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SUBJECT: Responds to NRC 901102 ltr re violations noted in Insp Repts
 50-528/90-39, 50-529/90-39 & 50-530/90-39 on 900825-0929.

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WILLIAM F. CONWAY
EXECUTIVE VICE PRESIDENT
NUCLEAR

102-01913-WFC/TRB/JJN
December 3, 1990

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Mail Station: P1-37
Washington, DC 20555

Reference: Letter from R. P. Zimmerman, Director Division of Reactor Safety
and Projects, NRC to W. F. Conway, Executive Vice President
Nuclear, Arizona Public Service, dated November 2, 1990

Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 1, 2, and 3
Docket No. STN 50-528 (License No. NPF-41)
Docket No. STN 50-529 (License No. NPF-51)
Docket No. STN 50-530 (License No. NPF-74)
Reply to Notice of Violation 50-528/90-39-01
File: 90-070-026

This letter is provided in response to the inspection conducted by Messrs.
D. Coe, J. Ringwald, J. Sloan, and C. Townsend from August 25 through
September 29, 1990. Based upon the results of the inspection, one apparent
violation of NRC requirements was identified. A restatement of the violation
and APS's response are provided in Appendix A and Attachment 1, respectively,
to this letter.

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

Very truly yours,

James M. Levine for WFC

WFC/TRB/JJN/dmn

Attachments

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

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APPENDIX A

NOTICE OF VIOLATION

Arizona Public Service Company
Palo Verde Unit 1

Docket Number 50-528
License Number NPF-41

During an NRC inspection conducted on August 25 through September 29, 1990, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1990), the violation is listed below:

10 CFR Part 50, Appendix B, Criterion XVI, states in part that, "In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. The identification of this significant condition adverse to quality, the cause of the condition, and the corrective action taken shall be documented and reported to appropriate levels of management."

Contrary to the above, on August 21, 1990, the Auxiliary Feedwater Pump AFA-P01 was inoperable due to a failed relay. The cause of this significant condition adverse to quality was not determined and corrective actions were not taken to preclude recurrence. Recurrence of the failure of an identical type of relay occurred in Unit 2 on September 26, 1990.

This is a Severity Level IV violation applicable to Unit 1 (Supplement I).



ATTACHMENT 1

REPLY TO NOTICE OF VIOLATION 50-528/90-28-03

I. REASON FOR THE VIOLATION

Although all site personnel have the responsibility to initiate a Root Cause of Failure (RCF) Engineering Evaluation Request (EER) and/or Material Nonconformance Report (MNCR) when appropriate, for the circumstances of this event, APS procedures specify that the Shift Technical Advisor (STA) had the responsibility to initiate a RCF EER. After the Operations Shift Supervisor has initiated a Technical Specification Component Condition Report (TSCCR) and checked the component failure block, the TSCCR procedure specifically requires the STA to initiate an RCF EER. A TSCCR was initiated for the failure of the Auxiliary Feedwater Pump (AFP) Surveillance Test (ST), but the STA failed to initiate the required RCF EER. The exact reason for the STA's failure to initiate the RCF EER could not be determined. The responsible individual could not recall this specific instance. However, the individual was fully aware of his responsibilities to initiate an RCF EER under these conditions.

After the AFP failed a ST, a Work Request was initiated. The planner, who developed the Work Order to troubleshoot the AFP, notified the



System Engineer (SE) as required when the Work Request identifies a condition requiring a RCF EER. During the troubleshooting, the SE was present and assisted in the determination that the relay had failed. The System Engineer had assumed that an RCF EER or an MNCR had been initiated but did not verify this assumption.

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

Although not specifically in response to this event, APS is providing root cause of failure training to the technical staff which includes the STAs, Planners, and SEs. This training will include the criteria for initiating an RCF EER.

The STA was counseled regarding his responsibilities for initiating an RCF EER. An STA night order was written to provide guidance for initialling the TSCCR form to identify that the required RCF EER has been initiated.

The System Engineer's Supervisor discussed his expectation with the SE that the SE initiate or verify the existence of an RCF EER for the failure.

III. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID VIOLATIONS

The TSCCR form will be revised to provide a positive indication that an RCF EER has been initiated. The procedure change is expected to be completed by January 31, 1991.

An evaluation of the administrative controls for EERs, MNCRs, and work control will be conducted to ensure that the responsibilities to initiate or ensure the existence of a RCF EER or MNCR are clearly defined. This evaluation will examine the implementation of the existing programs and the typical processes which identify when an MNCR and RCF EER is required. This evaluation is expected to be completed by December 31, 1990.

The STAs and SE's will be briefed on this event and the requirement to initiate an RCF EER or verify the initiation of an RCF EER as required. This briefing is expected to be completed by January 31, 1991.

IV. DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance was achieved on September 27, 1990, when RCF EER 90-AF-032 was initiated to determine the root cause for the failed Auxiliary Feedwater Pump relay.

