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Waterford 3

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A4.05
PR

November 23, 1994

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-38
NRC Inspection Report 94-19
Reply to Notice of Violation

Gentlemen:

In accordance with 10CFR2.201, Entergy Operations, Inc. hereby submits in Attachment 1 the responses to the violations identified in Appendix A of the subject Inspection Report.

If you have any questions concerning this response, please contact W.H. Pendergrass at (504) 739-6254.

Very truly yours,

DJWise for

R.F. Burski
Director
Nuclear Safety

RFB/WHP/tjs
Attachment

cc: L.J. Callan (NRC Region IV), C.P. Patel (NRC-NRR),
R.B. McGehee, N.S. Reynolds, NRC Resident Inspectors Office

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ATTACHMENT 1

ENTERGY OPERATIONS, INC. RESPONSE TO THE VIOLATION IDENTIFIED IN APPENDIX A OF INSPECTION REPORT 94-19

During an NRC inspection conducted on August 21 through October 1, 1994, three violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violations are listed below:

A. Technical Specification 6.8.1.a requires, in part, that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Item 1, requires that the licensee establish procedures for administrative controls.

Section 5.1.1 of Administrative Procedure UNT-007-006, Revision 6, "Housekeeping," requires, in part, that garbage, trash, scrap, litter, and other routine excess materials be collected and disposed of in a timely manner.

Contrary to the above, on September 8, 1994, auxiliary operators and fire patrols failed to observe and initiate the removal of oily wipes from Emergency Diesel Generator Room A.

This is a Severity Level IV violation. (Supplement I) (382/9419-01).

B. Technical Specification 6.8.1.a requires, in part, that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Item 1.g, requires that the licensee establish procedures for process radiation monitoring system operation.

Contrary to the above, Operating Procedure OP-004-001, Revision 5, "Radiation Monitoring, " did not specify that valve CMU-901 was required to be open to establish purge flow for downstream radiation monitors. The operating procedure discrepancy contributed to an inadvertent effluent release of radioactive materials between May 3 and 13, 1994.

This is a Severity Level IV violation (Supplement I) (382/9419-02)

C. Technical Specification 6.8.1.a requires, in part, that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Item 7.e, requires that the licensee establish procedures for radiation protection.

Section 6.0 of Health Physics Procedure HP-002-606, Revision 1, "Fume Hood Capture Velocity," specifies that fume hoods should be tested quarterly. Additionally, Section 9.1.3 requires that the face velocity for fume hoods with Class III containment substances be 150 fpm average and 125 fpm minimum. Section 4.3 categorizes radioisotopes as a Class III containment substance.

Contrary to the above, as of September 28, 1994, the licensee had not tested the primary sample panel to determine the minimum face velocity.

This is a Severity Level IV violation (Supplement IV) (382/9419-03)

RESPONSE

A. **VIOLATION NO. 9419-01**

(1) Reason for the Violation

Entergy Operations Inc. admits this violation and believes that the root cause for this violation is personnel error, in that the plant personnel touring the area and those responsible for maintaining the area failed to identify and have removed, saturated oil absorbent pads from the Emergency Diesel Generator room 'A'.

On September 8, 1994, during a walk down of the Emergency Diesel Generator Room 'A', saturated oil absorbent pads were observed on the Emergency Diesel Generator lube oil cooler, oil strainer outlet piping, and flooring below the lube oil strainer outlet piping. The oil absorbent pads had been placed around the Diesel to help contain some identified oil leaks. The leaks had been identified and evaluated as being minor in nature and were on the corrective maintenance list for work during the next scheduled component outage.

The placement of oil absorbent pads to contain oil from identified leaks on the diesel is a normal housekeeping practice at Waterford. The pads have been previously evaluated by the Fire Protection personnel as not being a potential fire hazard, and it is believed that this practice was generally understood by personnel who normally access the Emergency Diesel Generator room. Additionally, it was generally understood that the Radwaste personnel were tasked with maintaining these pads. Therefore, these pads were not being considered as excess materials or trash needing additional attention to be removed.

(2) Corrective Steps That Have Been Taken and the Results Achieved

The saturated oil absorbent pads were immediately removed by Radwaste cleaning personnel.

Radwaste cleaning personnel requested and received, from the Shift Supervisor, instructions on use and placement of absorbent pads for Emergency Diesel rooms and frequency of inspection with replacement criteria. Additionally, the Radwaste supervisor issued an Inner-Office memo to all Radwaste personnel providing guidance for performing routine housekeeping tasks and use of oil absorbent materials.

The security firewatch personnel received additional instruction from the Security Lead Training Specialist in the form of a memo and a Security Training Bulletin emphasizing the duties of firewatch patrols and the reporting of discrepancies. In addition, although this was not a potential fire hazard, the security force received instruction in an Inner-Office memo upgrading the method by which observations of potential fire hazards are documented.

Operations personnel received additional instruction in the daily instructions emphasizing the responsibilities of auxiliary operators while performing watchstation tours in the Emergency Diesel Generator rooms.

3) Corrective Steps Which Will Be Taken to Avoid Further Violations

Additionally, operations personnel will review this event via required reading.

(4) Date When Full Compliance Will Be Achieved

Review of the event via required reading will be completed by 12/31/94 at which time Waterford will be in full compliance.

B. **VIOLATION NO. 9419-02**

1) Reason for the Violation

Entergy Operations, Inc. admits to this violation and believes the root cause of the violation is inadequate procedures, in that Revision 6 to Operating Procedure OP-003-004, "Condensate Makeup", Standby Valve Line-up, failed to identify that a source of water for purge flow to radiation monitors was not maintained and that Revision 5 of OP-004-001, "Radiation Monitoring," did not require that the flush isolation valves for the listed radiation monitors be open to initiate monitor purge.

Between May 3 and 13, 1994, an unplanned release of radioactive effluent occurred through the CMU system while attempting to purge radiation monitors. The release was a result of inadvertently depressurizing the CMU header downstream of isolation Valve CMU-901, which was closed, to less than the discharge pressure of the containment sump pump while attempting to purge the radiation monitors with CMU water. Because the containment sump pump discharge pressure was greater than the pressure in the CMU header, radioactive liquid leaked from the containment sump past the purge isolation valve back into the CMU system.

Operating Procedure OP-003-004 (Revision 6), which provides the valve line-up for the CMU system, did not specify that Valve CMU-901 was required to be open for system operation. Maintaining CMU-901 open would have maintained the affected portion CMU piping at a higher pressure than that of the containment sump pump. Contributing to the release was leakage past radiation monitor purge isolation Valve PRM 014-102.

(2) Corrective Steps That Have Been Taken and the Results Achieved

After the event, an assessment of the radioactive leakage was conducted and it was determined that no liquid releases exceeded two times the limiting combined MPC for all radionuclides except tritium and dissolved noble gases, when averaged over a time period of one hour. There were no airborne radioactivity releases that exceeded two times the applicable concentrations of the limits specified in 10CFR20 Appendix B, Table II in unrestricted areas, when averaged over a time period of one hour. Also there was no detectable activity in any external tanks or systems which would constitute a concern related to external systems.

Valve PRM 014-102 was replaced to correct the leakage problem.

The valve line-up in Operating Procedure OP-003-004 was changed via Revision 7 to require Valve CMU-901 be in the open position.

(3) Corrective Steps Which Will Be Taken to Avoid Further Violations

Operating Procedure OP-004-001 will be revised to require that the flush valves for the applicable radiation monitors be open in order to initiate purging. Other operating procedures involving radiation monitor purging will be reviewed to assure proper valve lineup to prevent a similar occurrence.

(4) Date When Full Compliance Will Be Achieved

Full compliance with the corrective steps of Violation 9419-02 will be achieved by January 31, 1995.

C. VIOLATION NO. 9419-03

1) Reason for the Violation

Entergy Operations, Inc. admits to this violation. It is believed that the cause of the violation was lack of technical knowledge on the part of Health Physics by not classifying the Primary Sample Panel in the Hot Chemistry Lab as a fume hood.

During a routine NRC Resident inspection of plant status, the inspectors concluded that the Primary Sample Panel performs the same safety function as a fume hood; thus, this panel should have been classified as a fume hood and tested for capture velocity as required by HP-002-606 (Revision 1). The Primary Sample Panel was not classified or tested in the past as a fume hood because the Health Physics Group, who had responsibility for this effort, did not have the required knowledge level for understanding ventilation systems, flow patterns and system design basis.

(2) Corrective Steps That Have Been Taken and the Results Achieved

On September 28, 1994, Waterford 3 did perform a capture velocity test on the primary Sample Panel and found that the velocities met the acceptance criteria of HP-002-606 (Revision 1). The panel has also been included in the fume hood testing program. It has been determined that there is no evidence of internal deposition of radioactive material in personnel, resulting from the panel not being tested as a fume hood.

(3) Corrective Steps Which Will Be Taken to Avoid Further Violations

The Chemistry Department, being more knowledgable in the testing of fume hoods, will take responsibility for Waterford 3's fume hood testing program. Chemistry will develop a new procedure for testing of fume hoods on a periodic frequency. The Primary Sample Panel in the Hot Chemistry Lab will be included in the revised fume hood testing program. Also, the scope of the fume hood testing program will be reviewed to assure that all fume hoods are identified in the revised testing program.

Health Physics will delete HP-002-506 after the Chemistry Department develops and obtains approval of the new procedure for fume hood testing.

(4) Date When Full Compliance Will Be Achieved

Full compliance with the corrective steps of Violation 9419-03 will be achieved by January 31, 1995.