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SUBJECT: Forwards response to NRC 950828 ltr re violations noted in
 inap rept 50-530/95-14 on 950702-0813. Corrective actions:
 managers stopped all work & held recovery meeting.

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WILLIAM L. STEWART
EXECUTIVE VICE PRESIDENT
NUCLEAR

102-03484-WLS/AKK/RAS
September 27, 1995

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-37
Washington, DC 20555-0001

Dear Sirs:

**Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 3
Docket No. STN 50-530
License No. NPF-74
Reply to Notice of Violation 50-530/9514-01**

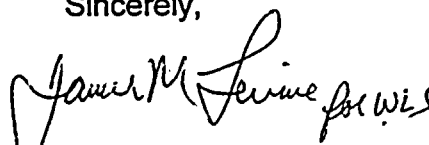
Arizona Public Service Company (APS) has reviewed the NRC Inspection Report 50-528/529/530/95-14 and Notice of Violation (NOV) dated August 28, 1995. Pursuant to the provisions of 10CFR 2.201, APS' response is provided in Enclosure 2. Enclosure 1 to this letter is a restatement of the NOV.

APS recognizes the significance of the failure of the lifting strap on the High Integrity Container and has taken extensive actions to investigate and prevent recurrence. This investigation was a multidiscipline effort which was led by the PVNGS maintenance organization which is responsible for the rigging program. This led to a comprehensive plan to address the NOV, prevent recurrence, and heighten the awareness of rigging operations at PVNGS.

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

Sincerely,

WLS/AKK/RAS/pv



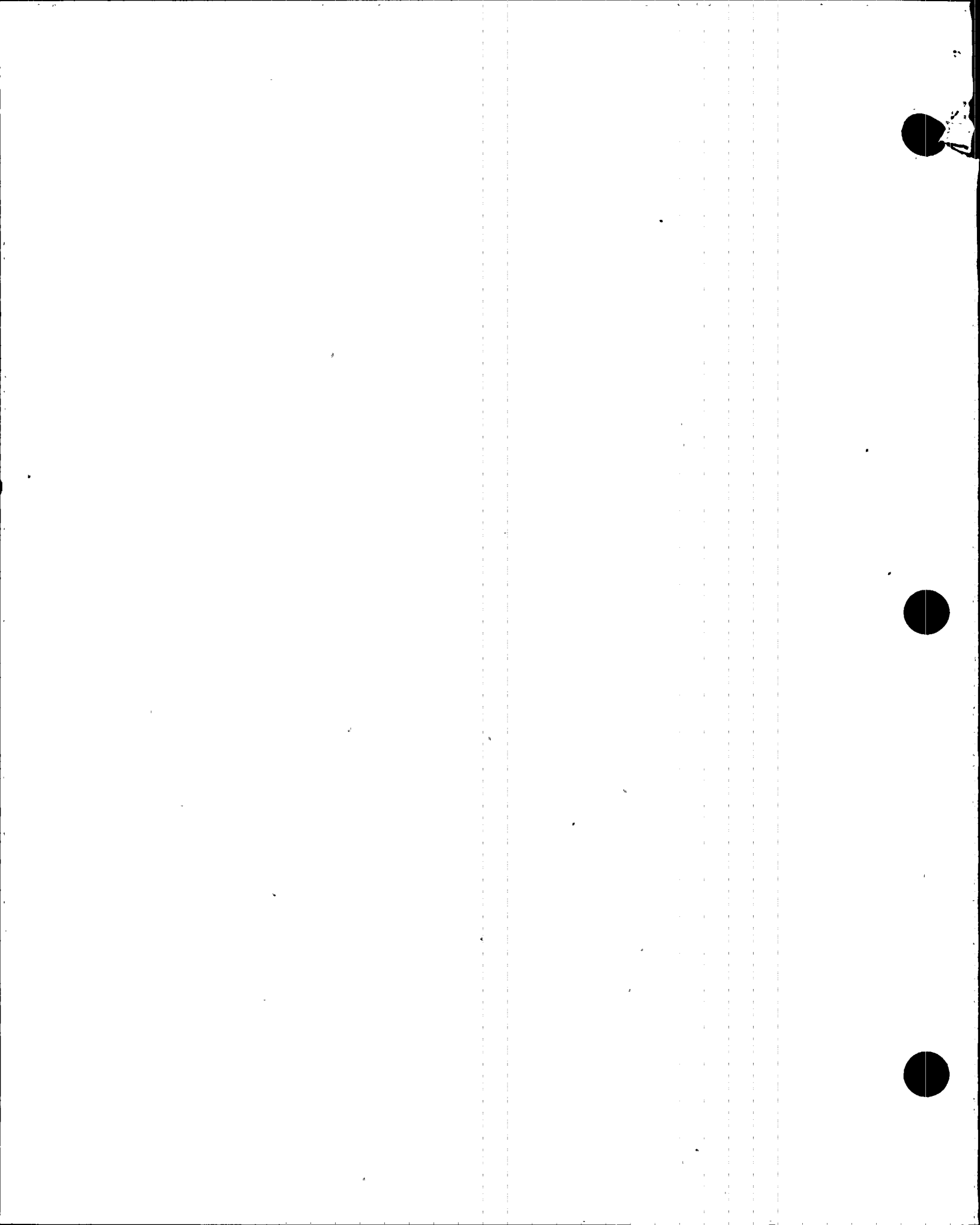
Enclosures

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

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

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ENCLOSURE 1

RESTATEMENT OF NOTICE OF VIOLATION 50-530/9514-01

NRC INSPECTION CONDUCTED

JULY 2, 1995 THROUGH AUGUST 13, 1995

INSPECTION REPORT Nos. 50-528/529/530/95-14

Restatement of Notice of Violation 50-530/9514-01

NOTICE OF VIOLATION

Arizona Public Service Company
Palo Verde Nuclear Generating Station

Docket: 50-530
License: NPF-74

During an NRC inspection conducted on July 2 through August 13, 1995, one violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 60 FR 34381; June 30, 1995, the violation is listed below:

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 handling of spent resin.

Licensee Procedure 30DP-9MP11, Revision 0, "Field Use Of Rigging," Step 3.5.3.2, applicable to handling of spent resin containers, requires the selection of rigging equipment with a capacity that exceeds the weight of the load to be lifted.

Contrary to the above, on July 21, 1995, the rigging equipment selected to lift a loaded spent resin container did not have a capacity that exceeded the weight of the load to be lifted.

This is a Severity Level IV violation (Supplement I) applicable to Unit 3.

ENCLOSURE 2.

REPLY TO NOTICE OF VIOLATION 50-530/9514-01

NRC INSPECTION CONDUCTED

JULY 2, 1995 THROUGH AUGUST 13, 1995

INSPECTION REPORT Nos. 50-528/529/530/95-14

REPLY TO NOTICE OF VIOLATION 50-528/9514-01

Reasons for the Violation

An investigation was performed, and it was determined that the work practices of the individual responsible for the inspection of the nylon sling rigging was one of the root causes of the violation. The individual did not perform the rigging inspection in accordance with program requirements or existing corrective actions for inspection of vendor supplied rigging of containers in high dose rate areas. The individual also made assumptions about the previously installed nylon sling and performed an inadequate inspection of the sling. Another root cause was determined to be that Palo Verde personnel involved in the lift were not aware of what a "knot" configuration is and were not aware that the formation of a "knot" in any configuration is unacceptable.

Other factors included the use of an inappropriate sling and rigging configuration, the unavailability of the remote grapple device, and missed opportunities by other PVNGS personnel to identify inadequate rigging practices.

It was also concluded from the investigation that the response to the event by the personnel involved was timely, thorough, and professional. Also, the recovery plan was robust, thoroughly communicated, involved the correct level of management, and minimized both short and long term exposure.

Corrective Actions Taken and Results Achieved

Immediately following the event the Site Shift Manager, Radiation Protection Management, and key personnel stopped all work and held a recovery meeting. The apparent cause of the failure of the sling was determined, and a recovery plan of action

was developed. The Radiation Exposure Permit which authorized the activity was revised to incorporate the current radiological conditions and recovery plan actions. A pre-job brief was held and the responsible work groups were assembled in the Unit 3 radwaste yard where a tailboard meeting was conducted by the Radiological Material Control (RMC) group Section Leader. The recovery plan was successfully implemented, ending the event approximately four hours after the HIC was dropped. Radiological surveys of the area verified that container integrity had been maintained, and follow-up surveys were performed which validated the initial survey results.

Subsequent to the recovery actions taken by APS, an extensive root cause investigation was performed to not only identify why the rigging failed but to also identify other inappropriate actions and factors which may have contributed to the event. Corrective actions to prevent recurrence have been identified and are described below.

RMC management directed that HICs be moved only by using vendor supplied rigging or the remote grapple device. All accessible rigging used by RMC personnel in Units 1, 2, 3, and at the Dry Active Waste Processing System was inspected to verify compliance with procedural requirements.

Safety newsletters and maintenance bulletins were released which defined the "knot" configuration and identified that direct contact between synthetic slings and wire rope is not a preferred rigging practice:

Corrective actions have been implemented for personnel performance issues related to the inspection of the nylon sling and crane operation responsibilities.

The event was discussed at Nuclear Assurance Safety meetings where the need to maintain a questioning attitude and be proactive was reinforced.

Corrective Actions That Will Be Taken to Avoid Further Violations

Training courses on rigging have been revised to define "knot" configurations and to reflect that the direct contact of synthetic slings with wire rope is not a preferred rigging practice. Radiological Protection's Industry Events training will include a discussion of the HIC event and the need for all personnel to maintain a questioning attitude and to be alert for potential problem areas.

Methods are being developed for RMC to perform inspections of rigging attached to containers stored inside shields due to higher level dose rates. Plans are also being developed for ensuring nylon slings are removed from HICs prior to their movement.

Evaluations are underway to determine the effects of radiation on synthetic slings for exposure over time, a means of improving the HIC transfer process and an action plan is being developed to determine if the HIC Certification of Compliance is still valid.

Procedure changes will be implemented to define the "knot" configuration and to disallow its use.

Date When Full Compliance Will Be Achieved

A recovery plan, which utilized rigging equipment of a sufficient capacity, was successfully implemented, achieving compliance at approximately 2130 hours, on July 21, 1995.

