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April 4, 1984

PGandE Letter No.: DCL-84-130

Mr. John B. Martin, Regional Administrator
U. S. Nuclear Regulatory Commission, Region V
1450 Maria Lane, Suite 210
Walnut Creek, CA 94596-5368

Re: Docket No. 50-275, OL-DPR-76
Diablo Canyon Unit 1
Response to IEIR 83-41 -- Notice of Violation

Dear Mr. Martin:

NRC Inspection Report 50-275/83-41, dated March 5, 1984, included three Severity Level IV violations and one Severity Level V violation. PGandE's response to this Notice of Violation is enclosed.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

W. A. Raymond

for J. O. Schuyler

Enclosure

cc: Service List

ENCLOSURE

RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT 50-275/83-41

On March 5, 1984, NRC Region V issued three Severity Level IV and one Severity Level V Notices of Violation as part of NRC Inspection Report 50-275/83-41 for Diablo Canyon Unit 1. The notices cited:

- A concern that the mechanical bypass, jumper and lifted circuit log was improperly filled out.
- A concern that welding activities were being conducted with improper fire prevention controls.
- A concern that the Solid State Protection System (SSPS) was removed from service without written procedures.
- A concern that the containment equipment door was not fully closed during core alterations (initial fuel load).

The inspection report also mentioned a concern by the NRC that schedule pressures, hurried atmosphere of work activities and extensive overtime may be a contributing cause of these observed discrepancies.

PGandE has recognized that the naturally occurring emphasis on the plant completion effort can lead to degraded personnel performance. In order to preclude this from happening as Diablo Canyon approaches initial operation, management actions have been undertaken in several areas.

One example of such action is the issuance of a letter from the Plant Manager in December 1983 to all Diablo Canyon Managers and Supervisors emphasizing that "The single most important thing at Diablo Canyon is quality of plant work activities," "Employees must never let schedule pressures or other considerations influence performance of a safe and quality job", "...take the necessary time to do the job right the first time", and "Procedures should not be violated, nor should an incorrect procedure be followed...". Another example is the special meeting of the Plant Staff Review Committee (PSRC) which convened on December 6, 1983, in order that senior plant management could assess the possible effects of schedule pressures on performance and consider steps which could be taken to maintain performance.

Management measures received additional implementation in late February and early March of 1984 when the Plant Manager and his senior staff reviewed the impact of schedule pressures on the groups performing the most overtime work. Further, because it was concluded that continuation through low power testing of the level of overtime worked in some groups, without relief, might cause performance degradation, a general standown from overtime was required during

March. This action was taken despite any effect on schedule, for the maximum possible number of people.

This relief, coupled with the completion of most of the "outage-intensive" work by the I&C Department (the most affected plant department), assures that the Diablo Canyon work force is able to continue its efforts in an alert and able manner.

A. JUMPER LOG WAS FILLED OUT IMPROPERLY

STATEMENT OF VIOLATION

[Technical Specification 6.8.1 stated that "Written procedures shall be established, implemented and maintained covering...applicable procedures recommended in Appendix 'A' of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A Item 1.j. "Bypass of Safety Functions and Jumper Control" is implemented by the licensee's Nuclear Plant Administrative Procedures (NPAPs) C-4 and C-4 S1. NPAP C-4S1, (Item 3.9.7), requires that any bypass of safety functions must be indicated on the Mechanical Bypass, Jumper and Lifted Circuit Log (jumper log).

Contrary to the above, jumper log number 83-190, 191, 193 and 194 indicated on July 30 and August 1, 2 and 3 respectively that the safety function of the pressurizer pressure transmitters had not been bypassed, even though the safety function was indeed bypassed.

This is a Severity Level V Violation (Supplement 1).]

STATEMENT OF EXPLANATION

The event was the result of belief that a Safety Function Bypass was not required, since the operability (including the effect of the jumper on the equipment) is typically verified when the equipment is returned to service.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

1. The Plant Staff Review Committee (PSRC) approved the bypass consisting of a jumper on the pressurizer pressure instrument on December 19, 1983.

2. The Operations Manager had discussed the importance of proper jumper log documentation with operation department supervisors, emphasizing the definition of the Safety Function Bypass.

3. The Operations Manager issued Shift Foreman memo 83-95 to emphasize that the Bypass of a Safety Function is not dependent upon the operating mode and must always be addressed.

4. The Operations Manager has required additional training of operators be immediately instituted on Administrative Procedures NPAP C-4 and C-4S1 emphasizing Bypass of Safety Functions.

5. Administrative Procedure NPAP C-4 and C-4S1 have been revised and approved by the Plant Staff Review Committee on March 15, 1984. The revisions clarify the requirements concerning jumpers and Bypass of Safety Functions.

CORRECTIVE STEPS WHICH WILL BE TAKEN

Based on the actions described above, PGandE believes that adequate corrective actions have been taken to prevent recurrence. Therefore, no additional corrective steps are necessary.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on April 3, 1984.

B. WELDING ACTIVITIES WERE BEING CONDUCTED WITH IMPROPER CONTROLS

STATEMENT OF VIOLATION

[Technical Specifications Section 6.8.1.f, "Procedures and Programs," specifies that written procedures shall be established, implemented and maintained for a Fire Protection Program. PGandE Nuclear Administrative Procedure (NPAP) C-13, Rev. 3, "Fire Loss Prevention," Item III.B.6.a specifies that "...combustible material...in the work area shall either be removed or protected by approved fire retardent material below and within a 35 foot radius circle of the work site." NPAP C-13, Rev. 3, Item III.B.6.d also specifies that "...suitable fire extinguishers shall be readily accessible to the area while the job is in progress and until the fire watch is completed."

PGandE NPAP C-13 S1, Rev. 1, "Supplement to NPAP Diablo Canyon Welding and Open Flame Permit," Item 3.e also specifies that "...the Welding Foreman is to assure that workers and fire watches are complying with the requirements of the applicable 'Welding and Open Flame Permit'" NPAP C-13 S1, Rev. 1. Item 4.e also specifies that "prior to the start of the actual welding or open flame work, the worker or the fire watch will initial the right side of the form after each of the requirements designated by the 'Welding Foreman' has been accomplished."

Contrary to the above requirements, on December 19, 1983, welding operations were being conducted near motor generator set No. 2 with combustible material nearby, no fire extinquisher or fire watch present and with no initials appearing on the welding and open flame permit.

This is a Severity Level IV Violation (Supplement 1).]

EXPLANATION AND CORRECTIVE STEPS TAKEN

The plant administrative procedures require that work involving welding or the use of an open flame be controlled. Specific fire protection requirements are designated by the "welding foreman" and are to be implemented by the worker and the fire watch.

It has been determined that the training of "welding foremen", workers, and fire watch personnel did not sufficiently address the Welding and Open Flame Permit system. This resulted in the workers and the fire watch not implementing the requirements of the Welding Permit.

The welding activity was stopped immediately on December 19, 1983, when the resident inspector notified the plant Fire Marshal of the situation. The Welding Permit was also cancelled immediately. Work was not allowed

to resume until the area was cleared of combustible materials and the involved personnel were instructed in their responsibilities. Work recommenced following an inspection of the work area by the Fire Marshal and issuance of a new Permit.

The plant Fire Marshal's office was augmented as of January 1984 with additional contract and Project personnel assigned to assist construction "Welding Foremen" with the completion of Welding and Open Flame Permits. These personnel also monitor work activities to assure that permit requirements are being implemented.

The December 19th event strongly contributed to the decision in late January 1984 to require project and contractor personnel to participate in training sessions covering work rules in Unit 1. These sessions were given on a rotating basis, covering all such personnel within a 2 week period. The Fire Protection program and the welding and open flame permit requirements were strongly emphasized during this training. The Fire Protection portion of the training program was conducted in multiple sessions by the Project Fire Marshal and was completed on February 3, 1984. Additionally, fire watch training sessions were completed on January 6, 1984 and again on February 7, 1984, which emphasize the importance of Welding Permits and the conduct of safe welding operations.

A training session emphasizing Welding Permits was conducted for NPO Maintenance personnel on January 30, 1984, by the plant Fire Marshal.

CORRECTIVE STEPS WHICH WILL BE TAKEN

Based on the actions described above, PGandE believes that adequate corrective actions have been taken. Therefore, no additional corrective steps are necessary.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on February 7, 1984.

C. THE SOLID STATE PROTECTION SYSTEM (SSPS) WAS REMOVED FROM SERVICE WITHOUT WRITTEN PROCEDURES

STATEMENT OF VIOLATION

[Technical Specification 6.8.1 states that "Written procedures shall be established, implemented and maintained covering...applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Rev. 2, February 1978." This regulatory guide required procedures for performing maintenance. Specifically, this guide requires procedures for "...Maintenance that can affect the performance of safety-related equipment..."

Contrary to the above, on December 7, 1983, in order to perform surveillance activities on the Solid State Protection System (SSPS), the licensee removed the SSPS from service without first establishing written procedures for the removal of the SSPS.

This is a Severity Level IV Violation (Supplement I).]

STATEMENT OF EXPLANATION

The Notice cites a concern that the SSPS was removed from service without first establishing written procedures. Step 1 of Surveillance Test Procedure STP 1-16C is the "REMOVAL FROM SERVICE" section of this procedure. In addition, Temporary Procedure TP-8307 covered the lifting of leads TB-607-9 and TB-607-11 in the SSPS to prevent loss of high voltage to the nuclear source range instrumentation. A Shopwork Follower was used to tie these two procedures together. Though written procedures were established and the proper steps were specified, the temporary procedure and shopwork follower were inadequately labeled, resulting in a misunderstanding as to the proper time to lift the leads to prevent the loss of high voltage to the nuclear source range instrumentation.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

1. The high voltage to the nuclear source range instrumentation was restored in approximately two minutes after it was deenergized.

2. Surveillance Test Procedure STP 1-16C has been revised to ensure that leads are lifted and reterminated in a proper manner. This revision eliminates the need for two procedures and reduces confusion.

3. A training session was conducted for I&C Supervision and covered the following points:

   a. The necessity to conduct training meetings on unfamiliar or non-routine evolutions.

   b. The importance of performing a job safely, correctly and in accordance with requirements is the number one priority regardless of the schedule.

   c. The responsibility of supervision is to ensure that technicians understand the importance of consulting with their supervisor if they don't fully understand their assignment.

4. Senior I&C Supervision conducted a training session for all I&C personnel to emphasize the importance of communicating with supervision when work assignments are not fully understood.

5. This item was reviewed subsequently in an "Incident Review Board" with NRC participation. Essentially the same conclusions were reached. The review board did suggest preparation and dissemination of a short written summary of any similar future event soon after the occurrence in order to preclude its repetition.

CORRECTIVE STEPS WHICH WILL BE TAKEN

Based on the actions described above, PGandE believes that adequate corrective actions have been taken to prevent recurrence. Therefore, no additional corrective steps are necessary.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on December 23, 1983.

D. THE CONTAINMENT EQUIPMENT DOOR WAS NOT FULLY CLOSED DURING CORE ALTERATIONS

STATEMENT OF VIOLATION

[Technical Specification 3.9.4 requires that "...the equipment door (shall be) closed...during core alterations..." and "...with the requirements of the above specifications not satisfied, immediately suspend all operations involving core alterations..."

Contrary to the above, on November 29, 1983, a gap of greater than one inch existed between the top of the equipment hatch and its mating surface on the containment. The equipment hatch was fastened in position with four bolts below the equipment hatch centerline. The licensee had previously performed core alterations during the period November 15 to November 20, 1983 (initial fuel load).

This is a Severity Level IV Violation (Supplement I).]

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Maintenance Procedure MPM-22, concerning the equipment door, was revised to give explicit instructions for Mode 6 (refueling), equipment door closure requirements. The revised procedure now requires a gap inspection to verify adequate door closure in Mode 6. After fuel load, the equipment door was removed for maintenance purposes in Mode 5 (cold shutdown). Currently, the equipment door is installed with a full compliment of closure bolts and has been leak tested.

CORRECTIVE STEPS WHICH WILL BE TAKEN

Based on the action described above, PGandE believes that adequate corrective action has been taken to prevent recurrence. Therefore, no additional corrective steps are necessary

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved by February 20, 1984.