

# PRIORITY 1

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SUBJECT: Forwards response to NRC 950627 ltr re violations noted in  
insp rept 50-529/95-10 on 950409-0520. Corrective actions:  
revised procedures for controlling preventive maint &  
preventive maint activities. O

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EXECUTIVE VICEPRESIDENT  
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102-03427-WLS/AKK/RAS  
July 27, 1995

U. S. Nuclear Regulatory Commission  
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Dear Sirs:

**Subject: Palo Verde Nuclear Generating Station (PVNGS)**  
**Unit 2**  
**Docket No. STN 50-529**  
**License No. NPF-51**  
**Reply to Notice of Violation 50-529/95-10-01 and 95-10-02**

Arizona Public Service Company (APS) has reviewed the NRC Inspection Report 50-528/529/530/95-10 and Notices of Violation (NOVs) dated June 27, 1995. Pursuant to the provisions of 10CFR 2.201, APS' response is provided in Enclosure 2. Enclosure 1 to this letter is a restatement of the NOV.

APS has reviewed the violations noted in the referenced letter and believes that these represent cases where individuals' performance and program weaknesses contributed to inoperable equipment. In the case of the out of calibration boronometer, the issue did not receive attention commensurate with the Technical Specification needs, however, the boronometer readings trended with RCS boron concentration throughout the period. While the safety significance is low, APS has taken actions to ensure the condition of Technical Specification equipment is clearly communicated to the operator.

A combination of missed opportunities lead to SIA-664 being inoperable beyond the Technical Specification allowed time. The investigation of the issue was not sufficiently thorough to determine operability and further evaluation as prompted by the residents. Corrective actions have been taken to ensure MOV issues are clearly communicated between Operations and Maintenance, and that data gathered from MOV tests are used whenever appropriate.

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Reply to Notice of Deviation 50-528/95-10-01 and 50-528/95-10-02  
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APS has instituted in February, 1995, a number of enhancements and improvements to the corrective action program which includes the establishment of a Condition Report/Disposition Request (CRDR) review committee whose responsibilities include the assignment of significance and responsible organization to conduct root cause evaluations. The CRDR review committee and personnel responsible for preparing Licensee Event Reports (LERs) will ensure all events resulting in LERs will receive a root cause evaluation. APS has also completed programmatic changes affecting the preventive maintenance and motor operated valve testing procedures.

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

Sincerely,



WLS/AKK/RAS/pv

Enclosures

1. Restatement of Notice of Deviation
2. Reply to Notice of Deviation

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



**ENCLOSURE 1**

**RESTATEMENT OF NOTICE OF VIOLATIONS 50-529/95-10-01 AND  
50-529/95-10-02**

**NRC INSPECTION CONDUCTED APRIL 9, 1995 THROUGH**

**MAY 20, 1995**

**INSPECTION REPORT Nos. 50-528/529/530/95-10**





**Restatement of Notice of Violations 50-529/95-10-01 and 50-529/95-10-02**

During an NRC inspection conducted on April 9 through May 20, 1995, two 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, the violations are listed below:

- A. Technical Specification 3.6.2.1 states in part that two independent containment spray systems shall be operable with each spray system capable of automatically transferring suction to the containment sump on a recirculation actuation signal.

The action statement for Technical Specification 3.6.2.1 requires for one containment spray system inoperable in mode 1 that the licensee restore the inoperable spray system to an operable status within 72 hours or be in at least Hot Standby within the next 6 hours.

Contrary to the above, from August 17 to September 5, 1994, Unit 2 was in Mode 1 and Valve SIA-664 was not able to close on a recirculation actuation signal, a condition which caused the "A" train containment spray system to be inoperable, and the licensee did not restore the "A" train containment spray system to an operable status within 72 hours or shutdown the plant to Hot Standby within the next 6 hours.

This is a Severity Level IV violation applicable to Unit 2 (Supplement I).

- B. 10 CFR Part 50, Appendix B, Criterion XII, requires in part, that measures be established to assure that instruments used in activities affecting quality are properly calibrated at specified periods to maintain accuracy within necessary limits.

Contrary to the above, on February 18, 1994, the Unit 2 reactor coolant system boronometer was used to determine reactor coolant system boron concentration for compliance with Technical Specifications and it was not properly calibrated.

This is a Severity Level IV violation applicable to Unit 2 (Supplement I).



**ENCLOSURE 2**

**REPLY TO NOTICE OF VIOLATIONS 50-529/95-10-01 AND  
50-529/95-10-02**

**NRC INSPECTION CONDUCTED APRIL 9, 1995 THROUGH**

**MAY 20, 1995**

**INSPECTION REPORT Nos. 50-528/529/530/95-10**



## REPLY TO NOTICE OF VIOLATION 50-529/95-10-01 (B)

### Reasons for the Violation

An uncalibrated boronometer was used to determine reactor coolant system boron concentration because the Operator using the boronometer was unaware it was not calibrated. Considerable time has elapsed since the events first occurred, and it can not be conclusively determined if the condition of the boronometer was communicated to and understood by Operations personnel or whether the communication was made and procedural guidance for identifying and tracking control room discrepancies was not followed.

A contributing cause was that preventive maintenance schedules were not followed and administrative controls failed to ensure performance of the preventive maintenance tasks which would have calibrated the boronometer.

Another contributing cause was a lack of sensitivity to the possibility that the boronometer would be used to satisfy a Technical Specification action.

### Corrective Actions Taken and Results Achieved

Procedures for controlling preventive maintenance and preventive maintenance activities have been revised to require notification of the shift supervisor for waived preventative maintenance tasks and to require notification of the duty Shift Technical Advisor (STA) or other appropriate engineering personnel when out-of-tolerance results are found during surveillance testing.



The STA/engineer is required to perform a documented evaluation of the significance of the problem or deficiency and ensure that a corrective action document is generated, if required.

Boronometer work requests were reviewed to determine the extent of this condition. The review revealed the majority of boronometer discrepancies were identified in accordance with program requirements. Some instances were identified which prompted the additional corrective actions that are listed below.

A night order was issued to all three units outlining the actions to be taken if the Boronometer is not available. These actions include initiating a Control Room Discrepancy Log entry to make the status of the boronometer obvious to Control Room personnel.

The need for Operations evaluators to review work requests for deficiency tracking was also stressed to the Operations Work Control supervisors.

#### Corrective Actions That Will Be Taken to Avoid Further Violations

The event is being reviewed in the Industry Events training for Operations personnel.

#### Date When Full Compliance Will Be Achieved

Unit 2 boronometer was repaired and returned to service on November 12, 1994.





**REPLY TO NOTICE OF VIOLATION 50-529/95-10-02 (A)**

**Reason for the Violation**

The reasons that valve SIA-664 was not able to close on a recirculation actuation signal, a condition which caused the "A" train containment spray system to be inoperable, was due to a degraded packing condition which did not meet the current packing configuration.

A contributing factors was that the valve was stroked several times on August 17, 1994, which masked the valve closing problems and prevented the MOV engineer from determining the failure mode. A subsequent valve failure on September 5, 1994, did not prompt an evaluation of valve's past performance from an operability perspective.

**Corrective Actions Taken and Results Achieved**

The MOV Operating Guidelines procedure was revised to incorporate the requirements for controlling equipment and utilizing Valve Services personnel.

The diagnostic data for the valves which have not been repacked since the issuance of Valve Packing Specification (July 1, 1990) was reviewed to determine if adequate margin is available to ensure the valves will perform their safety function. No operability issues were noted.



A night order was issued to ensure the Valve Services personnel are contacted and participate in root cause evaluations and operability decisions when motor operated valve (MOV) failures occur.

Licensee Event Report 529/95-001-00 was submitted to report the event as a violation of Technical Specification Limiting Condition for Operation 3.6.2.1.

Corrective Actions That Will Be Taken to Avoid Further Violations

Break-away torque phenomenon will be reviewed at Industry Events training for Valve Services personnel to ensure it is considered when determining the acceptability of running loads for rising-rotating stem valves.

The last diagnostic trace characteristic of each MOV included in the Generic Letter 89-10 program will be reviewed to ensure anomalous trace characteristics are correctly analyzed.

Valves that have not been repacked since the issuance of Valve Packing Specification (July 1, 1990) will be repacked during the next available outage of sufficient duration.

The event is being reviewed in the Industry Events training for Operations personnel.

The Nuclear Assurance department will evaluate the effectiveness of the operability determination process during an upcoming audit.



Date When Full Compliance Will Be Achieved

Valve 2JSIAUV0664 was repacked, tested, and returned to service on  
September 7, 1994.

