Arizona Public Service Company

ANPP-30838-WFQ/TJB
October 12, 1984

U. S. Nuclear Regulatory Commission
Region V
Creekside Oaks Office Park
1450 Maria Lane - Suite 210
Walnut Creek, California 94596-5368

Attention: Mr. T. W. Bishop, Director
Division of Reactor Safety and Projects
Reactor Projects and Engineering Programs

Subject: Responses to Notice of Violation (50-528/84-28-01) and Concern about Proper Equipment Lineups.
File: 84-019-026; D.4.33.2

Reference: (1) Letter from T. W. Bishop to E. E. Van Brunt, Jr., dated September 14, 1984

Dear Sir:

This letter refers to the inspection conducted by Messrs. R. Zimmerman, G. Fiorelli, and C. Bosted on July 2 - August 11, 1984. Our response to the Notice of Violation is enclosed as Attachment A.

Our response to the concern identified in the referenced letter is enclosed as Attachment B and explicates the corrective actions taken in response to the incidents identified in paragraphs 6 and 9 of the referenced inspection report, as well as in response to the reactor vessel overfill incident of August 27, 1984.

Very truly yours,

E. E. Van Brunt

E. E. Van Brunt, Jr.
APS Vice President
Nuclear Production
ANPP Project Director

EEVB/TJB/nj

Enclosures

cc: See Page Two

1/1
IE-01

cc: Richard DeYoung, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

T. G. Woods, Jr.
D. B. Karner
W. E. Ide
D. B. Fasnacht
A. C. Rogers
L. A. Souza
D. E. Fowler
T. D. Shriver
C. N. Russo
J. Vorees
J. R. Bynum
J. M. Allen
A. C. Gehr
W. J. Stubblefield
W. G. Bingham
R. L. Patterson
R. W. Welcher
H. D. Foster
D. R. Hawkinson
R. P. Zimmerman
L. Clyde
M. Woods
T. J. Bloom
J. E. Kirby
J. D. Houchen
P. Huber
P. Barbour
P. Coffin
D. Canady
K. Gross
W. F. Quinn
J. Self

ATTACHMENT A

NOTICE OF VIOLATION

As a result of the inspection conducted on July 2 - August 11, 1984, and in accordance with NRC Enforcement Policy, 10 Part 2, Appendix C, 47 FR 9937, the following violation was identified.

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires that for significant conditions adverse to quality such as component failures and malfunctions, measures shall be established to assure that the cause of the condition is determined and corrective action taken to preclude repetition.

APS Operations Quality Assurance Criteria Manual, Revison 0, dated September 22, 1982, Criterion 16, Corrective Action, requires in part that significant conditions adverse to quality be evaluated with regard to safety significance in accordance with written procedures, focusing on the cause of the condition, and actions that must be taken to prevent recurrence.

Palo Verde Nuclear Generating Station Manual Procedure, 90GA-0ZZ19, Startup Field Report, Revision B, dated April 2, 1984, states that Resident Engineering is responsible for the disposition of Startup Field Reports (SFRs).

Contrary to the above, on July 20, 1984 Resident Engineering failed to properly disposition SFR-1S1-723, documenting a failure of containment sump recirculation valve 1JSIAUV673 to open remotely from the Control Room on July 5, 1984, in that the SFR was incorrectly closed as "not valid" without: (1) adequately evaluating the safety significance of the failure of the valve to open, (2) determining the full cause of the condition which prevented the valve from opening, and (3) taking appropriate corrective action to preclude repetition.

RESPONSE TO NOTICE OF VIOLATION

I. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED:

1. The physical problem reported by SFR 1-SI-723 has been readdressed as SFR 1-SI-761 and Deficiency Evaluation Report (DER) 84-54.

2. To determine the scope of the problem with SFRs, Resident Engineering will review approximately 400 SFRs. The SFRs will be reviewed to determine:

   a) adequacy of invalidation decisions,

   b) technical adequacy of disposition, and

   c) completion of action prior to closeout.

   The results of the review and the evaluation of the results will be documented in a memorandum to Bechtel Quality Asssurance. Based on the results of this review, the necessity to review other SFRs will be determined.

3. Prior to the NRC violation, APS Corporate Quality Assurance had initiated an investigation (QI-84-006) of the invalidation, technical adequacy of resolution, and completion of closeout of project documents that are used to document problems. Although the review is still in process, the preliminary results indicate the incorrect invalidation or closure or inadequate technical resolution of these documents is not a generic problem, although isolated problems do exist.

II. CORRECTIVE STEPS TAKEN TO AVOID RECURRENCE:

A Quality Talk will be presented. Bechtel Resident Engineering is including this problem into their regularly scheduled Quality Talk sessions. The sessions will stress to resident engineers the importance of continual communication (feedback and follow-up), affecting thorough efforts at determining root cause and assuring adequate justification exists to support their dispositions.

Additional actions will be taken as required after the aforementioned investigations have been completed and the root cause identified.

III. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

1. The Bechtel Resident Engineers review of SFRs is expected to be completed by October 19, 1984.

2. Quality Investigation QI-84-006 is expected to be completed by October 25, 1984.

3. The Bechtel Quality Talks will be completed by October 15, 1984.

4. A supplemental report will be issued by October 31, 1984, identifying the root cause and the results of the investigations.

ATTACHMENT B

After reviewing the noted incidents for a common or reoccurring trend, we have identified knowledge of system status as the item of most concern whether it be due to improper lineups being provided to Operations or failure to adequately maintain/use system status. To correct this generic problem, APS has taken the following corrective actions:

A. Operating Department Instruction (ODI) #17, Rev. 1, "System Status," has been issued amplifying and clarifying our methods for System Status. This document among other things, requires that requests for valve alignments be of a formal nature.

B. When vent/drain valves are opened within a clearance boundary, they must be tagged per ODI #17.

C. Requests for valve alignments will be accompanied by P&IDs with intended flow path highlighted at the shift supervisor's request.

D. To ensure that all Operations personnel are periodically exposed to ODI #17, the Training Department has included ODI #17 in the Requalification Training Program, the Auxiliary Operator Training Program, and the Simulator Training Program.

E. Startup personnel have been issued instructions that they are responsible for presenting valve and breaker lineups to Operations that will safely conduct the tests and prove the equipment being tested.

As each of the above incidents has occurred, an Operating Department Experience Report (ODER) was generated that indicated the factors which lead up to the event and the corrective actions taken in response to the event. The ODERs are disseminated to each operating crew, and along with ODI #17 are required reading for new operators prior to their assignment in the field. In addition, individuals involved in the incidents have been counseled by Supervision regarding the seriousness of the event, the importance of good communication, and the importance of following procedures and written instructions.

As an additional measure to increase Management's awareness of these type of incidents, a member of the Transition Team has been reviewing the daily unit control room logs for unusual events which may have occurred as a result of inadequate communication or coordination. As these items are identified, they are brought before the daily Transition Team meeting and an action is assigned to a responsible department to investigate and resolve the problem. These are documented on an Operations/Startup Interface Event Form and are maintained by the Transition Team. This practice has been in effect since September 6, 1984 and is expected to continue for Unit 1 until transfer of responsibility to Operations is complete. This practice will continue for Unit 2 until such time that it is no longer viewed as a valuable tool.