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AUTH.NAME AUTHOR AFFILIATION
RUEGER,G.M. Pacific Gas & Electric Co.
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 950428 ltr re violations noted in insp repts 50-275/95-06 & 50-323/95-06.Corrective actions:operator responsible received coaching & counseling on self verification.

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Pacific Gas and Electric Company

77 Beale Street, Room 1451-B14A
San Francisco, CA 94105
Mailing Address
Mail Code B14A
P.O. Box 770000
San Francisco, CA 94177
415/973-4684 Fax 415/973-2313

Gregory M. Rueger
Senior Vice President and
General Manager
Nuclear Power Generation

May 30, 1995

PG&E Letter DCL-95-118

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Docket No. 50-275, OL-DPR-80
Docket No. 50-323, OL-DPR-82
Diablo Canyon Units 1 and 2
Reply to Notice of Violation in NRC Inspection Report Nos. 50-275/95-06 and 50-323/95-06

Gentlemen:

NRC Inspection Report Nos. 50-275/95-06 and 50-323/95-06, dated April 28, 1995, contained a Notice of Violation that cited one Severity Level IV violation regarding failure to follow procedural requirements. PG&E concurs that further procedural adherence improvement is necessary. We believe the recent procedural adherence problems can be attributed to some employees becoming over-confident in performing routine tasks and thus exhibiting a lack of appropriate attention to details and overly burdensome procedures. PG&E management is emphasizing procedural adherence in communication meetings and other forums, reducing unnecessary procedural requirements and as discussed in PG&E letter number DCL 95-108 dated May 17, 1995, will be conducting a human error prevention course by an industry recognized expert focusing on the role of the supervisor in creating a high performance environment.

PG&E's response to the Notice of Violation is enclosed.

Sincerely,

Gregory M. Rueger

cc: L. J. Callan
Melanie A. Miller
Kenneth E. Perkins
Michael D. Tschiltz
Diablo Distribution

Enclosure

N0001893

IE01

ENCLOSURE

REPLY TO NOTICE OF VIOLATION IN NRC INSPECTION REPORT NOs. 50-275/95-06 AND 50-323/95-06

On April 17, 1995, as part of NRC Inspection Report Nos. 50-275/95-06 and 50-323/95-06, NRC Region IV issued a Notice of Violation citing one Severity Level IV violation for Diablo Canyon Power Plant, Units 1 and 2. The statement of violation and PG&E's response follow.

STATEMENT OF VIOLATION

During an NRC inspection conducted between February 19 and April 1, 1995, several examples of a violation 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:

Diablo Canyon Technical Specification 6.8.1. states, 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.

Appendix A of Regulatory Guide 1.33, Revision 2, recommends procedures covering the operation of emergency core cooling systems, surveillance testing of safety systems required Technical Specifications, chemical control, and administrative procedures for equipment control.

1. Revision 10 of Operations Procedure (OP) B-3B:I, "Accumulators Fill and Drain," Step 6.5.6, requires operation of Flow Control Valve (FCV) FCV-8878B to fill Accumulator 1-2.

   Contrary to the above, on March 22, 1995, Valve FCV-8876B was operated instead of Valve FCV-8878B, resulting in a partial drain down of the accumulator.

2. Revision 11A of STP M-16N, "Operations of Trains A and B Slave Relays K632 and K634," Step 12.10.3, requires restoration of both Valves FCV-37 and FCV-38 to the open position.

   Contrary to the above, Step 12.10.3 was incorrectly marked N/A, on March 14, 1995, resulting in failure to restore the valves to proper position at the conclusion of the surveillance.

3. Revision 1 of OP I.DC20, "Sealed Components," Step 4.2.5, requires that Category I valve seals may be broken, when the checklist is required to be current, only after receiving documented authorization by the appropriate Shift Foreman.

   Contrary to the above, on March 28, 1995, the licensee operated sealed Valve SI-2-8920B without documented authorization or Shift Foreman approval.

4. Revision 8 of OP C-7C:III, "Condensate Polishing System Transferring Resin Beds," Step 6.4, contains a manual valve alignment sequence for transfer of resin and requires a 25-minute drain of the demineralizer prior to proceeding with the manual transfer procedure.

   Contrary to the above, on April 1, 1995, neither the manual valve alignment sequence nor the 25-minute drain requirement were followed. The incorrect valve alignment resulted in overpressurization of the resin transfer system and rupture of the anion regeneration tank.

This is a Severity Level IV violation (Supplement I).

REASON FOR THE VIOLATION

PG&E agrees with the violation as stated in the Inspection Report. PG&E's responses to the four specific instances of failure to follow procedures identified in the violation are as follows:

1. Accumulators

   This event was caused by personnel error, inattention to detail. A licensed operator failed to perform an adequate self-verification. During a routine fill of the Unit 1 accumulators, a licensed operator in the control room following the requirements of Operations Procedure (OP) OP1.DC2, "Verification of Operating Activities," for self verification, noted the correct valve operating switch number in the procedure. However when he turned away from the operating procedure to look at the switch, he made a number error and verified the wrong switch. The switch number agreed with the one he remembered from the procedure so he operated the incorrect switch, resulting in partial draining of Accumulator 1-2.

2. FCV-37 and FCV-38

   Due to minor problems with the data in two sections of the STP data sheets, two partial data sheets were used to complete the performance of STP M-16N. The two partially completed procedural data sheets when combined with the original copy constituted one completed surveillance. During the NRC inspection, the inspector was given only one of the partially completed data sheets. Subsequent to the close of the inspection report, PG&E determined that the

second partially completed data sheet had been completed which in conjunction with the original copy of the STP correctly documented the performance of STP M-16N.

3. Sealed Valve SI 2-8920B

This event was caused by personnel error, inattention to detail, in that written permission to operate a sealed valve was not obtained, in accordance with OP I.DC20, prior to operating the valve. SI Pump 2-2 failed a surveillance test performed by plant operations and engineering personnel when the pump differential pressure did not meet the test acceptance criteria. As part of the troubleshooting efforts, the sealed valve SI 2-8920B was manipulated slightly while the SI pump was still operating to determine if the position of this valve could have affected the outcome of the surveillance test. Although the valve could be moved slightly without breaking the seal, the valve seal was inadvertently broken. The valve was subsequently returned to fully open and sealed. The operator and shift foreman knew that SI Pump 2-2 had failed the surveillance and been declared inoperable and that the associated isolation valves, including SI 2-8920B, would be closed and tagged out shortly. Both the operator and shift foreman considered manipulation of the valve to be troubleshooting. Since the alignment of SI 2-8920B would have to be verified prior to the pump being declared operable, the operator and shift foreman believed manipulation of the valve was acceptable. However, this event was not consistent with management expectations regarding implementing the requirements of OP 1.DC20.

4. Resin Regeneration System Overpressurized

During a resin regeneration activity, a licensed operator failed to perform an adequate self-verification, inadvertently resulting in an incorrect valve alignment. This valve alignment resulted in a portion of the condensate polisher regeneration system being overpressurized. The operator was performing the evolution in manual in accordance with OP C-7C.III, rather than the automatic mode and intentionally bypassed a 25-minute draindown of the condensate polisher vessel that was required by the procedure. The operator knew that the tank had been previously pressurized with air and therefore felt that the draindown was not necessary. Intentionally bypassing a procedural step without obtaining managerial permission was not consistent with management expectations regarding implementing the requirements of OP C-7C.III.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The actions taken to address the specific causes are discussed below.

1. Accumulators

   a. The operator responsible received coaching and counseling on self verification.

   b. A case study was prepared to communicate the lessons learned from this event.

2. FCV-37 and FCV-38

   No corrective actions were deemed necessary.

3. Sealed Valve SI-2-8920B

   a. Sealed Valve SI-2-8920B was verified to be in the correct position and sealed.

   b. A shift order was issued to remind all crews of the need to get written authorization from the shift foreman prior to manipulation of sealed components.

4. Resin Regeneration System

   a. The operator responsible received discipline in accordance with PG&E's Positive Discipline Program.

   b. OP C-7C:III, Revision 8 was revised to require operation of the regeneration system in automatic mode unless approved by Operations supervision.

   c. An Operations incident summary was issued to all operating crews.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

An interdepartmental continuous improvement team is being formed to review and develop improvements in the operation of the condensate polisher system.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

PG&E is currently in full compliance. The continuous improvement team is scheduled to have its recommendations prepared by September 30, 1995.