

APPENDIX A

NOTICE OF VIOLATION

Pacific Gas and Electric Company  
Diablo Canyon Units 1 and 2

Docket Nos. 50-275, 50-323  
License Nos. DPR-80, DPR-82

As a result of the inspection conducted during the period of February 2 through February 13, 1987, a violation of NRC requirements was identified. In accordance with the General Statement of Policy and Procedure for NRC Enforcement Actions, 10 CFR Part 2, Appendix C, the following violation was identified:

10 CFR 50, Appendix B, Criterion V, states in part, "Activities affecting quality shall 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."

Plant administrative procedure, AP D-753, Revision 10, dated April 25, 1986, titled "Control of Plant Lubricants," establishes the requirements for the storage and use of lubricants for plant equipment. AP D-753 states in part:

"Small cans used to transfer lubricants from bulk storage shall be uniformly identified and dedicated to a specific lubricant to preclude mixing of unlike lubricants."

and

"A log book shall be available at the bulk storage areas to keep a record of all lubricants dispersed, including approximate quantity and where used. This log book will be reviewed by the foreman at the same frequency as the foreman's logs."

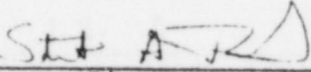
Contrary to the above, at the time of the inspection, a one gallon unlabeled container filled with oil was in the tool shed area of the intake structure, a one gallon unlabeled container filled with oil was in a storage cabinet in the new cold machine shop, and three unlabeled filled grease guns were in the hot machine shop tool room. In addition, log books were not being maintained at the bulk storage areas or at any other of the dispensing areas.

This is a Severity Level IV Violation (Supplement 1)

Pursuant to the provisions of 10 CFR 2.201, Pacific Gas and Electric Company is hereby required to submit to this office within 30 days of the date of this Notice, a written statement or explanation in response to the above violation, including: (1) the corrective steps which have been taken and the results achieved, (2) corrective steps which will be taken to avoid further violations, (3) the date when full compliance will be achieved. Consideration may be given to extending your response time for good cause shown.

MAR 26 1987

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Dated

  
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Stuart Richards, Chief  
Engineering Section

## APPENDIX B

### Areas Inspected and Results

#### Postulated Significant Events

Three postulated significant off-normal scenarios based on actual events at other sites were developed to allow evaluation of plant procedures, hardware and operator training. The simulator Control Room was used to direct auxiliary operators (AOs) stationed in a "ready room" in the plant to go to specific locations in the power block and to simulate the operation of various manual backup valves and controls needed to control the events. The main emphasis of the walkdown of these events was to assess the auxiliary operator actions and equipment function ability during the use of manual backup methods.

The team found that the control and auxiliary operators were very knowledgeable about plant operation and the location and operation of the manual valves and electrical breakers that were needed to contain the casualties.

#### Manual Valve Maintenance

The walkdowns of various portions of safety and non-safety related piping systems indicated that the manually operated valves were generally not being greased or maintained by a preventative maintenance program.

A formal program to maintain the manual valves was being developed, but had not been finalized and implemented at the site.

#### Action Requests

From the discussions with several operators with various levels of experience and qualifications, including licensed senior reactor operators, it was readily apparent that the operators lacked confidence in the "Action Request" (AR) program identified in procedure APC-1256, "Identification and Processing of Power Plant Action Requests and Quality Evaluations." The operators stated that they have requested work to be done by the maintenance department, but the work was not scheduled until a much later time than the operators considered reasonable.

Plant management was aware that a large backlog of ARs had been building and was attempting to resolve the priority of the ARs.

#### Emergency Training for Auxiliary Operators

The training program for the auxiliary operators (AO) involves a lengthy "on the job" (OJT) type environment with some supplementary classroom training. Actual formal emergency training has not been included in AO training until the individuals enter control operator training.

Although regulatory requirements do not specify that AOs receive formal emergency training, the licensee stated that the benefits of a formal emergency training program for the AOs will be evaluated.

#### Surveillance

The surveillance test procedures examined and tests observed appeared to be comprehensive. No anomalies were identified.

#### Control of Lubricants

The inspection of lubricant storage areas on site disclosed a lack of log books to record the type and quantity of lubricants dispensed, and the approximate location of use. The inspector also observed several instances of unlabeled lubricant containers. These observations appear to be a violation of requirements of the licensee's administrative procedure on the control of plant lubricants.

Lubrication records for the valve actuators of several motor operated valves for each unit in safety related systems were examined. The vendor manuals filed in the Record Management System related to preventive maintenance of valve actuators were reviewed. Several instances were identified where it was unclear whether the appropriate version of the vendor manuals were on file.

#### Equipment Condition/Housekeeping

During walk-downs of both units, the following anomalies were observed: 1) on three of four RHR pumps inspected, motor housing oil was on the pump lagging; 2) cigarette butts were found inside the dedicated shutdown panels in the auxiliary building; 3) debris was found in several electrical control panels; 4) numerous boric acid crystals were in evidence in the plant and Action Request tags to correct the problem were not noted; 5) calibration tags were out of date on various permanent panel meters throughout both units. The above examples indicate an increased need for management to tour the plant and assure that their expectations are being implemented.

The walk-down of the Compressed Air System control air supply lines and air operators for a number of safety related valves showed that the control air supply lines for several valves tended to slope toward the air operator. With the present configuration of the control air lines, water may accumulate at the valve operator if significant amounts of moisture were to enter the control air supply lines.

#### Maintenance

The evaluation of the maintenance program included the interviewing of key staff members working in the maintenance area plus reviewing maintenance procedures and the administrative procedures which govern the maintenance program process. Also, action requests, work orders, and equipment history files for maintenance performed on components in the RHR system were examined.

Maintenance program planning was in a state of transition, but appeared to be basically sound. While no regulatory violations were identified, the following weaknesses were noted:

- 1) There appeared to be a lack of formal operating procedures to govern some activities in the Work Planning Center.
- 2) The full history of maintenance work performed on plant components was difficult to retrieve. We understand that the licensee plans to consolidate past shop work folder equipment history into the current PIMS system.
- 3) It was not apparent that there was routine monitoring of priority corrective maintenance.

Strong Quality Control involvement in the review of ARs and Work Orders was viewed as a strength.

#### Quality Verification Activities

The team examined the QC organization structure, QC procedures, personnel qualifications, the QC program for control of in-process work, trending, corrective actions, and interviewed QC personnel. The team concluded that the program was generally effective in identifying problems; however, the corrective action program needed to be strengthened and receive additional management attention as evidenced by the repeated failures of the containment air lock doors.

#### IE Information Notice and Industry Experience Report Followup

The program for followup of IE Information Notices and Industry Experience Reports was examined and appears to have been effectively implemented.

#### Internal Events

The licensee was found to have implemented the stated corrective action for the six internal events that were examined.

#### Procurement

An assessment was made of the program and its implementation for the procurement, control and dedication of commercial grade components for safety-related systems. While it appears that components were being properly controlled on-site, it was not apparent that Corporate Engineering was maintaining records of the analysis used for the basis for certification of these components.

The licensee agreed to examine this apparent deficiency and effect appropriate corrective action.