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AUTH.NAME AUTHOR AFFILIATION
 MARTIN,J.B. Region 5, Ofc of the Director
 RECIP.NAME RECIPIENT AFFILIATION
 KARNER,D.B. Arizona Nuclear Power Project (formerly Arizona Public Serv

SUBJECT: Discusses insps on 880520-1012 & forwards notice of violations & proposed imposition of civil penalty.

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UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION V

1450 MARIA LANE, SUITE 210
WALNUT CREEK, CALIFORNIA 94596

DEC 01 1988

Docket Nos. 50-528, 50-529 and 50-530
License Nos. NPF-41, NPF-51 and NPF-74
EA 88-182

Arizona Nuclear Power Project
ATTN: Mr. D. B. Karner
Executive Vice President
Post Office Box 52034
Phoenix, Arizona 85072-2034

Gentlemen:

SUBJECT: NOTICE OF VIOLATIONS AND PROPOSED IMPOSITIONS OF CIVIL PENALTIES
NRC INSPECTION REPORT NOS. 50-529/88-14, 50-529/88-22, 50-528/88-24,
50-529/88-26, 50-528/88-30, 50-528/88-35, 50-529/88-37 and
50-530/88-33 AND LICENSEE EVENT REPORTS (LER's) UNIT 1 88-017-01,
UNIT 2 88-011-01, AND UNIT 3 88-005-00

This letter refers to inspections conducted from May 20, 1988 through October 12, 1988, concerning events reported by you in the referenced LER's, and concerning other activities at your Palo Verde Nuclear Generating Station. The results of these inspections were reported in the referenced NRC inspection reports. Several significant violations of NRC requirements were identified by these inspections. The apparent violations, their causes, and your corrective actions were discussed with you during an enforcement conference held in this office on August 17, 1988. A summary of the Enforcement Conference was sent to you by our letter dated September 15, 1988.

Two Notices of Violation and Proposed Imposition of Civil Penalties are enclosed. The violation set forth in the first Notice involves inoperability of the essential chilled water system at Unit 1 when operability was required by the Technical Specifications. The violations in the second Notice involve the overexposure of an individual to radiation; failure to perform radiation surveys adequate to evaluate the extent of radiation hazards in work areas; failure to properly control access to high radiation areas and locked high radiation areas by locking, posting, and/or barricading, as appropriate; failure to implement your program to maintain radiation exposures as low as is reasonably achievable; and failure to transmit a required radiation exposure report to an individual.

The violation in the first of the enclosed Notices resulted from poor operator performance in that inadequate informal communications between operations personnel led to the inadvertent inoperability of both trains of the Unit 1 essential chilled water system for a period of nine days. The operator who disabled the system apparently sensed that what he was doing was incorrect, but nonetheless chose to proceed rather than to elevate his concern to his supervisors. This error resulted in both trains of a safety system being rendered potentially inoperable, and under the NRC Enforcement Policy this violation could have been assessed at Severity Level II. However, the NRC

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staff has done a preliminary assessment of your analysis of the event and has concluded that the loss of the essential chilled water system resulted in a degradation rather than a loss of safety function. Therefore, the violation has been categorized at Severity Level III.

The violations in the second Notice are associated with the radiation overexposure of an individual at Unit 2 and with other significant deficiencies in your ALARA and Radiation Protection Programs. Some of the specific examples cited therein occurred after the enforcement conference but are included because of their similarity to the previously discussed problems. We have concluded that the overexposure event could have been prevented if your personnel had terminated work activities when faced with uncertainty regarding radiation levels in the refueling cavity. Additionally, we were particularly concerned that your oversight groups had identified the continuing failure of your ALARA committee to carry out its responsibility, and yet senior management was denied an opportunity to act by not being provided this information. This Notice also contains a violation not assessed a civil penalty. The violation relates to the failure to properly notify the individual who received the cumulative overexposure of that problem, as described in Section I of the Notice.

In reviewing your performance since July 1987, we have become concerned with your failure to adequately control access to high radiation areas and locked high radiation areas. We view very seriously the September 8, 1988 event involving the defeat of the lock on a high radiation area by using a screwdriver to slide the lock bolt on the door clear of the strike plate. It was only fortuitous that the event did not result in another personnel overexposure. We are also concerned with your failure to implement prompt and effective corrective action to prevent recurrence of items brought to your attention as early as July 1988. We base this observation on the repetitive nature of violations that have been identified since the Enforcement Conference of August 17, 1988. Overall, these violations indicate significant weakness in your Radiation Protection Program.

Upon consideration of the above events, we conclude that ANPP management has not established the proper working atmosphere at Palo Verde; has not effectively utilized oversight groups; and has not consistently demanded thorough, critical reviews of events so that lessons learned can be used as teaching tools to improve future performance.

During the enforcement conference, I asked you to reevaluate the overexposure event to assure that you have fully identified those areas which represent the greatest potential for improved performance at the site. On September 14, 1988, your representatives presented the results of your reevaluation to my staff.

Based on review of your evaluation and on our discussions with your personnel, we are convinced that you should implement the proposed corrective actions.

In particular, you should implement the recommendations related to the generic areas beyond radiation protection, such as supervisory training, problem identification and resolution, and the conduct of incident investigations.

To emphasize the importance of establishing the proper working atmosphere at Palo Verde, the need to thoroughly review events to promote improved



performance, and the need to improve your activities related to plant operations and radiation safety, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Regional Operations, to issue the enclosed Notices of Violation and Proposed Imposition of Civil Penalties in the amounts of Fifty Thousand Dollars (\$50,000) and Two Hundred Thousand Dollars (\$200,000), respectively, for the violations described in the enclosed Notices. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions, 10 CFR Part 2, Appendix C (1988) (Enforcement Policy), the violation in the first Notice has been categorized as a Severity Level III violation, and the violations in the second Notice have been categorized in the aggregate as two separate Severity Level III problems. The base value of a civil penalty for a Severity Level III problem or violation is \$50,000. The escalation and mitigation factors in the Enforcement Policy were considered for the violations in each Notice. No adjustment of the base penalty was deemed appropriate for the violation described in the first Notice. For the problems described in the second Notice the base civil penalty amount was increased by 100% in each case. For the violations in Section I of this Notice, the base civil penalty was increased by 100% based on your failure to take necessary corrective actions following the identification of significant weaknesses in your radiation protection program as a result of NRC inspections in the Fall of 1987 and early 1988 and two independent self audits addressing your ALARA program. This failure resulted in a delay, for an extended time, in the implementation of actions to assure compliance with radiation safety requirements as evidenced by the multiple violations. For the violations in Section II of the Notice, the base civil penalty amount was also increased by 100% based on the many instances from July 1987 through September 1988 in which you failed to post or control high radiation areas and the lack of adequate corrective actions permitting these examples to occur.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notices when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Additionally, you should address the specific actions that have been taken to instruct your employees about the need to consult supervision when questions about tasks or procedures arise. After reviewing your response to the Notices, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notices are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



John B. Martin
Regional Administrator



Enclosures:

1. Notice of Violation and Proposed Imposition
of Civil Penalty (Reactor Operations)
2. Notice of Violation and Proposed Imposition
of Civil Penalties (Radiological Controls)

cc w/enclosures:

J. G. Haynes, Vice President, Nuclear Production, ANPP
Timothy Hogan, Chief Counsel, Arizona Corp. Commission
A. C. Gehr, Esq, Snell & Wilmer
Arizona Nuclear Power Project

