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United States Nuclear Regulatory Commission
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Perry Nuclear Power Plant
Docket No. 50-440
Response to Notice of Violation

Gentlemen:

This letter provides the Perry Nuclear Power Plant response to the Notice of Violation contained within NRC Inspection Report 50-440/94014, dated December 22, 1994. The inspection report documented the results of a special announced inspection conducted October 8 through November 23, 1994. The response to the Notice of Violation is provided by Attachment 1.

If you have questions or require additional information, please contact Mr. James D. Kloosterman, Manager - Regulatory Affairs, at (216) 280-5833.

Very truly yours,

DHL:sc

Attachment

cc: NRC Project Manager
NRC Region III
NRC Resident Inspector

27006

Operating Companies
Cleveland Electric Illuminating
Toledo Edison

IE01
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RESPONSE TO NOTICE OF VIOLATION

1. **Violation 94014-01(DRP)**

Restatement of the Violation

10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality be prescribed by documented instructions appropriate to the circumstances.

Contrary to the above, on April 1, 1994, the instructions for work on the Division I Emergency Diesel Generator Testable Rupture Disk were not appropriate for the circumstances.

Acceptance of the Violation

Cleveland Electric Illuminating Company accepts the violation as written, with the correction that the violation involved work on the Division 2 Emergency Diesel Generator.

Reason for the Violation

The root cause of this event are inadequate work procedure and personnel error/failure to follow procedure.

The Division 2 Emergency Diesel Generator Testable Rupture Disc (TRD) was tested during the previous refuel in accordance with an approved work procedure and surveillance instruction (SVI) The work procedure and SVI contained the steps necessary to install and remove a lifting rig to test the lift pressure of the TRD. During the test procedure the TRD gasket was identified as damaged and requiring replacement. Upon completion of the test on March 31, 1994, the test rig and bridge clamp were removed. The work procedure was revised on April 1, 1994, to replace the damaged gasket. The revised work procedure utilized for replacement of the TRD gasket did not provide positive steps for controlling the work. A clamp was utilized to access the TRD gasket. The work procedure revision did not contain specific steps for replacing the TRD gasket or for installation and removal of the rigging (containing the clamp) utilized to access the gasket. Verification that the rigging was removed was not required by the revised work procedure. Further, no retest of the TRD was specified after the gasket replacement. Post maintenance inspection was not performed to the extent necessary to identify that the clamp remained installed. As a result, the clamp remained installed until discovery on November 8, 1994.

Corrective Action Taken and Results Achieved

Immediate corrective action was to verify that a similar condition did not exist on the Division 1 and 3 Emergency Diesel Generators and restoration of the Division 2 Emergency Diesel Generator to operable status.

Actions to Avoid Further Violations

A Human Performance Enhancement System (HPES) evaluation was conducted for this event and identified corrective actions which included:

-Training of work planning personnel to this event and to the need to include specific controlling steps for additional work added by revision. This action was completed on December 1, 1994.

-Training of appropriate personnel to management expectations for the completion of the post maintenance checklist. This action will be completed by February 15, 1995.

-Development of a single document to control all normal maintenance and testing on the TRD for all three diesel generators. This action will be completed by June 30, 1995.

Direction was provided to work planning personnel on January 18, 1995, that the revision of the work procedure utilized to replace the TRD gasket is not to be used in future work procedures dealing with gasket replacement of the TRD associated with any of the Emergency Diesel Generators.

Corrective actions have been initiated to address problems in the area of procedural development and revision, and work control. Specifically, a review of the procedure development and revision process has been conducted and recommendations will be implemented to improve the process. A Maintenance Performance Monitoring Program has been implemented to periodically observe and evaluate work order processing and field execution from job planning through closure. This process will ensure that activities will be performed in a manner consistent with management expectations.

Date When Full Compliance Will be Achieved

Full compliance was achieved with completion of the corrective actions to train the work planning personnel and direct that the work procedure revision not be utilized in the future. The Division 2 Emergency Diesel Generator was declared operable at 2115 on November 9, 1994.

2. **Violation 94014-02(DRP)**

Restatement of the Violation

10 CRF 50.9, requires that records required by the NRC to be maintained by the licensee be complete and accurate.

Contrary to the above, in March - April 1994 initials and other information in a work order were falsified.

Acceptance of the Violation:

This Cleveland Electric Illuminating Company accepts the violation as written.

Reason for the Violation:

The Perry Nuclear Power Plant Policies and Practices Manual issued July 2, 1993 contained Policy Pers.-5, Falsification of Records. This policy presented management's position on falsification of records and the disciplinary actions which would be imposed if falsification of records, reports or forms, or knowing approval of documents containing false information occurred.

Prior to the fourth refueling outage, on February 1, 1994, communication was made to management personnel at the plant site concerning deliberate misconduct and its ramifications as cited in NRC Information Notice 92-27, "Implementation of the Deliberate Misconduct Rule". This information was provided for dissemination, to contract personnel who would be at PNPP during the refueling outage, of the stringent requirements for working at PNPP and the seriousness of deliberate misconduct in documenting completeness and accuracy in the performance of work activities.

The individual responsible for falsifying the work package did so knowingly, by his own admission, in violation of PNPP Policy. The rationale was that the falsification would not affect safety related components or their operation, though the falsification was recognized as wrong.

The inspection report also identified several facets of the investigation and corrective action which reflected mixed performance. The first of these issues was cited as a lack of demonstrated sensitivity to the falsification issue. This did not provide for adequate and timely resolution of the issue when it was raised. In addition, there was a failure to communicate to the plant staff the falsification and disciplinary actions taken in this event to reinforce the serious nature and unacceptability of falsifications.

The lack of sensitivity, as cited in the inspection report, was caused by personnel losing sight of the seriousness of the issue from a site perspective. The individuals were aware of the seriousness of the particular incident as indicated by the significant remedial actions taken regarding the individual involved, but were not sensitive to the need to communicate the actions taken with regard to the falsification issue and to reiterate and re-emphasize that the practice was unacceptable and would not be tolerated.

Corrective Actions Taken and the Results Achieved

Investigation of the incident resulted in the dismissal of the individual involved. In addition, other work packages in which the individual was involved were revieved to determine if this type of falsification issue was a pervasive part of the individual's work. This review, completed on July 11, 1994, provided a conclusion that the identified work package was the only work package involved with this individual that contained falsified information. The affected work was corrected and the work order was reverified as complete on June 11, 1994.

Corrective Actions Taken to Prevent Recurrence

On January 4, 1994, the Vice President - Nuclear, Perry issued a memorandum to PNPP Managers and Directors directing that they address the following issues, with their entire staff:

i) Reinforcement of the policy as presented in Polices and Practice Manual Pers.-5,

ii) Assurance that the employees understand that it is their responsibility to identify any suspected incidences of falsification of records to their supervisor. Assurance that supervisors aggressively investigate such allegations until they have a firm understanding of the facts involved in the allegation. Where allegations of falsification of records are substantiated, it is expected that fair and appropriate disciplinary action will be taken.

iii) Re-emphasis of the availability of the Office of Ombudsman to those employees who do not feel they can identify a falsification of records issue to their supervisor.

The issuance of the memorandum cited above and its presentation to PNPP site employees provides the necessary communication and reinforcement of management expectations regarding falsification issues. No other actions are deemed necessary.

Date When Full Compliance Will Be Achieved

Full compliance was achieved during the investigation when the affected work was corrected and the work package was reverified on June 11, 1994.