Leo C. Zell
[redacted]

April 15, 1998

Ellis Merschoff
Regional Administrator
US Nuclear Regulatory Commission,
Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, Texas 76011

Subject: RESPONSE TO AN APPARENT VIOLATION OF NRC REQUIREMENTS
(NRC Investigation Report No. 4-97-022S)

Dear Mr. Merschoff:

Attached is my response to your letter to me dated March 20, 1998. A facsimile copy was sent to you under separate cover by William H. Briggs, Jr. This is the original.

Sincerely,

Leo C. Zell

DECLARATION OF LEO CHARLES ZELL IN RESPONSE TO MARCH 20, 1998 APPARENT VIOLATION OF NRC REQUIREMENTS

1. This will respond to the March 20, 1998 letter from Mr. Ellis W. Merschoff, Regional Administrator, Region IV, Nuclear Regulatory Commission ("NRC") to me concerning an Apparent Violation of NRC Requirements (NRC Investigation Report No. 4-97-022S) ("the March 20 letter").

2. The March 20 letter asks me to address four different subjects -- (1) the reasons for the apparent violation; (2) the corrective steps that have been taken to address this incident; (3) the corrective steps that have been taken to avoid future instances of deliberate misconduct; and (4) the date when corrective action will be completed.

3. As you know, I have discussed these matters at length in my testimony before the Office of Investigations, in my testimony and in written statements I submitted to the NRC at the March 31, 1998 Arizona Public Service Company ("APS") pre-enforcement conference, and in statements that I gave to APS during its investigation of this matter. I ask that you refer to these earlier statements and that you consider them in full before you decide the action that you wish to take in this matter. I have been complete and honest when I have tried to explain to OI, to the NRC, to APS, and to my fellow employees and friends the mistake I made, why it happened, and the professional and personal toll that it has taken on me and my family.

4. With regard to the first subject that you have asked me to address, in my earlier statements I explained the reasons for the apparent violation to the best of my ability.. Rather than repeat these statements here, let me simply reiterate what I have said repeatedly in my earlier statements -- I made a terrible mistake and in so doing I failed to fulfill my responsibilities as a licensed operator and a supervisor.

5. The remaining three subjects that you have asked me to address deal with corrective steps that have been taken. The following is a list of the corrective actions that have been or will be taken and the dates of their completion:

- My SRO license has been terminated at APS's request. [redacted] I will not be permitted to reapply for a NRC license or perform 10 CFR Part 55 duties for a period of at least one year. *Completed, 2/19/98.*
- I have been demoted from department leader (manager) to section leader (supervisor). My base pay has been reduced[redacted] *Completed, 2/10/98.*
- I have completed a two week unpaid Decision-Making Leave. *Completed, 2/24/98.*
- I have completed writing a special edition of the Palo Verde News, along with the others involved in this incident. This article discusses the basics of the incident and focuses on the associated issues and lessons learned. The title of the article is *Compromising Our Personal Integrity* and it was published

and distributed to all Palo Verde personnel. See attachment #1. *Completed, 3/27/98.*

- In accordance with the direction of Dave Smith, Operations Director, I will provide a personal presentation and discussion regarding this incident with Operations personnel either as a part of special meetings or as a part of Industry Operating Experience presented during operator training. This presentation will include supervisory responsibilities, license responsibilities, personal integrity and other issues and lessons learned. *To be completed by 7/31/98.*
- For a period of one year, I will provide a personal presentation and discussion regarding this incident at the request of any APS officer or leader as a part of special meetings, Industry Operating Experience or all-hands meetings. This presentation will include supervisory responsibilities, license responsibilities, personal integrity and other issues and lessons learned. *To be completed by 2/10/99.*
- I will meet with Dave Smith and Gregg Overbeck, Vice President, Production, on a quarterly basis to discuss performance and progress in this program. *To be completed by 2/10/99.*

6. In addition, and equally as important, are the corrective actions I have taken upon myself. While those who know me say they believe in me and know and trust my character, I hold myself to a standard of perfection. One mistake is one too many. I believe in high personal ethics, integrity and honesty. And yet I allowed this to happen. It is difficult for me to internally wrestle with this dilemma. I will never again allow myself to lower my standards or go against something I believe in. And I will not allow it to happen to someone else.

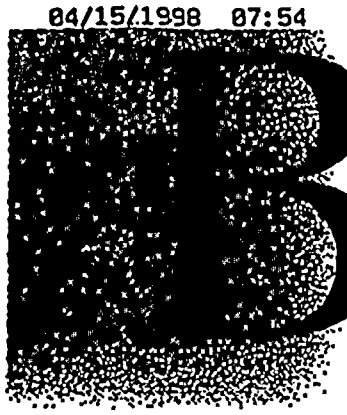
7. I ask that you consider the information submitted here and in my earlier statements when making the final decision concerning this apparent violation of NRC requirements. Let me state again that I made a mistake when this incident occurred and I did not follow NRC requirements, good supervisory practices or my own personal ethics. I am truly sorry for what I did and I give you my word it has never happened before or since, and I give you my word that it will never happen again. Additionally, I will ensure that the painful lessons I have learned are passed on to my coworkers so that they will not make a similar mistake.

I thank you for your consideration and this opportunity.

I declare under penalty of perjury that the foregoing is true and correct.

Leo Charles Zell

Executed on the 15 day of April, 1998.



Bulletin

March 27, 1998

LATE-BREAKING NEWS

Compromising Our Personal Integrity

Recently, an NRC Office of Investigation inquiry revealed that in March of 1993 a Palo Verde operating crew failed in their licensed responsibilities and compromised their ethics by back-timing a time dependent surveillance test (ST) in order to prevent incurring a Licensee Event Report (LER).

The individuals involved have been subsequently removed from Part 55 licensed duties and those with operating licenses have had their licenses expired. Additional disciplinary action has been taken by APS.

This bulletin presents the issues and lessons learned from the individuals involved to assist every employee in making the right choice while performing their job at Palo Verde.

We make choices every day in personal matters and in our jobs. The process of making choices often involves consulting family members and peers as a self-check to ensure the decision you are about to make is appropriate and ethically sound.

Thousands of decisions are made every day at nuclear facilities across the country. As employees of APS, which holds the operating license for Palo Verde, we are entrusted with the responsibility for making choices in such a manner as to ensure the safe

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and reliable operation of the facility. Nowhere is this trust more conspicuous than in the case of licensed operators. They have been entrusted with the operational responsibilities of this facility based on their in-depth technical skill and sound decision-making abilities. Their operational philosophy and ethical standards must be unquestionable.

There are important lessons to be learned for all. As unfortunate as this event was for Palo Verde, on a personal level, the 1993 event was even more detrimental to the individuals involved. All employees at Palo Verde must reexamine their personal understanding of the administrative and regulatory requirements associated with their jobs. It is important to understand how this incident happened and apply the lessons from this event to ensure similar incidents will never again occur at Palo Verde.

Good teamwork and mutual respect among peers can significantly influence the decision-making process. When considering appropriate alternatives in response to any situation, you are encouraged to seek advice from someone with an objective view of the problem that will provide sound technical and ethical advice.

In the 1993 incident, there was an identified failure to complete a 'one-hour' surveillance documentation required by technical specifications. The individuals involved in this incident were experienced Operations personnel who understood the requirements to submit a CRDR for missing the time-dependent requirement. So why didn't they do what they knew they should? How did they cross the line and make the wrong decision?

It becomes apparent this incident occurred because the elements of good decision making were compromised in a very subtle and seductive way.

Prior to removing the diesel generator from service, the Operations personnel normally review plant conditions to ensure appropriate support for the equipment outage. In this event, the crew clearly understood plant conditions met all surveillance requirements prior to removing the engine from service. Approximately four hours later the engine was restored to service. No retest was required because the only work performed was a visual inspection.

- Several hours later it was discovered that the documentation of plant conditions had been missed.

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- The operators knew what plant conditions existed for the duration of the diesel generator outage and believed as a practical matter they had performed the equivalent of the surveillance requirements.
- Rather than initiating a CRDR for the incident, the crew members back-timed documentation.

Regulatory requirements, administrative control procedures and individual integrity dictated the course of action to be taken. Instead, technical understanding of plant conditions, knowledge of systems status and determined lack of safety significance worked against making the only correct choice -- to report the surveillance as missed.

Crew personnel decided to perform the surveillance test, as they should have, but they also chose to back-time the completion to reflect meeting the one-hour surveillance requirement. Obviously, this was the wrong call. The crew's confidence in their knowledge, experience levels, conditions of the plant and the perceived safety significance served to influence their understanding of the significance of back-timing the documentation. Instead of exercising good decision making, the crew rationalized the situation and subverted one of the main reasons for having more than one licensed person on shift to make decisions. Not all of the crew necessarily sponsored the decision. Not all of them necessarily thought it was a good idea. However, none of them refused to go along with it.

The details of this incident focus on subject matter directly related to control room activities and license responsibilities. However, it is vitally important for all employees at Palo Verde to clearly understand the potential liability and personal responsibilities to which they are entrusted. Every employee at Palo Verde must recognize the significance of this incident and apply the lessons learned to their own individual areas of responsibility.

Never allow your personal ethics or integrity to be compromised by the will of the group. When you are faced with difficult decisions, remove the emotional aspects that might taint your ability to remain objective. If your supervision is promoting doing something that in your mind is wrong, you need to challenge it. If you witness or are a

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part of a decision-making process you believe to be wrong, be strong enough to stand firmly on your objections. If needed, elevate your objections or concerns through the management chain to obtain resolution.

As members of the Palo Verde Team, we must look out for the interests of each other. Don't allow your fellow team members to make errors of any type. Never assume that even if you were not the sponsor of a decision, but merely someone who went along with it and helped implement it, that you will escape responsibility. That is not only bad decision making, but an incorrect gauge of your personal responsibility. Each employee is responsible to the public, the company and the NRC, not only for safety of the facility but also to assure compliance with NRC regulations and station procedures.

When incidents of this nature are made public, it can cause many to question the integrity of our workforce and of others in the nuclear industry. The safety of our employees as well as those who live and work around us, depends on the honesty and trustworthiness of every one of our employees. This trust can never be compromised if we are to remain a viable power generation facility in the years to come.

The responsibility entrusted to us is personal and it is individual. Personal integrity is all that stands between success and failure when faced with crossing the line in your decision making.

(end)