Documentation of that review will be in accordance with the method discussed above.

B.IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance will be achieved by January 31, 1990, upon completion of PRB review of the 1989 Technical Specification violations.



ATTACHMENT 1

(CONTINUED)

REPLY TO NOTICE OF VIOLATION 50-529/89-43-03

C.I. REASON FOR VIOLATION

At the time of the event the Nuclear Licensing Department was in the process of developing a procedure to identify and describe incapacitation of a licensed operator resulting from disability or illness including notification of the NRC. The procedures were not in place as of the date of the event which is the subject of the violation and timely notification was not made.

C.II CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Nuclear Administrative and Technical Manual procedure 93GB-OLC09, "Incapacitation of Licensed Operators," became effective on October 3, 1989, and incorporates the reporting requirements of 10 CFR 50.74(c) and 10 CFR 55.25 into the PVNGS Operator licensing program.

C.III CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Implementation of Nuclear Administrative and Technical Manual procedure 93GB-OLC09 should ensure no further violations of the cited regulation, therefore, no further corrective steps for this specific



violation are planned. As an additional activity however, a systematic review of 10 CFR Part 55 and 10 CFR 50.74 has been performed to identify all additional requirements for licensee notifications and submittals related to Operators' Licenses. Procedures to ensure controls exist for all notifications required by 10 CFR Part 55 and 10 CFR 50.74 will be developed.

The Vice President, Nuclear Production; Manager, Nuclear Licensing; Operations Managers; Senior Nurse, Palo Verde Medical Department; Manager, Nuclear Training; and Licensed Operators have been sent a copy of procedure 93GB-OLC09 with their respective responsibilities and procedural requirements highlighted.

C.IV DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on September 15, 1989, upon submittal of notification of incapacitation of a licensed operator.

Procedures to ensure controls exist for all notifications required by 10 CFR Part 55 and 10 CFR 50.74 are scheduled to be completed by March 31, 1990.



ATTACHMENT 2

To ensure that future references to Inspection Report 89-43 do not rely on inaccurate statements in the report, APS would like to point out the following corrections:

1. Appendix A, Item A.2 states that Work Order (W.O.) 381401 was used to adjust valve SGE-PSV-0556. W.O. 381399 is for valve SGE-PSV-0556 and is the W.O. discussed in Paragraph 11 of the Inspection Report. A discussion with the NRC resident inspector confirmed that W.O. 381399 was the W.O. in question.
2. Appendix A, Item A.2 states that the mechanic performed the work. This is incorrect. The vendor performed the work as required by Step 1.1A of the work order.
3. Paragraph 11 of the Inspection Report states that "gauge OP2040 does not have a 0.113 inch end, it is constructed with a .058" tip and a 0.171" step." This is incorrect. Gauge OP2040 has a .058" tip and a 0.113" step with a total thickness of 0.171." It should be noted that either gauge 2040 or 2041 can perform the ring clearance measurement (0.113" + or - .020") required by the work order.
4. Paragraph 11 of the Inspection Report states that "The work order was very specific in requiring particular tools for the mechanics to measure the ring clearances but made no mention of which tool the



Quality Control (QC) Inspector was to use..." This is incorrect. The work order specifically states that "QC holdpoint/verify the gauge portion of upper ring acceptable per Step 4.5A and EER 89-SG-281." This holdpoint requires the QC inspector to perform the identical inspection that the vendor performed per Step 4.5A. Additionally, EER 89-SG-281 states that gauge EM-3195 is to be used to verify the clearance. The QC inspector used EM-3195 as documented in the work order.

5. Paragraph 11 of the Inspection Report states that mechanics used a slugging wrench and then a sledge hammer to loosen a stuck plug. This is incorrect. A light ballpeen hammer was used. This practice is acceptable in cases where a bolt or plug is stuck or exhibits signs of corrosion.

11-11-11

