

September 7, 1994

U.S. Nuclear Regulatory Commission
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Subject: Reply to a Notice of Violation IR 94-15
River Bend Station - Unit 1/Docket No. 50-458

File No.: G9.5, G15.4.1

RBG- 40861
RBF1-94-0016

Gentlemen:

Pursuant 10CFR2.201, please find attached Entergy Operation's response to the notices of violation described in NRC Inspection Report (IR) 94-15. The inspection was performed by Messrs. Ward Smith and Chris Skinner during June 5 through July 16, 1994, of activities authorized by NRC Operating License NPF-47 for River Bend Station (RBS) - Unit 1.

In the inspection report, NRC raised concerns regarding procedure inadequacies, poor communication and reviews performed by the work management center (WMC), compliance with the radiation protection procedures, and an improper performance of an independent verification. RBS management understands the significance of the issues identified and, as communicated previously, has initiatives underway which will effect improvements in these key areas. We are confident that the actions we have implemented will effectively resolve your concerns.

Regarding RBS procedure quality, interim procedure improvement initiatives are being implemented as part of the Procedures Upgrade Project (PUP) to provide an immediate focus on improvement of site procedures. The interim improvement initiatives focus on those procedures most important to continued safe operation and establish the foundation for implementation of the PUP.

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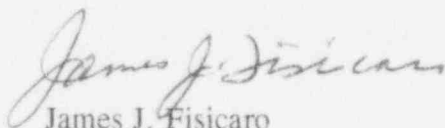
Regarding the failure to comply with the radiation protection procedure, Entergy Operations understands the significance of a failure to comply with program requirements. The LTPIP includes initiatives which will improve the processes and qualifications of personnel associated with the control and the routine bagging and tagging of radioactive material.

The WMC is a new process that has been initiated to help reduce the burden on control room operators. However, we share your concern about the weaknesses associated with the control of information flow out of the WMC to support plant operations and are taking steps to improve WMC communication. To further this endeavor, communications that concern limiting conditions of operation (LCO) actions are required to be directly between senior reactor operators (SRO).

In summary, RBS management shares your concerns about these issues and has taken immediate corrective measures and initiated long term actions to ensure resolution. In addition, as described above, we have implemented long term corrective actions that will resolve the underlying causes and provide permanent improvement in the areas of procedure quality and human performance.

Should you have any questions, please contact Mr. T. W. Gates at (504) 381- 4866.

Sincerely,



James J. Fisicaro

Director - Nuclear Safety

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ATTACHMENT A

REPLY TO NOTICE OF VIOLATION IR 458/9415-01

VIOLATION (EXAMPLE 1)

Technical Specification 6.8.1 states, in part, that written procedures shall be maintained covering surveillance and test activities of safety-related equipment and the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A, states in part, that maintenance that can affect the performance of safety-related equipment should be properly performed in accordance with written procedures appropriate to the circumstances.

Contrary to the above, a procedure was not maintained in that Maintenance Work Order E568208 did not include a step for the installation of a jumper to prevent the interruption of a power supply neutral circuit during the replacement of Agastat Relay 1B21H*K163, which would have precluded an engineered safety feature actuation.

REASON FOR THE VIOLATION

Entergy Operations concurs with this violation and has determined the reason for the condition was inattention to detail by the electrical discipline technical specialist in preparing the maintenance work order (MWO), in that he did not adequately review and assess the risk and consequences of the impact that this could have on plant systems.

During replacement of relay 1B21H*K163, as part of the Agastat relay replacement effort at RBS, under MWO E568208 it was discovered that the relay base was defective and needed to be replaced. This was not in the scope of the original MWO; therefore, the equipment qualification preventive maintenance (EQPM) job plan was revised in order to complete the work. However, during this process a step was left out of the MWO that would have precluded the interruption of the power supply neutral.

An additional factor contributing to the inadequate procedure governing the relay work was that system engineering did not review the extended scope of the job plan before it was worked as required by MSP-0003 and the Maintenance Planning Guidelines.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

MWO E568208 was subsequently corrected to include the necessary steps to replace the base of relay 1B21H*K163. The relay base replacement was then successfully completed under the revised MWO after the daisy chain neutral circuitry was restored.

Consistent with RBS's new philosophy of involving upper management in the review of significant personnel error, the electrical discipline technical specialist was counseled in a meeting with his immediate supervisor and the general manager - plant operations.

The importance of devoting the proper amount of time for each task has been reiterated and stressed to I&C and electrical supervisors, technical specialists and technicians.

Briefings for maintenance management personnel have been conducted to emphasize the importance of obtaining appropriate cross-disciplinary reviews during corrective rework under a preventive maintenance (PM) work order.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

CR 94-0733 along with information regarding similar events will be discussed at the next training advisory committee (TAC) meeting for inclusion into the electrical and I&C training programs for EOI and contract personnel. This will be completed by September 30, 1994.

MSP-0003 will be evaluated by maintenance to determine if this procedure needs to be revised. If a revision is deemed necessary, it will be completed by September 30, 1994.

The long-term performance improvement plan includes an initiative to address human performance effectiveness. The objectives of this program are improvement in the River Bend Station human performance enhancement system (HPES), development of a human performance database, and improvement in the effectiveness of the self-checking program. Details of this program are provided in Section 13 of the LTPIP, submitted to the NRC on March 28, 1994 (RBG-40428).

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend is in full compliance. However, long term corrective actions are being implemented and will continue to address problems associated with human errors and inadequate procedures. These long term plans will be completed in accordance with the schedules outlined in the LTPIP.

VIOLATION (EXAMPLE 2)

Technical Specification 6.8.1 states, in part, that written procedures shall be maintained covering surveillance and test activities of safety-related equipment and the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A, states in part, that maintenance that can affect the performance of safety-related equipment should be properly performed in accordance with written procedures appropriate to the circumstances.

Contrary to the above, a procedure was not maintained in that Surveillance Test Procedure STP-200-0602, " Division II Remote Shutdown System Control Circuit Operability Test, " Revision 7, did not provide instructions to prevent an engineered safety feature actuation when isolating the reactor plant component cooling water system.

REASON FOR THE VIOLATION

Entergy Operations concurs with this violation and has determined that the reason for this event was procedural deficiencies in that pertinent information required to prevent the ESF actuation was not included in the text of the procedure.

STP-200-0602 contained procedural deficiencies in that certain key information required to prevent the ESF actuation was not included in the body of the procedure. If the procedure had locked out the division II standby service water (SSW) pumps and placed the division II SSW test switches in the test position, the ESF actuation would have been prevented with no impact on plant safety or on components cooled by reactor plant component cooling water system (CCP).

Also, a contributing factor was that a temporary change notice (TCN) 89-0831 originally incorporated the caution statement into STP-200-0602. This caution statement recommended actions be taken to install a jumper, isolate the necessary CCP valves, and place the division II test switch in the test position. This procedure had been reviewed by operations personnel in accordance with operations section procedure (OSP)-0005, "Operations Procedure Review and Revision." During this review cycle, attachment seven of the OSP procedure review checklist had been checked off; thus, declaring that STP-200-0602 contained no notes, cautions, or warnings that included action steps. However, it was discovered during subsequent technical analysis that these actions are prudent for system chemistry, and that they should be included as action steps and removed as recommended actions from the caution statement.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

In response to the ESF the operating crew entered Abnormal Operating Procedure (AOP)-0053, "Standby Service Water Initiation." SSW was subsequently returned to standby status.

Precautions were taken to place the RPCCW and SWP test switches in the test position. The surveillance was successfully completed.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

Surveillance test procedure (STP)-200-0602 will be revised to include provisions for locking out the division II SSW pumps and placing the division II SSW test switch in the test position prior to taking any actions which could cause an ESF to occur. In addition, the action statements found in the caution will be rewritten and included as procedural steps in accordance with the River Bend Station Procedure Writer's Guide. This revision will be completed by October 31, 1994, which is before the next scheduled performance of this procedure.

Surveillances on an 18 month frequency which operate SSW valves or components will be reviewed to determine if similar procedural deficiencies exist. This will be completed by October 31, 1994. The upgrading of other STPs to meet the standard expectations of the new RBS procedure writers guide is being performed as part of the ongoing PUP.

A team consisting of operations, engineering, and training personnel has been formed to review the operating history and performance of the SSW system to determine if additional operating training, system modification or additional procedure improvements are required to prevent additional ESF actuations. If appropriate, corrective actions with implementation schedules will be developed. Corrective actions which impact procedures will be coordinated with the procedures upgrade project.

Regarding RBS procedure quality, interim procedure improvement initiatives have been developed as a part of the long term Procedures Upgrade Project (PUP) Plan to provide an immediate focus on improvement of site procedures. The interim improvement initiatives focus on those procedures most important to continued safe operation and establish the foundation for the implementation of the PUP. Both the PUP and the interim procedure improvement initiative will include activities which will verify implementation of regulatory commitments.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend is in full compliance. However, long term corrective actions are being implemented and will continue to address problems associated with inadequate procedures and human errors. These long term plans will be completed in accordance with the schedules outlined in the LTPIP.

ATTACHMENT B

REPLY TO NOTICE OF VIOLATION IR 458/9415-02

VIOLATION

Technical Specification 3.3.1.b, Table 3.3.1-1, Action 9, requires, in part, that the reactor mode switch be locked in the "Shutdown" position within 1 hour of the time that less than the minimum operable channels per trip system are operable.

Contrary to the above, on June 10, 1994, the reactor mode switch was out of the "Shutdown" position for approximately 4 hours, during a period when both divisions of the manual scram functional unit were not operable.

REASON FOR THE VIOLATION

Entergy Operations concurs with this violation and has determined that the reason for the condition was inadequate communications between the WMC supervisor and the control room supervisor (CRS).

On June 10, 1994, preparations were made to allow the performance of weekly nuclear instrumentation surveillance testing for the replacement of relays in the control room. The CRS questioned the WMC supervisor via a third party to inquire about the operability status of the Division II reactor protection system (RPS). After the WMC supervisor investigated the systems operability, the third party incorrectly informed the CRS that Division II RPS was operable when in fact it was still considered inoperable because functional testing had not been performed. The inaccurate transfer of information allowed the CRS to place the mode switch in the "Startup\Hot Standby" position which lead to the failure to comply with the action requirements in Technical Specification (TS) 3.3.1(b) Action 9.

Note that during the four hours and twenty eight minutes that the requirements of TS 3.3.1, Table 3.3.1-1 Action 9 were not being met, there was no decrease in the margin of safety and no threat to the health and safety of the public.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

After shift turnover, a review of limiting conditions of operations (LCO) were reviewed as required by procedure. When this LCO had been reviewed, the control room was informed and the reactor mode switch was placed in the "Shutdown" position.

Licensed operators and shift technical advisors were required to read the condition report associated with this event.

Operations Policy #16, " Work Management Center Guidelines," has been reviewed and enhanced to clarify the responsibilities of the CRS assigned to the WMC regarding compliance with LCO requirements. Communications concerning LCO actions are required to be directly between senior reactor operators (SRO).

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

The condition report (CR) 94-0780 will be included in requalification training for all licensed operators and STAs. This training will also cover any revisions to Operations Policy #16, "Work Management Center Guidelines." This will be completed by November 30, 1994.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend is in full compliance. However, long term corrective actions are being implemented and will continue to address problems associated with human errors. These long term plans will be completed in accordance with the schedules outlined in the LTPIP.

ATTACHMENT C

REPLY TO NOTICE OF VIOLATION IR 458/9415-03

VIOLATION

Technical Specification 6.11 states, in part, that procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR Part 20 and shall be adhered to for all operations involving personnel radiation exposure.

Section 6.1.2 of Radiation Section Procedure RSP-0213, "Control and Handling of radioactive materials," Revision 7, requires material left inside a posted contamination area to be tagged or labeled when the dose rate from the material equals or exceeds 100 millirem per hour, deep dose equivalent, on contact.

Contrary to the above, on June 2, 1994, a bag without a tag or label was left in a contaminated area and the dose rate of the bag was 1000 millirem per hour on contact.

REASON FOR THE VIOLATION

Entergy Operations concurs with this violation and has determined that the reason for the condition was that a contract Radiation Protection (RP) technician improperly interpreted tagging requirements cited in radiation section procedure (RSP)-0213, "Control and Handling of Radioactive Materials," section 6.1.2, in that he did not follow the procedural tagging requirement.

The technician stated that his actions centered around the rationale that the room in the hot machine shop was already posted as a locked high radiation area and that he would be providing the RP coverage; tagging the bag was not necessary since RP would be controlling access into this area. He believed that the locked high radiation area posting adequately indicated that dose rates of greater than 1 R/hr at 12 inches may be present.

He did not understand that even though the bag was located in a locked high radiation area, the procedure still required the technician to label or tag packaged material left inside of posted contamination areas when the dose rates from the material equal or exceed 100 mRem/hr deep dose equivalent on contact. The language in RSP-0213 section 6.1.2 does not state explicitly or fully convey the tagging requirements inside of high radiation areas or locked high radiation areas; therefore, the contractor RP technician incorrectly interpreted this step.

He failed to comply with the procedure even though quick field reference cards containing important criteria from numerous RP procedures, one of which was the RSP-0213 tagging requirement, were issued to the contract RP technician while he was in orientation training.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Upon discovery of the unlabeled component in the locked high radiation area, a completed radioactive material tag was immediately secured to the bag, and the contract RP technician was counseled on the tagging requirements specified in RSP-0213.

A complete radiation survey was conducted of the hot machine shop to ascertain if there were more unlabeled bags stored in this location. No other items were identified.

Other contaminated areas in the plant were surveyed to ensure that materials within these locations were tagged in accordance with RSP-0213. No other items were found that did not comply with RP procedures.

RP technicians were informed during safety meetings of the criteria in RSP-0213 concerning the tagging of material in C-Zones that are located in high radiation and locked high radiation areas.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

Condition report 94-0737 will be routed to Radiation Protection training for inclusion into the radiation protection lesson plan pertaining to pump and valve maintenance. This will be completed by December 30, 1994.

Radiation Protection will develop a job guide pertaining to the general development of radiation work permits (RWP) and maintenance work orders (MWO) that address radiological aspects of the work to be performed. Material and component disposition and storage during and after the maintenance activity will be addressed. This will be completed by December 30, 1994.

An evaluation will be conducted of industry practices of tagging radioactive materials within posted contaminated areas. Corrective actions will be developed, as necessary, based on the results of the evaluation. The evaluation will be completed by October 30, 1994.

Specific criteria and warnings will be added to the radiation protection posting standard as to the conditions and considerations that should be evaluated prior to down posting areas. This same information will be routed to radiation protection training for possible inclusion into radiation protection training programs pertaining to posting radiologically controlled areas (RCA). This will be completed by October 30, 1994. Also fully qualified radiation protection technicians and foremen will be trained on this guidance once developed. This will be completed by October 30, 1994.

Tagging criteria will be revised to clarify the requirements of labeling packaged material in the RCA regardless of how the area is posted. This will be completed by October 30, 1994.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend is in full compliance. However, long term corrective actions are being implemented and will continue to address problems associated with human errors and personnel accountability. These are long term plans and will be completed in accordance with the schedules outlined in the LTPIP.

ATTACHMENT D

REPLY TO NOTICE OF VIOLATION IR 458/9415-04

VIOLATION

Technical Specification 6.8.1 requires, in part, that written procedures be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33 Appendix A, recommends general procedures for the control of maintenance, repair, replacement, and modification work on safety-related equipment.

Step 6.7 of General Maintenance Procedure GMP-0042, "Circuit Testing and Lifted Leads and Jumpers," Revision 7B, states, in part, that independent verification of restoration shall be performed on all lifted leads. Step 8.4.9 states, in part, that the independent verifier shall remove each lifted lead/jumper tag upon completion of each individual verification and sign and date the "Verified Restored" block of the lifted lead and jumper tag sheet.

Contrary to the above, on June 29, 1994, licensee personnel implementing Maintenance Work Order C306902 for the replacement of relay K-1 on the lower containment airlock failed to perform independent verification of the lifted leads during the restoration of the new relay. The performer, in lieu of the independent verifier, removed the lifted lead/jumper tag upon restoring the connections.

REASON FOR THE VIOLATION

Entergy Operations concurs with this violation and believes that the reason for the condition was that the crew supervisor did not read or fully understand the requirements of the independent verification actions found in GMP-0042 "Circuit Testing and Lifted Leads and Jumpers."

Since the plant modification and construction (PM&C) supervisor involved in this incident did not originally view his actions as a procedural violation of GMP-0042, PM&C management personnel took steps to ensure that they fully established and understood the supervisors assumptions. His basis for not performing the independent verification was that paragraphs 8.4.8.1, 8.4.8.2, and 8.4.8.3 indicated that independent verification is required when performing work in the control room. Based on his understanding of this section of the procedure the supervisor believed that independent verification was *only* required when working in the control room; however, paragraph 6.7, which is in the limitations section, requires independent verification for restoration of all lifted leads and jumpers.

Based on the interview with the responsible supervisor, it was determined that he was familiar with the responsibilities of the independent verifier, although, he was not aware of

Section 6.7 which required him to independently verify restoration of all lifted leads and jumpers. This is because he had a high confidence level in his understanding of the procedure due to his personal involvement with GMP-0042 as a former RBS I&C maintenance supervisor. Based on his previous experience, the supervisor made an incorrect assumption that he did not need to review the procedure prior to performing the work. Once he had been apprised of this requirement, it became apparent to supervisor that he had violated the procedure.

Based on management review of GMP-0042, there was no specific procedural deficiency identified. The reason for the violation was the failure of the individual to follow the specified requirements in GMP-0042.

There was no impact to plant equipment due to the failure to perform the step independently verifying restoration of the lifted leads to the relay.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The independent verification step was later completed by the supervisor as required by the procedure. This process ensured that the leads were properly landed.

The supervisors and electrical technicians of PM&C were briefed on expectations in regards to the independent verification process of lifted leads and jumpers and were given a synopsis on the proper interpretation of the independent verification requirements in GMP-0042.

In addition, other site personnel received a general briefing on the verification requirements for restoration of lifted leads and jumpers via a new site-wide communications bulletin.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

GMP-0042 is currently scheduled to be revised for clarification of general requirements. This will be completed by December 31, 1994.

The long-term performance improvement plan includes an initiative to address human performance effectiveness. The objectives of this program are improvement in the River Bend Station human performance enhancement system (HPES), development of a human performance database, and the improvement in the effectiveness of the self-checking program. Details of this program are provided in Section 13 of the LTPIP, submitted to the NRC on March 28, 1994 (RBG-40428).

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend is in full compliance. However, long term corrective actions are being implemented and will continue to address problems associated with human errors. These long term plans will be completed in accordance with the schedules outlined in the LTPIP.