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SUBJECT: Responds to 900330 enforcement conference re violations noted in IRs 50-528/90-04,50-529/90-13 & 50-530/90-13.

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EXECUTIVE VICE PRESIDENT
NUCLEAR

102-01682-WFC/TRB
May 3, 1990

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

Reference: Letter from R. A. Scarano, Director, Division of Radiation Safety and Safeguards to W. F. Conway, Executive Vice President Nuclear, Arizona Public Service, dated April 6, 1990

Dear Sirs:

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 Violation 50-528/90-04-02, 50-530/90-13-01 and 50-530/90-13-02
File: 90-070-026

This letter is provided in response to an enforcement conference held on March 30, 1990 and inspections conducted by NRC inspectors during January - March, 1990. Based on the results of the inspections, 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 and 2, respectively, to this letter.

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

Very truly yours,

WFC/TRB/tlg

Attachments

cc: J. B. Martin
D. H. Coe
A. C. Gehr
A. H. Gutterman
T. L. Chan

IE01
1/1

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APPENDIX A

NOTICE OF VIOLATION

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

Docket Nos. 50-528, 50-529 and 50-530
License Nos. NPF-41, NPF-51 and NPF-74
EA No. 90-56

During an NRC inspection conducted on January 31, 1990 through February 9, 1990, and February 28, 1990 through March 9, 1990, four 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 (1990), as modified by 53 Fed. Reg. 40019 (October 13, 1988), the violations are listed below:

A. Technical Specifications, Section 6.12.2, provides in part that doors to areas where the dose rate is greater than 1000 mrem/hour shall remain locked except during periods of access control by personnel under an approved REP.

Contrary to the above,

(1). On November 6, 1989, a Unit 3 locked high radiation area (LHRA) gate (#A-B07), that provides access to the "A" shutdown cooling heat exchanger room located on the 70' elevation of the Auxiliary Building, was open, unoccupied and unguarded. Maximum radiation levels measured in the room when the discovery was made were 2000 mrem/hr at 18" from the source of radioactive material located in the room.

(2). On November 9, 1989, a Unit 1 LHRA gate (#R-132) that provides access to the high level storage area located on the 112' elevation of the Radwaste Building, was open, unoccupied, and unguarded. Maximum radiation levels measured in the room when the discovery was made were 2000 mrem/hr at 18"

(3). On February 22, 1990, a Unit 3 LHRA gate (#A-B07, see Item 1 above) that provides access to the "A" shutdown cooling heat exchanger room located on the 70' elevation of the Auxiliary Building, was open, unoccupied and unguarded. Maximum radiation levels measured in the room upon discovery were 2200 mrem/hr at 18".

These are repetitive Severity Level IV Violations. (Supplement IV)

B. Technical Specifications, Section 6.11.1 states: "Procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR Part 20 and shall be approved, maintained, and adhered to for all operations involving personnel radiation exposure." Licensee procedure 75RP-90P02, "Control of Locked High Radiation Areas" identifies responsibilities and actions for the control of locked high radiation areas. The procedure provides that the radiation protection shift lead technician shall be responsible for the control of locked high radiation area (LHRA) keys and radiation protection technicians issued keys for entry to LHRA are responsible to verify that the area is properly secured upon exit and that the keys are returned and the key control log is initialed in the "secured by" block.

Contrary to the above, on February 22, 1990, the Unit 3, day shift lead radiation protection technician failed to control keys to LHRA's as required by the procedure, a Unit 3 radiation protection technician failed to return a LHRA key and initial the key control log as required by the procedure, and during the period of February 27, 1990 through March 7, 1990, ten occasions existed at Unit 2 wherein LHRA keys were returned by someone other than the individual to whom the key had been issued.

This is a Severity Level IV Violation (Supplement IV)

ATTACHMENT 1

Reply to Notice of Violation 50-528/90-04-02 (TWO EVENTS)

I. REASON FOR VIOLATIONS

NOVEMBER 6, 1989 UNIT 3 EVENT

The reason for this violation has been determined to be a probable unauthorized forced entry by an individual(s). The gate in Unit 3 and its locking mechanism showed evidence of tampering. This action is contrary to approved administrative controls.

NOVEMBER 9, 1989 UNIT 1 EVENT

The reason for this violation has been determined to be a probable unauthorized forced entry by an individual(s). The Unit 1 gate could have been opened with common hand tools. This action is contrary to approved administrative controls.

II. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

Special locking mechanisms have been installed on currently posted locked high radiation area (LHRA) doors and gates, outside containment, in all 3 units.

Applicable Radiation Protection procedures have been revised to require dual verification of LHRA door closure upon exit to reduce the probability of personnel error.

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

APS believes that the actions described above are adequate to prevent recurrence.

Additional corrective actions have been taken as detailed in the response to notice of violation 50-530/90-13-01. Although the corrective actions detailed in 90-13-01 are not a direct result of these violations, APS believes that the additional measures taken will also serve to prevent recurrence of these violations.

IV. DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance was achieved for the cited violations on November 6, and November 9, 1989, respectively, when the LHRA gates were shut and locked upon discovery.

ATTACHMENT 1 (CONTINUED)

Reply to Notice of Violation 50-530/90-13-01

I. REASON FOR VIOLATION

The reason for the violation has been determined to be the failure of Radiation Protection (RP) personnel to follow approved LHRA control procedures, including dual verification of LHRA door closure.

II. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

RP personnel responsible have received appropriate disciplinary action. In addition, the individuals conducted briefings with their peers in all three units on the lessons learned.

The Site RP Manager (RPM) has written a memo to RP personnel detailing management's expectations concerning work practices that control access to LHRA's.

The Unit RPMs have instructed their respective RP personnel on management expectations.

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

As an additional response to the events discussed in this attachment, APS will take the following additional actions to strengthen the level of respect for the administrative controls associated with LHRA's:

General Employee Training will be evaluated to ensure specific emphasis is placed on the potential hazards and necessity for control of radiation areas. This evaluation will be completed by May 15, 1990.

An article will be published in the May 1990 issue of "New Era", which is distributed site wide, detailing the potential hazards and necessity for control of radiation areas.

A videotape will be produced to reinforce management expectations and the potential hazards and necessity for control of radiation areas. This video will be required viewing for personnel currently having access to the RCA by May 31, 1990.

IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance for the cited violation was achieved on February 22, 1990, when the LHRA gate was shut and locked.

ATTACHMENT 2

Reply to Notice of Violation 50-530/90-13-02

I. REASON FOR VIOLATION

The reason for the violation has been determined to be the failure of RP personnel to follow approved LHRA key control procedures. As a point of clarification, the violation cites ten (10) occasions wherein someone, other than the individual to whom the LHRA key was issued, returned the key to the key locker. In fact, the individual to whom the key was issued returned the key however, the incorrect block was initialed on the key control log. Although an administrative error occurred, there was no loss of key control.

II. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

Applicable RP procedures have been revised to include a review by RP supervision of the LHRA Key Control Log to ensure compliance with administrative controls by RP personnel.

Additional instruction in key control requirements has been provided to Unit RP personnel.

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

APS believes that the action taken above, in conjunction with the corrective actions taken in response to the violations discussed in Attachment 1, are adequate to prevent recurrence.

IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance for the generic issue of control of keys was achieved by April 15, 1990, upon approval of the procedure to require supervisory review of the key control log.