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SUBJECT: Responds to NRC 950120 ltr re violations noted in insp repts 50-528/94-38-01,50-529/94-38-01 & 50-530/94-38-01 on 941212-21.Corrective actions:performance of CRS was reviewed by Unit 3 operations dept leader & director of operations.

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WILLIAM L STEWART
EXECUTIVE VICE PRESIDENT
NUCLEAR

102-03255-WLS/AKK/DRL
February 17, 1995

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
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Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Units 1, 2, and 3
Docket Nos. STN 50-528/529/530
Reply to Notice of Violation 50-530/94-38-01
File: 95-070-026

Arizona Public Service Company (APS) has reviewed NRC Inspection Report 50-530/94-38 and the Notice of Violation (NOV) dated January 20, 1995.

APS recognizes the significant nature of the valve misalignment during Unit 3 drain down. Our thorough investigation identified the root cause of the valve misalignment to be personnel error on the part of the Control Room Supervisor. During this evolution, he did not demonstrate effective command and control of the operating crew which resulted in overall performance not meeting expectations

Apparent concerns of adherence to procedures, crew performance and communications, procedure adequacy, and shift supervisor performance were either a contributing factor or a result of weak performance of the Control Room Supervisor. Research into his history and past performance reveal this is an isolated case in otherwise strong performance as demonstrated by performance during equally or more challenging situations both in the Control Room and during training.

With regard to the identified root cause, any further extrapolations or conclusions concerning this evolution or crew performance beyond this event is unwarranted. The incident and this position were discussed fully during a management meeting held at Region IV Headquarters on February 9, 1995.

IE01

The NRC cover letter for Inspection Report 50-530/94-38 also identified an issue with procedure weakness. However, to clarify this issue it should be noted that the NRC inspector did identify some procedure weaknesses with the Reactor Coolant System Drain Operation procedure in Unit 2. After discussion with the inspector, these procedure weaknesses as well as additional enhancements were addressed and the resulting procedure was successfully used in the second drain to mid-loop in Unit 2.

As further enhancement to assist the operators, the entire RCS Drain Operations procedure was reviewed, simplified, and reissued prior to the Unit 3 mid-cycle outage at the direction of a shift supervisor. APS believes this procedure is fully adequate and was used during the Unit 3 drain down. The procedural change, made as a result of the Unit 3 valve alignment error, was not the cause of the error. As discussed previously, the procedure was not the root cause of the valve misalignment, but the event was the direct result of loss of command and control by the control room supervisor.

Furthermore as a clarification, there has been a level 1 action to develop a plan to review general operating procedures to identify areas needing simplification. This effort will determine and remove actions that do not need to be taken. Additionally, APS has had an ongoing effort (as discussed in the management meeting) to implement the rewritten Emergency Operating Procedures (EOPs). The EOP effort will result in more simple and easy to use procedures. This effort will be complete by August 25, 1995.

Pursuant to the provisions of 10 CFR 2.201, APS' response is enclosed. Enclosure 1 to this letter is a restatement of the NOV. APS' response is provided in Enclosure 2.

Should you have any further questions, please contact Ms. Angela K. Krainik at (602) 393-5421.

Sincerely,

WLS/AKK/DRL

Enclosures:
1. Restatement of Notice of Violation
2. Reply to Notice of Violation

cc: L. J. Callan
B. E. Holian
K. E. Johnston
K. E. Perkins

ENCLOSURE 1

RESTATEMENT OF NOTICE OF VIOLATION 50-530/94-38-01

NRC INSPECTION CONDUCTED DECEMBER 12 THROUGH

DECEMBER 21, 1994

INSPECTION REPORT No. 50-530/94-38

Restatement of Notice of Violation 50-530/94-38-01

During an NRC inspection conducted on December 12-21, 1994, one 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, the violation is listed below:

A. Unit 3 Technical Specification 6.8.1 requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, dated February 1978. Regulatory Guide 1.33, Revision 2, Appendix A, requires, in part, written procedures for draining the Reactor Coolant System (RCS).

Licensee Procedure 43OP-3ZZ16, Revision 9, "RCS Drain Operations," Step 7.2.15 (prerequisites for entering a RCS reduced inventory condition), requires the shift supervisor to designate the makeup flow paths to the RCS and that the appropriate appendices are completed (to align the selected flow paths).

Contrary to the above, on November 28, 1994, control room operators failed to follow Procedure 43OP-3ZZ16, Step 7.2.15, in that a reduced RCS inventory condition was entered and the appropriate appendices to align the specified RCS makeup flow paths were not completed.

This is a Severity Level IV violation (Supplement I).

ENCLOSURE 2

REPLY TO NOTICE OF VIOLATION 50-530/94-38-01

NRC INSPECTION CONDUCTED DECEMBER 12 THROUGH

DECEMBER 21, 1994

INSPECTION REPORT Nos. 50-530/94-38

Reply to Notice of Violation 50-530/94-38-01

Reason For The Violation

The root cause of the failure of the Control Room Supervisor (CRS) to follow procedure 43OP-3ZZ16, step 7.2.15, which ensured that the specified RCS makeup flow path was aligned, was personnel error. The CRS lost command and control in that he did not direct the alignment to be made or verify that the alignment was made by reviewing the applicable appendix or receive reports from the Primary Operator (PO) that the alignment was made or other means. Instead, the CRS signed off the procedure step to make the alignments based on overhearing a conversation between the Shift Supervisor (SS) and the PO in which the alignment was discussed. The CRS was fully aware that he had command and control responsibility and management expectation that he give direction for the alignment and verify by report back to him that the alignment was made prior to signing the step off in the procedure. Although there are other weaknesses in the manner the evolution was conducted, which could be classified as "missed opportunities," the personnel error on the part of the CRS is the cause of this violation for failure to follow procedure.

Corrective Actions Taken And Results Achieved

Since the cause was a personnel error, the performance of the CRS was reviewed by the Unit 3 Operations Department Leader and the Director of Operations. This review determined that the CRS' normal behavior is to maintain tight control of the evolution and to meticulously ensure that each activity is completed properly. The Director of Operations also discussed the

event with the CRS to ensure he understood the seriousness of the error, expectation for command and control, and verification. This discussion indicated that the CRS fully understood these expectations. Considering this discussion and performance review, it can be concluded that the performance error by the CRS was an isolated performance error and the CRS was returned to on-shift duties.

Corrective Actions That Will Be Taken To Avoid Further Violations

Palo Verde has taken significant action to raise the standard of command and control and formality within Operations. These efforts are described in letter 102-03219 "Reply to Notice of Violations 50-529/94-31-02, 50-529/94-31-03, 50-529/94-31-04, 50-529/94-31-05, 50-530/94-31-08 and Notice of Deviation 50-528/94-31-07" dated January 6, 1995. APS is monitoring the success of these standards and expects that they will assist in future efforts to prevent a loss of command and control as identified in this violation.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on November 28, 1994, at approximately 1305 when the appendices to procedure 43OP-3ZZ16 were completed and the valves were aligned.