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RECIP.NAME RECIPIENT AFFILIATION
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SUBJECT: Responds to NRC 970114 ltr re violations noted in insp repts 50-528/96-17,50-529/96-17 & 50-530/96-17.Corrective actions: night order was written on 961126 to reinforce requirements for initiating manual SSES alarms.

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CATEGORY 1 DOCUMENT

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102-03872- JML/AKK
February 20, 1997

U. S. Nuclear Regulatory Commission
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Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Units 1, 2, and 3
Docket Nos. STN 50-528/529/530
Reply to Notices of Violation 50-528/529/96-17-01, 50-528/529/530/96-17-02, and 50-529/96-17-04

Arizona Public Service Company (APS) has reviewed NRC Inspection Report 50-528/529/530/96-17 and the Notices of Violation (NOV) dated January 14, 1997. Pursuant to the provisions of 10 CFR 2.201, APS' response is enclosed. Enclosure 1 to this letter is a restatement of the NOVs. APS' response is provided in Enclosure 2.

The concerns expressed in your cover letter that forwarded the inspection report regarding procedural compliance and problem identification and resolution were specifically shared and discussed with Palo Verde employees at "All Hands Meetings" and during a recent plant stand down. Palo Verde expectations regarding procedure compliance were reinforced in the meetings and the plant stand down provided a forum for employees to discuss the events and to realize ways that each individual could continue to contribute to strong plant performance.

Should you have any further questions, please contact Ms. Angela K. Krainik at (602) 393-5421.

Sincerely,

JML/AKK/DLK

Enclosures

1. Restatement of Notice of Violation
2. Reply to Notice of Violation

IE01

cc: J. E. Dyer
K. E. Perkins
J. W. Clifford
K. E. Johnston

ENCLOSURE 1

RESTATEMENT OF NOTICES OF VIOLATION 50-528/529/96-17-01, 50-528/529/530/96-17-02, and 50-529/96-17-04

NRC INSPECTION CONDUCTED NOVEMBER 17 THROUGH

DECEMBER 28, 1996

INSPECTION REPORT NO. 50-528/529/530/96-17

RESTATEMENT OF NOTICE OF VIOLATION "A" (50-528/529/96-17-01)

During an NRC inspection conducted on November 17 through December 28, 1996, several violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violations are listed below:

Units 1 and 2 Technical Specifications (TS) 6.8.1 require, 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, February 1978.

Regulatory Guide 1.33, Revision 2, Appendix A, Section 1.c. requires written procedures for equipment control. In addition, Section 9e requires general procedures for the control of maintenance, repair, replacement, and modification work.

1. Procedure 40DP-9OP02, Revision 0, "Conduct of Shift Operations," provides instructions necessary to control system and component status. Step 6.2.1 states, in part, when conditions result in disabling a safety-related system for which no automatic input to the safety equipment status system (SESS) panel is provided, a manual bypass/inoperable signal shall be initiated on the SESS panel.

   Contrary to the above, on November 25, 1996, Unit 2 operations personnel disabled the Train A high pressure safety injection, low pressure safety injection, and containment spray pumps by closing Valve SIA-UV-660 (the combined miniflow recirculation valve) for which there was no automatic input to the SESS panel, and did not initiate a manual bypass/inoperable signal on the SESS.

2. Procedure 40DP-9OP30, Revision 8, "Clearance Processing," provides instructions for processing station clearances. Step 2.8.2 requires that if a discipline is working more than one work document under a clearance, each work document shall be listed on the tagout separately and clearance shall be authorized and accepted separately.

   Contrary to the above, on October 23, 1996, mechanical maintenance was working more than one work document under Clearance 96-01734 and each work document was not listed nor was clearance authorized and accepted separately. Work Order (WO) 0756527, which included work to install a temporary restraining device on Unit 1 reactor coolant Pump 2B, was not listed, authorized, nor accepted separately on Clearance 96-01734.

3) Procedure 30DP-9WPO2, Revision 19, "Work Document Development and Control," provides instructions for the development and control of work instructions for maintenance activities. Appendix O of Procedure 30DP-9WP02, requires that a work order be submitted to a work planner, to amend the work instructions, if the work changes involve a scope change as defined by licensee Technical Dictionary 01IG-OAP02, Revision 6. Included under the definition of scope change is the expansion of tagging boundaries.

Contrary to the above, on October 23, 1996, maintenance allowed a scope change to WO 0756527, in that the installation of a temporary restraining device to Unit 1 reactor coolant Pump 2B required the expansion of tagging boundaries, and the work order was not submitted to a work planner to amend the work instructions.

This is a Severity IV violation (Supplement 1) applicable to Units 1 and 2.

RESTATEMENT OF NOTICE OF VIOLATION "B" (50-528/529/530/96-17-02)

10 CFR Part 50, Appendix B, Criterion V, requires that activities affecting quality be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures or drawings.

1. Licensee Specification 13-PN-204, Revision 6, "Installation Specification for Field Fabrication and Installation of Nuclear Piping Systems," Section 8.6.3 provides allowable installation tolerances for pipe supports. Step 8.6.3.3.1 provides verification requirements for 0-inch/free-to-slide clearances between pipe wall and steel supports. Verification of this dimension may be demonstrated by either the ability to physically measure a space, insert a standard feeler gauge, or see visible light between the pipewall and standard feeler gauge; or see visible light between the pipewall and within the support.

   Contrary to the above, between October 1 and November 22, 1996, the licensee installed piping system modifications to both trains of essential cooling water in Units 1, 2 and 3, in accordance with Specification 13-PN-204, and did not verify a 0-inch/free-to-slide clearance between Train A lines PEWAL-026 and Train A pipe support EW-026-H-27, and Train B lines PEWBL-038 and Train B pipe support EW-038-H-7. The licensee could not either physically measure a space, insert a standard feeler gauge, or see visible light between the pipe walls and pipe supports; or physically move the pipes by hand within the supports.

2. WO 0775357 provided instructions to test and clean out the charging pump well drain line from Unit 3 charging Pump E to the charging pump oil drain tank. Precaution 2.1.4 of this work order required that operations be contacted to secure seal lube for the duration of the task if one of the other charging pumps had excessive seal lube leakage into the pump well.

   Contrary to the above, on November 7, 1996, Unit 3 charging Pump B had excessive seal lube leakage into the pump well, and maintenance personnel performing WO 0775357 did not contact operations to secure seal lube for the duration of the task.

This is a Severity IV violation (Supplement 1) applicable to Units 1, 2, and 3.

RESTATEMENT OF NOTICE OF VIOLATION "C" (50-529/96-17-04)

Unit 2 Technical Specification 6.8.1 requires, 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, February 1978.

Regulatory Guide 1.33, Revision 2, requires, in part, written procedures for security and visitor control.

Procedure 20AC-OSK04, Revision 17, "Protected/Vital Area Personnel Access Control," step 3.7.6.2 requires that visitors shall remain in the line of sight and in positive control of their escort.

Contrary to the above, on November 22, 1996, a visitor performing work in the Unit 2 Train B emergency diesel generator room, a vital area, was not maintained within the line of sight nor within positive control of the escort, who was in an adjacent room.

This is a Severity Level IV violation (Supplement III) applicable to Unit 2.

ENCLOSURE 2

REPLY TO NOTICES OF VIOLATION 50-528/529/96-17-01, 50-528/529/530/96-17-02, and 50-529/96-17-04

NRC INSPECTION CONDUCTED NOVEMBER 17 THROUGH

DECEMBER 28, 1996

INSPECTION REPORT NO. 50-528/529/530/96-17

REPLY TO NOTICE OF VIOLATION "A" (50-528/529/96-17-01)

Reason For The Violation

The Notice of Violation (NOV) included three examples of failure to follow procedure. Each example is addressed separately.

The first example involved a failure to input a manual Safety Equipment Status System (SESS) alarm after taking a Low Pressure Safety Injection (LPSI) pump out of service. The SESS provides bypassed and inoperable status indication of selected safety-related equipment automatically to control room personnel. The capability for initiating a manual bypass indication and alarm is provided via a system level manual bypass switch used to indicate the bypass condition to control room personnel for those manual valves and other components which are not automatically monitored. Procedurally, the initiation and removal of manual bypass indication is controlled under "Conduct of Shift Operations."

On November 11, 1996, operations personnel aligned train A of the LPSI system to the Refueling Water Tank. The valve alignment required the operators to reposition manual valves which are not automatically monitored as part of the SESS. When the LPSI system line-up was changed and the system declared inoperable, a manual alarm was not initiated on the SESS. The operating crew believed that manual initiation of an SESS alarm was only needed when the system could not be returned to operable status during their shift. The "Conduct of Shift Operations" procedure provides this

provision for documenting inoperable equipment on a Technical Specification Component Condition Report but does not extend the same provision to manual initiation on an SESS alarm.

The SESS is an aid to operations personnel and does not directly affect plant operations. Failing to manually initiate an alarm on a system that would be returned to service before the end of shift had minimal safety significance relative to plant operations.

The reason for the first example was personal error on the part of the operating crew who rendered the LPSI system inoperable and did not initiate a manual alarm on the SESS.

The second example involved a clearance associated with the installation of a tool to prevent the reverse rotation of a de-coupled Reactor Coolant Pump (RCP). During the Unit 1 refueling outage, work was performed on all four RCPs using several WOs and overlapping clearances. Included in the scope of RCP work was the replacement of RCP 2B's motor. During post installation testing, operations and engineering personnel observed that the motor for RCP 2B attempted to rotate backwards and later discovered the electrical motor leads had been reversed during installation. To prevent unnecessary delays in the outage schedule, steam generator sweeps using RCP 2A were planned during the same time the electrical motor leads for RCP 2B were being re-worked. With RCP 2B de-coupled the installed anti-reverse rotation device was

disabled. In order to prevent reverse rotation of RCP 2B's impeller during the steam generator sweeps, the pump shaft needed to be restrained.

Maintenance personnel were tasked with restraining the pump shaft. To accomplish the task, a tool designed by engineering in 1986 and described in a 1986 Engineering Evaluation Request (EER) was installed on the pump coupling. As discussed in more detail below in the third example, engineering did not adequately verify that the tool was acceptable to use under the current plant conditions. Therefore, no restrictions, precautions, or amplifying work instructions were provided to maintenance personnel. Maintenance personnel treated the task as a support activity for RCP 2A operation and steam generator sweeps. The temporary restraining device was installed using a brief description in the 1986 EER and "skill of the craft" - no work steps were added to a WO. Prior to installing the temporary restraining device on RCP 2B, maintenance personnel reviewed the clearance associated with RCP 2A, determined that additional protection was needed, and had additional tags added to the clearance on RCP 2A.

The reason a WO number was not added to a clearance prior to installing the tool was because the tool was not installed under a WO - it was installed using the brief description in an EER and "skill of the craft." Additional information regarding the failure to amend a WO for installation of the temporary restraining device is discussed below in the reason for the third example.

The third example involved a change in scope to work being performed on RCP 2B without submitting the change to a work planner to amend the work instructions. As discussed in the second example, maintenance personnel considered the task of restraining the pump shaft a support function for operating RCP 2A as opposed to a change in the scope of work being performed on RCP 2B. The restraining device used was designed as a tool. Using a tool on a piece of equipment for which it was designed generally does not require a WO amendment and is considered "skill of the craft." However, engineering did not perform a thorough evaluation for using the tool under existing plant conditions. Therefore, no restrictions, precautions, or amplifying instructions were provided to maintenance personnel prior to installing the tool. A WO continuation sheet was written after the tool was installed and included in the work package for RCP 2B to ensure the restraining device was removed prior to operation of RCP 2B.

The reason for the third example was personnel error on the part of engineering. A thorough evaluation of existing plant conditions was not performed and no restrictions, precautions, or amplifying instructions were provided to maintenance personnel prior to using the tool. As such, maintenance personnel treated the restraining device as an ordinary tool and installed it using "skill of the craft."

Corrective Steps That Have Been Taken and Results Achieved

For the first example, a night order was written on November 26, 1996 to reinforce the requirements for initiating manual SESS alarms. The night order alone did not prevent recurrence. On January 14, 1997, similar events occurred when a Control Room Essential Air Filtration Unit and Hydrogen Analyzer were declared inoperable and a manual SESS alarm was not initiated. A Condition Report/Disposition Request (CRDR) was initiated to document the additional events.

Supervisors for the operating crews were coached on the procedural requirements for initiating manual SESS alarms following the additional events.

Instruction Change Requests were written to evaluate and enhance the affected operating, surveillance test, and "Conduct of Shift Operations" procedures.

The second and third examples are closely related and the corrective steps taken apply to some degree to both examples.

The responsible maintenance engineering personnel were counseled on the need to fully evaluate current plant conditions against previous evaluations when determining actions to be taken in the field.

The responsible maintenance personnel were counseled on the need to properly sign WOs onto the applicable clearance.

The following corrective steps apply to all three examples:

"All Hands Meetings" were conducted by the Senior Vice President Nuclear with Palo Verde employees. Procedural compliance and attention to detail were emphasized during the meetings. Excerpts from the cover letter that forwarded this violation were used as examples to illustrate the need for continued vigilance in these areas.

A plant stand down was conducted on February 4, 1997 to discuss recent events at Palo Verde that should have been avoided. The stand down provided a forum for employees to discuss the events and to realize ways that each individual could continue to contribute to strong plant performance.

Corrective Steps That Will Be Taken To Avoid Further Violations

The following corrective steps will be taken to prevent further violations:

For the first example, selected operating and surveillance test procedures will be revised by June 30, 1997, to add specific guidance for initiating manual SESS alarms.

The "Conduct of Shift Operations" procedure will be revised by March 31, 1997, to clarify the time requirements for manually initiating an SESS alarm.

The Control Room Supervisor Shift Turnover Checklist will be revised by March 31, 1997, to include a verification that any required manual SESS alarms have been initiated.

The second and third examples are closely related and the corrective steps that will be taken to prevent further violations apply to some degree to both examples.

A briefing will be provided by March 31, 1997 to appropriate maintenance and outage management personnel on the correct use of WO amendments including detailed instructions for implementing engineering information.

Engineering will review the programmatic controls used to govern field implementation of previously completed engineering evaluations. Any changes and necessary additional administrative controls to the program will be implemented by June 30, 1997.

Date When Full Compliance Will Be Achieved

Full compliance for the first example was achieved on January 14, 1997 when manual SESS alarms were initiated on the Control Room Essential Air Filtration Unit and Hydrogen Analyzer (the repeat events).

Full compliance for the second and third example was achieved on October 24, 1996 when the WO for RCP 2B was amended to remove the restraining device and documented on the appropriate clearance.

REPLY TO NOTICE OF VIOLATION "B" (50-528/529/539/96-17-02)

Reason For The Violation

The NOV included two examples of failure to follow written instructions. Each example is addressed separately.

The first example involved a plant modification to the Essential Cooling Water (EW) return line from the Essential Chiller (EC) condensers. Some new valves and piping were added to the system. Specification 13-PN-204, "Installation Specification for Field Fabrication and Installation of Nuclear Piping" was referenced in the modification work WO for installation details. Specification 13-PN-204 contained the acceptance criteria for pipe support to piping clearance as follows: "Where 1/16 inch clearance is specified at each side, inspection may be from 0 inch (free to slide) to 1/8 inch (lateral total for both sides)." The specification requires ANE (engineering) approval for zero clearance conditions.

Between October 1 and November 22, 1996, the modifications were installed in Units 1, 2, and 3. Questions raised by an NRC inspector regarding flange misfits, maximum allowable pipe cold spring, and minimum allowable pipe support to piping clearance prompted engineering personnel to walk down the EW piping modifications to evaluate the as-built pipe support to piping clearances. Engineering personnel found zero clearance at hanger locations EW-038-H-007 and EW-026-H-027 between the pipe support and piping in all three Units. The acceptance criteria for a zero clearance fit,

"the ability to physically move the pipe by hand within the standard restraint strap or miscellaneous steel support" could not be verified because of the piping size and configuration.

The acceptance criteria was defined in the WOs as "clearances per design" but did not include the acceptance criteria associated with zero clearance conditions. Specification 13-PN-204, requires ANE approval for clearance conditions similar to those found at hanger locations EW-038-H-007 and EW-026-H-027, but the work document did not identify the requirement to contact engineering. Consequently, engineering was not notified for assistance in evaluating the zero clearance conditions.

Maintenance personnel (both utility and contract) are not expected to be familiar with all aspects of construction specifications like 13-PN-204. As such, when WOs require the use of a construction specification, relative information about the acceptance criteria including the specific sections and paragraphs of the specification should be clearly referenced in the WO. The acceptance criteria included in the WOs associated with this violation was incomplete.

The reason for the violation was that the incomplete work document acceptance criteria led maintenance personnel to rely on previous "skill of the craft" experience when the pipe support to piping clearances were verified instead of contacting engineering for further evaluation.

The second example involved a charging pump seal leakoff drain system test. Palo Verde uses three charging pumps per unit which are designed with a pump well between the crankcase and pump housing to collect oil and water leakoff. The leakoff drain system for each pump connects to a common header. When the system is tested on one pump, the drain lines for the other pumps are isolated in order to prevent backflow. If the water level in the pump well gets too high, water will flow into the pump crankcase and contaminate the crankcase oil. For this reason, the maintenance instruction requires the pump wells to be monitored when their drain line is isolated. Additionally, if a pump is experiencing excessive seal lubrication leakage, the seal lubrication is required by the maintenance instruction to be isolated for the duration of the test.

On November 7, 1996, maintenance and operations personnel performed a routine drain line flush of charging pump E in Unit 3. The WO being used included instructions to have seal lubrication secured on running charging pumps known to have excessive seal lubrication leakage. The WO also required water levels in the pump wells on charging pumps A and B to be monitored. As a result of an inadequate tailboard and poor communications during the flush, seal lubrication on charging pump B (known to have excessive leakage) was not isolated and water levels in the pump wells on charging pump A and B were not monitored. While restoring the drain system to a normal valve lineup, one of the auxiliary operators noticed that the water level in charging pump B's well may have been high enough during the flush to allow flow into the pump crankcase.

The reason for the second example was a breakdown in verbal communications between maintenance and operations personnel which resulted in the work instructions not being followed.

Corrective Steps That Have Been Taken and Results Achieved

In the first example, engineering personnel performed an analysis on the affected as-built piping and verified that under worst conditions the maximum potential cold spring would not have induced stress in the EW piping in excess of the maximum allowed by the ASME Section III Code. No changes to the as-built piping were required.

In the second example, on November 7, 1996, the control room was notified about the potential water intrusion into charging pump B's crankcase and a work request was written to draw and analyze an oil sample from charging pump B. On November 15, 1996, the results of the oil sample indicated an unsatisfactory amount of water in the crankcase of charging pump B. Charging pump B was declared inoperable on November 15, 1996 and the crankcase oil was changed. Following the oil change, the pump was declared functional, an operability evaluation was performed, and the pump was returned to operable status. Between November 7 and November 15, charging pump B continued to operate and perform its safety function.

The applicable maintenance instruction was revised to include a detailed tailboard between maintenance and operations personnel. The required topics of discussion in the tailboard now include team member responsibilities and the precautions needed to preclude water intrusion into the charging pump crankcases during the flush.

The following corrective steps apply to both examples:

"All Hands Meetings" were conducted by the Senior Vice President Nuclear with Palo Verde employees. Procedural compliance and attention to detail were emphasized during the meetings. Excerpts from the cover letter that forwarded this violation were used as examples to illustrate the need for continued vigilance in these areas.

A plant stand down was conducted on February 4, 1997 to discuss recent events at Palo Verde that should have been avoided. The stand down provided a forum for employees to discuss the events and to realize ways that each individual could continue to contribute to strong plant performance.

Corrective Steps That Will Be Taken To Avoid Further Violations

The following corrective steps will be taken to prevent further violations:

For the first example, a briefing will be provided to personnel associated with piping structure, system, or component replacement and modifications on the expectations and requirements of properly performing verifications. Additionally, a briefing will be provided to planners associated with piping structure, system, or component replacement and modifications on the expectations and requirements of properly defining and identifying acceptance criteria. These briefings will be completed by March 31, 1997.

For the second example, no additional corrective steps are planned.

Date When Full Compliance Will Be Achieved

For the first example, full compliance was achieved on January 8, 1997, when engineering personnel completed the piping stress evaluations and determined that the as-built condition was within the allowable ASME Section III stress limits.

For the second example, full compliance was achieved on November 7, 1996, when control room personnel were notified of the potential water intrusion into charging pump 2B's crankcase and a work request was written to sample the oil for possible water contamination.

REPLY TO NOTICE OF VIOLATION "C" (50-529/96-17-04)

Reason For The Violation

The NOV involved the failure of an escort to comply with requirements to maintain control of his visitor inside the protected area. The approved procedure controlling protected area access requires escorts to maintain positive control over their escorted visitors at all times while in the protected area. Additionally, the procedure requires escorted visitors to remain in the line of sight of their escorts.

On November 22, 1996, an NRC inspector observed an employee (contractor) cleaning the floor in a Unit 2 diesel generator control room and noticed that the employee was wearing an escort badge, but there was no escorted visitor with him in the room. The escorted visitor was found painting in an adjacent room, out of sight of his escort. The escort had shifted his focus from his escort duties to the cleaning activity and momentarily lost positive control over his visitor. The visitor was out of the line of sight of the escort for approximately one minute.

The reason for the violation was personnel error on the part of the escort and visitor for failing to remain focused on their responsibilities as an escort and visitor while cleaning and painting inside the protected area.

REPLY TO NOTICE OF VIOLATION "C" (50-529/96-17-04)

Reason For The Violation

The NOV involved the failure of an escort to comply with requirements to maintain control of his visitor inside the protected area. The approved procedure controlling protected area access requires escorts to maintain positive control over their escorted visitors at all times while in the protected area. Additionally, the procedure requires escorted visitors to remain in the line of sight of their escorts.

On November 22, 1996, an NRC inspector observed an employee (contractor) cleaning the floor in a Unit 2 diesel generator control room and noticed that the employee was wearing an escort badge, but there was no escorted visitor with him in the room. The escorted visitor was found painting in an adjacent room, out of sight of his escort. The escort had shifted his focus from his escort duties to the cleaning activity and momentarily lost positive control over his visitor. The visitor was out of the line of sight of the escort for approximately one minute.

The reason for the violation was personnel error on the part of the escort and visitor for failing to remain focused on their responsibilities as an escort and visitor while cleaning and painting inside the protected area.

Corrective Steps That Have Been Taken and Results Achieved

The work area supervisor, who was also in the area, immediately transferred control of the visitor to another employee who was working in the same room and in close proximity to the visitor.

The responsible contract organization stopped all work in the diesel generator room and performed a training session on escort duties.

The event was logged as a security violation per 10 CFR 73.71 and an investigation was initiated in accordance with the Palo Verde Corrective Action Program. The investigation included a Human Performance Evaluation performed by Nuclear Assurance which was used to determine the cause of the event.

The responsible escort, visitor, and work area supervisor received individual counseling on the procedural requirements for escorts and visitors.

Based on the results of the Human Performance Evaluation, heightened awareness of escort responsibilities was needed. To address this, several articles discussing escort requirements and responsibilities have been written and communicated to Palo Verde employees via the Palo Verde News, Palo Verde Instant News, and "Top Ten Security Rules for the Protected Area." The Security Department Leader has met with new employee classes to review escort responsibilities.

"All Hands Meetings" were conducted by the Senior Vice President Nuclear with Palo Verde employees. Procedural compliance and attention to detail were emphasized during the meetings. Excerpts from the cover letter that forwarded this violation were used as examples to illustrate the need for continued vigilance in these areas.

A plant stand down was conducted on February 4, 1997 to discuss recent events at Palo Verde that could have been avoided. The stand down provided a forum for employees to discuss the events and to realize ways that each individual can contribute to avoiding future unwanted events.

Corrective Steps That Will Be Taken To Avoid Further Violations

Based on the extensive action already taken, no further corrective steps are planned.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on November 22, 1996, when the work area supervisor transferred escort responsibilities to another employee who was working in the same room and in close proximity to the visitor.