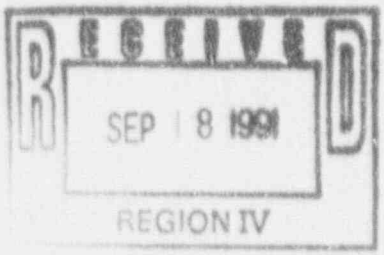
ENTERGY

Entergy Operations, Inc.

R. F. Burski



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September 17, 1991

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 91-21
Reply to Notice of Violations

Gentlemen:

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

If you have any questions concerning this response, please contact L.R. LeBlanc at (504) 739-6379.

Very truly yours,

RFB/LRL/ssf
Attachment
cc: R.D. Martin, NRC Region IV
R.B. McGehee
N.S. Reynolds
NRC Resident Inspectors Office

91-1614

ATTACHMENT 1

ENTERGY OPERATIONS, INC. RESPONSE TO THE VIOLATIONS IDENTIFIED IN APPENDIX A OF INSPECTION REPORT 91-21

VIOLATION NO. 382/9121-001

10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" requires, in part, that measures shall be established to assure that conditions adverse to quality, such as deficiencies and nonconformances, are promptly identified and corrected.

Site Directive No. W2.501, Revision 0, "Corrective Action," Section 4.7.1 requires Waterford 3 personnel to initiate the applicable corrective action document upon discovery of a condition adverse to quality.

Quality Assurance Procedure QAP-012, Revision 9.0, "Quality Notice," Section 5.1.1 requires any individual identifying a condition adverse to quality shall initiate a Quality Notice (QN).

Contrary to the above:

1. On May 20, 1991, an improperly configured speed governor withdrawn from spare parts was installed on Emergency Feedwater Pump A/B, resulting in a failed test run. Licensee personnel identifying the deficiency failed to document this on a QN such that appropriate permanent corrective actions would be assured.

2. On July 10, 1991, the licensee failed to initiate a QN when it was recognized that a speed sensor for Emergency Feedwater Pump A/B was improperly disassembled during the fourth refueling outage. The improper disassembly resulted in a broken amphenol connector.

3. On July 15, 1991, during motor winding resistance testing per Procedure ME-04-371, "Maintenance Procedure, Emergency Feedwater Pump Motor," a temperature conversion was incorrectly calculated. The subsequent independent verification did not reveal the error. A QN was not initiated until the NRC inspector brought the issue to licensee management's attention.

RESPONSE

(1) Reason for the Violation

Entergy Operations, Inc. admits this violation and believes that the root cause of this violation was failure of maintenance personnel to understand when corrective action documents should be initiated. For clarity, each of the cited examples are discussed separately.

(i) Upon receipt of the failed test run, investigations for the Emergency Feedwater Pump A/B governor were performed to determine the cause and corrective actions necessary to prevent recurrence. Maintenance personnel incorrectly failed to initiate a QN, as required by the corrective action program, believing that the elements of the corrective action were evident and that the issue had been adequately addressed without needing to generate a QN. A QN was subsequently issued for the incident on August 6, 1991.

(ii) When the amphenol connector for the emergency feedwater pump speed probe was discovered disconnected and the speed probe damaged, a precursor trending card was completed to document the problem. The I&C Planning Supervisor was investigating the incident to determine how and when the damage had occurred. He incorrectly failed to initiate a QN to document the problem he was investigating as required by the corrective action program. A QN was subsequently issued for the incident on August 9, 1991.

(iii) The technicians and acting supervisor involved with the independent verification error failed to realize that a QN was required by the corrective action program. The discussions relating to the need for corrective action documentation with the resident inspector were misinterpreted by the acting supervisor and technicians involved which delayed the initiation of a QN. A QN was subsequently initiated on July 25, 1991.

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

In all three instances a QN was issued to document the condition adverse to quality. QN QA-91-149 was originated on August 6, 1991 for the emergency feedwater turbine governor problem. QN QA-91-153 was originated on August 9, 1991 for the broken speed probe amphenol. QN QA-91-148 was originated on July 25, 1991 for the improper independent verification of calculations.

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

A memorandum will be sent to discipline superintendents to provide additional guidance on initiation of corrective action documents. Shop meetings will be held to communicate to shop personnel the importance of initiating corrective action documents and when they are required.

A corrective action task group is currently evaluating Site Directive W2.501, "Corrective Action," to determine if the program should be streamlined or simplified. This evaluation commenced prior to the violations cited and is not considered as part of the corrective actions. However, this does demonstrate the continuing effort to improve the corrective action program at Waterford 3.

(4) Date When Full Compliance Will Be Achieved

The memorandum will be issued and the shop meetings completed by September 30, 1991.

VIOLATION NO. 382/9121-003

Technical Specification 3.8.1.1, Action b requires, in part, with one diesel generator inoperable and the plant in Mode 1, that the licensee demonstrate the operability of the offsite A.C. circuits by verifying correct breaker alignments and indicated power availability within 1 hour and at least once per 8 hours thereafter.

Contrary to the above, on June 20, 1991, with Emergency Diesel Generator A inoperable, the 1-hour off-site circuit operability verification was not completed for nearly 8 hours, and on June 21, 1991, with Emergency Diesel Generator A inoperable, the verification was not completed for 2 hours in one instance and for nearly 6 hours in a second instance.

RESPONSE

(1) Reason for the Violation

Entergy Operations, Inc. admits this violation and believes that the root cause of this event is inadequate attention to detail. The control room supervisor (CRS) properly entered Technical Specification 3.8.1.1, but did not initiate the electrical breaker alignment check in order to satisfy the action requirements of Technical Specification 3.8.1.1.

NRC Inspection Report 50-382/91-21 identified this event as a recurring problem in which past measures to prevent recurrence did not appear to prevent future recurrences. This particular technical specification action has been unique in that it generally has been a problem when cascading down from support system outages. In this particular event the inoperability of the EDG cascaded from placing essential chillers out of service. A contributing cause of these events was that the procedures in place at the time did not include sufficient clarification and guidance on entering cascading technical specifications.

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

At approximately 2220 on June 21, 1991 during a review of the control room logs it was discovered that Technical Specification 3.8.1.1 action b had not been performed as required. At 2223 on June 21, 1991, OP-903-066, Electrical Breaker Alignment Check, was performed and verified that offsite AC electrical power was available as required by Technical Specification 3.8.1.1 action b. Licensee Event Report (LER) 91-012 dated July 22, 1991 was written to report this event. The control room supervisor involved in this event was debriefed. To prevent recurrence, a new procedure, "Technical Specification Compliance," OP-100-014, was issued which provides additional clarification and guidance on entering cascading technical specifications. The purpose of this new procedure is to provide guidance for determining operability of technical specification related equipment and for ensuring that compliance with the technical specifications is maintained.

In addition, other procedures were revised to provide clarification and guidance. Procedure OP-002-003, "Component Cooling Water System," was revised to add a precaution to section 3.1, and a caution to section 6.5 which states if a CCW train is inoperable, then cascading technical specifications should be entered in accordance with OP-100-14, Technical Specification Compliance. Procedure OP-002-004, "Chilled Water System," was revised to add a precaution to section 3.1, and a caution to sections 6.2, 6.3, and 6.5, requiring that if a chilled water train is inoperable, then cascading technical specifications shall be entered in accordance with OP-100-014, Technical Specification Compliance.

LER 91-012 and OP-100-014 were entered into the Operations Department Priority 2 Required Reading.

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

All corrective actions for this violation have been completed.

(4) Date When Full Compliance Will Be Achieved

Full compliance was achieved on August 16, 1991, at which time all associated corrective actions were complete.