



ENTERGY

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W3F1-95-0074

A4.05

PR

May 19, 1995

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 95-13
Reply to Notice of Violation

Gentlemen:

In accordance with 10CFR2.201, Entergy Operations, Inc. hereby submits in Attachment 1 the response to the violations identified in Appendix A of Inspection Report 50-382/95-13. The inspection was conducted by Messrs. R. Huey, C. Clark, and W. Wagner from March 6 through March 17, 1995. The inspection provided a review of the Waterford 3 Corrective Action Program (CAP).

Waterford 3 is encouraged by several observations made in the inspection report and the conclusion that we have implemented a strong program that is capable of identifying, correcting, and precluding recurrence of plant problems. We believe that this conclusion is a direct result of the streamlining of the process and lowering of the condition report (CR) threshold that has occurred over the past two years. We are confident that the current CR threshold exceeds regulatory requirements on identifying and correcting conditions adverse to quality. Refinements in the process and its implementation are ongoing and we believe that the CAP will continue to progress in effectiveness and efficiency.

Waterford 3 is concerned about other aspects of this inspection report. Specifically, the inspection report identified three violations that involved failure to properly identify and correct plant materiel condition deficiencies, failure to implement appropriate controls to maintain plant

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design configuration, and failure to properly initiate condition reports when adverse conditions are identified by plant personnel. Waterford 3 is concerned about the regulatory application of many of the examples cited in these violations. Many of the examples cited have no safety significance and were not intended to be addressed in our CAP and, we believe, should be below NRC regulatory concern. Others are old issues or issues already being addressed at Waterford 3 and are not indicative of programmatic problems with our CAP. Yet, the Inspection Report, while recognizing the minor significance of the individual issues involved, concludes that the issues do not appear to be isolated and seem to indicate an overall weakness in Waterford 3's CAP. Waterford 3 does not agree with these conclusions and is concerned that this characterization could unnecessarily focus the attention of our CAP on non-safety significant issues. Additional discussion of these violations follows.

Violation 9513-03 lists nine materiel plant conditions which had not been identified by plant personnel. Two of the nine examples represent conditions adverse to quality and are addressed in the attached response to the violation. The remaining examples, however, represent materiel/housekeeping issues with minor or no safety significance which are not considered to be conditions adverse to quality and, as such, we believe should be below regulatory concern. While we agree that these conditions need to be identified, prioritized, and corrected, we do not believe they represent a weakness in Waterford 3's Corrective Action Program.

Violation 9513-06 cites three configuration control deficiencies identified during the inspection. These examples are the result of configuration changes that were implemented several years ago. Additionally, Waterford 3 identified configuration control deficiencies as a generic issue in 1994, and a condition report was generated to address this matter and initiate a root cause analysis. This is discussed further in the response to the violation.

Violation 9513-07 is cited as a failure to initiate CRs when adverse conditions are identified by plant personnel. However, three of the four examples listed in violation 9513-07 are conditions which were discovered before the utilization of a single corrective action document (the CR) and the lowering of the CR threshold, and therefore do not represent failures to generate CRs under the current CAP. We believe that the remaining

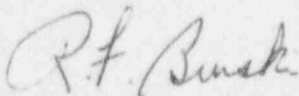
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example does not meet our CR threshold, however procedural guidance linking drawing deficiencies and conditions adverse to quality needs to be clarified. These examples do not represent a general weakness in the implementation of the Waterford 3 CAP.

Although we believe that many of the conditions identified in the inspection report, as well as those identified more recently during system walkdowns, are below regulatory concern and do not meet the threshold of a condition adverse to quality, Waterford 3 has taken proactive steps to address and correct these deficiencies using the resources and mechanisms we feel are appropriate and effective.

We hope that this feedback is constructive and beneficial and is keeping with our shared interest in open communications. If you have any questions concerning this response, please contact me at (504) 739-6774.

Very truly yours,



R.F. Burski
Director
Nuclear Safety

RFB/DFL/tjs
Attachment

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

ATTACHMENT 1

ENERGY OPERATIONS, INC. RESPONSE TO THE VIOLATIONS IDENTIFIED IN
APPENDIX A OF INSPECTION REPORT 95-13

VIOLATION NO. 9513-03

A. 10 CFR Part 50 Appendix B, Criterion XVI (Corrective Action) requires that measures be established to ensure that conditions adverse to quality are promptly identified and corrected.

Contrary to the above, as of March 17, 1995, the licensee had not established appropriate measures to ensure that conditions adverse to quality were promptly identified and corrected, as evidenced by the following examples of plant material condition deficiencies which had not been identified by licensee personnel:

- (1) The exhaust port cover was broken on Emergency Diesel Generator (EDG) A fuel oil overspeed trip Valve (EGA1SSCV3006 1A) and there was debris inside of the exhaust port.
- (2) The gasket was improperly installed (e.g., extruded out of its compression groove) on EDG-B starting air control Valve (EGAMVAAA159B).
- (3) Component cooling water (CCW) Pump B and AB outboard bearings were leaking oil.
- (4) The sight glass was cracked on the leak detector line for high pressure safety injection Pump AB suction Valve (SI-MV-202 B).
- (5) There was loose debris on the CCW Pump B and AB skids (a bent nail on the B skid; and a paper clip and wire on the AB skid).
- (6) Covers were not properly installed on several conduit pull boxes for low pressure safety injection (LPSI) and shutdown heat exchanger (SDHX) components. Specifically:
 - SDHX-B CCW outlet valve solenoid (SV-CC-131 B1),
 - LPSI-A discharge flow control Valve (BSI-307-SA), and
 - LPSI-A flow control valve open Limit Switch (SI-IZS-0129 A).
- (7) A mounting bolt was loose on the bottom of the north support bracket for the SDHX-A room cooling unit.

- (8) A pipe hanger support rod was missing on the valve leak detector lines above and southwest of Valve CS-MV-117 B.
- (9) Both SDHX CCW outlet solenoid valves were leaking through their exhaust ports (CC-ISV-0963 A1 and B1). Also, a lock washer was improperly installed on Valve SV-CC-130 A1.

This is a Severity Level IV violation (Supplement I) (382/9513-03).

RESPONSE

(1) Reason for the Violation

Entergy Operations, Inc. admits this violation for two of the nine examples listed as conditions adverse to quality which were not identified by Waterford 3 personnel. Seven of the nine examples are not considered by Waterford 3 to be conditions adverse to quality but, rather, minor plant materiel conditions which fall below the threshold of our Corrective Action Program (CAP). These conditions are being, or have been, corrected under programs outside of the CAP.

The first example of a condition adverse to quality identified by the inspectors (example 1 of the violation) was an exhaust port cover on Emergency Diesel Generator (EDG) A Fuel Oil Overspeed Trip Valve, EGAISV3006 1A, being found broken with debris inside of the exhaust port. Entergy Operations, Inc. believes that the root cause of this condition was inattention to detail in that engineering personnel failed to update documents to provide for controls of the vent ports, which were installed under Design Change DC-3025 in 1988. A condition report (CR 95-0179) was initiated to address this condition and several similar conditions. This item is discussed further in the response to violation 9513-06.

The second identified example of a condition adverse to quality (example 2 of the violation) was a gasket found to be improperly installed on EDG B Starting Air Control Valve EGA-159 B. Entergy Operations, Inc. believes that the root cause of this condition was also inattention to details in that the workers who installed the gasket did not realize the unique design of the valve as compared to most similar valves. Typically, bonnet gaskets are located between the valve body and bonnet. The EDG starting air control valves are unique in that they have a stem guide between the body and bonnet. Although the associated work package referenced a valve drawing which shows the correct location of the gasket (below the stem guide), the gasket was improperly installed above the stem guide.

Examples 3 through 9 cited in violation 9513-03 are not considered by Waterford 3 to be conditions adverse to quality and, hence, are below the threshold of a condition report:

Example 3 cites CCW Pump B and AB outboard bearings were leaking oil. No CR was necessary for this condition because of the extremely small amount of leakage observed. Approximately one drop per 45 minutes was noted to be leaking from the pumps. This is the result of normal wear and is not an unusual condition. In addition, the oil levels are checked each shift to identify any significant leakage problems. CI 295519/WA 01134107 replaced the oil cooler gaskets for pump B. Pump AB is being addressed by CI 295518.

Example 4 cites a sight glass being cracked on the leak detector line for HPSI Pump AB suction valve SI-202B. The purpose of the sight glass is to provide a visual means of quantifying a significant packing leak. The leakoff lines are not pressure-retaining (end at floor drain), are not safety-related, and have no operational function. In fact, many of these leakoff lines have been abandoned due to improved packing methods. This is a minor maintenance item. The sight glass has been replaced by CI 295806.

Example 5 cites a bent nail on the CCW Pump B skid and a paper clip and wire on the CCW Pump AB skid. This is strictly a housekeeping type issue which does not constitute a CR or even a CI. The loose items were removed from the pump skids.

Example 6 cites covers found not properly installed on several conduit pull boxes for LPSI and SDHX components. The primary purpose of these covers is to prevent moisture intrusion or debris from entering the pull boxes. The boxes are non-EQ items and cables housed by the conduit are fully insulated, thus giving no concern of cable damage due to the covers not being properly installed. In this case, the covers were not missing, but they were not tightened down fully. This type of condition can be corrected without even a CI being generated. The covers are now properly installed.

Example 7 cites a mounting bolt found loose on the bottom of the north support bracket for SDHX-A room cooler. There is no obvious seismic or operability concern caused by this condition. This is the only bolt found in the area in this condition. The bolt was found to be backed off several threads. This is a maintenance condition which does not require a CR. CI 296642 was generated to fully tighten the bolt.

Example 8 cites a pipe hanger support rod missing on the valve leak detector line for CS-117. Once again, leak detection lines serve no

operational function other than the indication of valve packing leakage. The subject line is an abandoned line. This is a minor maintenance item. Because the line connects to other active lines, the U-bolts were replaced under CI #295807.

Example 9 cites both SDHX CCW outlet solenoid valves leaking through their exhaust ports. The air leakage is so minor that it is barely detectable. The operation of the components are in no way affected. Example 9 also cites a lock washer being improperly installed on one of the solenoid valves. The lock washers are installed on the bolt side of the wall mounting for the solenoid valves rather than on the nut side. There is no structural concern presented by this minor discrepancy. These items are scheduled to be addressed by CI #'s 295547 and 295548. They are maintenance items and do not require a condition report.

Waterford 3 agrees that the first two examples should have been in the CAP, but these examples are not indicative of a programmatic breakdown in the current CAP. As shown above, the other examples cited under the violation are considered to be below the threshold of the CAP and are being corrected by other means.

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

The corrective actions associated with the broken port cover on EGAISV3006 are discussed in the response to violation 9513-06.

Condition Report 95-0182 was generated to address the improperly installed gasket on EGA-159 B. Engineering evaluation under this CR determined that the improperly installed gasket could not have affected the operability of EDG B. Any leakage which may occur between the valve body and stem guide would not affect the operation of the valve. The other air start valve on EDG B and both air start valves on EDG A were visually inspected, and no additional discrepancies were noted.

Two of the three workers responsible for installation of the gasket were contractors and are no longer employed at Waterford 3. The third worker, who is currently employed at Waterford 3, was debriefed with the foreman in accordance with maintenance directives.

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

Actions to prevent recurrence associated with the broken exhaust port cover are discussed in the response to violation 9513-06.

The improperly installed gasket on EGA-159 B will be removed and properly installed during the next refueling outage.

(4) Date When Full Compliance Will Be Achieved

The proper installment of the EGA-159 B gasket will be completed no later than the end of Refuel 7 which is scheduled to begin in September, 1995.

VIOLATION NO. 9513-06

B. 10 CFR Part 50, Appendix B, Criterion III (Design Control) requires that measures be established to ensure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions.

Contrary to the above, as of March 17, 1995, the licensee had not established appropriate design control measures, as evidenced by the following design configuration control deficiencies:

- (1) Exhaust port covers, designated for installation by Design Change DC-3025 in 1988, were missing from the exhaust ports of several emergency diesel generator solenoid valves, including: EGAISV3006 1A, EGAISV307 A, EGAISV308 A, EGAISV3001 A, EGA420 A, EGA442 A, EGAISV410 B, EGAISV305 B, EGAISV0307 B, EGAISV308 B, EGAISV3001 B, EGA420 B, and EGAMV442 B.
- (2) Several exhaust port covers, installed by Design Change DC-3025 in 1988, were painted over, in conflict with design requirements that the covers not be painted over. Examples included: EGAISV0305 A, EGAISV0306 A, and EGAISV0306 B.
- (3) Terminal box weep holes, designated for installation by design modification (FAN: 4664-1861) in 1991, were missing on several environmentally qualified terminal boxes, including: B3CC-F122A-SA, F123B-SB, F269B-SB, B3CC-F268A-SA, and B3CC-F110A/B-SB.

This is a Severity Level IV violation (Supplement 1) (382/9513-06).

RESPONSE

- (1) Reason for the Violation

Entergy Operations, Inc. admits this violation and believes that the apparent cause of the design configuration control deficiencies associated with the installation of the exhaust port covers on several Emergency Diesel Generator solenoid valves (Examples 1 & 2) was due to personnel error in the form of inadequate attention to details. The System Engineer that processed Design Change (DC) 3025 in 1988, which installed the exhaust port covers, did not recognize that several documents needed to be revised to reflect the configuration change. An assumption was made that Instrumentation and Control (I&C) personnel would, as a matter of course or automatically, replace the vent port covers as required. A

contributing cause of this situation was the perception by some I&C personnel that the installation of the vent port covers was considered to be a recommended good practice and was not part of the plant design. This perception was the result of information supplied by the vendor (Cooper-Bessemer) in January 1988 during a Emergency Diesel Generator controls training session. Compounding the situation is the fact that most I&C technicians did not attend the training session and therefore were unaware of the vent port covers existence.

Entergy Operations, Inc. believes the apparent cause of the missing weep holes on the terminal boxes associated with Environmentally Qualified equipment (Example 3) was also the result of personnel error in the form of inadequate attention to details. The weep holes were installed in response to NRC Information Notice 89-63. Weep holes were installed in necessary containment components during Refueling Outages 3 and 4. However, Waterford 3 personnel did not adequately control the review, evaluation, and implementation of actions in response to Information Notice 89-63 in the Reactor Auxiliary Building.

These examples of design configuration control deficiencies are the result of configuration changes that were implemented several years ago. Since that time the design configuration control program at Waterford 3 has been revised to provide specific guidance regarding the preparation, review, and implementation of design changes. These improvements should preclude the type of personnel errors described above from occurring in the future. The Waterford 3 Corrective Action Program has been substantially modified and improved in the time period following the referenced configuration changes. As a result of the improvements, the Waterford 3 Corrective Action Program had identified deficiencies in the configuration control process prior to this violation being cited. A generic Condition Report (CR-94-0761) addressing configuration control issues was generated and a task force was formed. This Condition Report was dispositioned as significant, which requires a Root Cause Analysis to be performed. During the performance of this ongoing Root Cause Analysis, three key areas were identified as having the most documented configuration control discrepancies requiring further investigation. The three areas identified were Motor Control Center components, Electrical Distribution Panel wiring, and Flow Diagram accuracy. Each of these areas is being explored in depth by a cross disciplinary team of Waterford 3 personnel.

Included in generic Condition Report 94-0761 were several condition reports addressing Fuse Control. In 1991, Waterford 3 recognized a need for improvement in the Fuse Control Program. A task force was

subsequently established to address Fuse Control configuration issues and several improvements were implemented. The corrective actions for these Condition Reports will be the final closure for the main configuration issues identified by the task force.

Any additional corrective actions which are identified during the performance of the Root Cause Analysis for generic Condition Report 94-0761 will be evaluated for implementation as these actions are identified.

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

Immediately following the identification of the missing, broken, and painted over vent port covers, a Condition Report (CR 95-0179) was generated in accordance with Waterford 3 Administrative Procedure UNT-006-011 "Condition Report". A Condition Identification (CI) was initiated and the painted over vent port covers were immediately replaced. Other CIs were generated to replace all missing or broken vent port covers associated with the Emergency Diesel Generator solenoid valves. Also, System Engineering and Design Engineering have performed an Emergency Diesel Generator System review and walkdown to determine if additional valves may need vent port covers. Based on this review and walkdown additional vent port covers will be installed as deemed necessary.

A condition report (CR 95-0184) was immediately generated after the discovery of the missing weep holes in terminal boxes associated with Environmentally Qualified equipment. A field inspection of the affected terminal boxes was performed by Design Engineering. A determination was made that the terminal boxes do not require weep holes due to the conduit configuration associated with these boxes and the lack of evidence indicating prior water intrusion into these boxes. An evaluation was performed by Design Engineering to determine if generic moisture problems exist for other terminal boxes in the Reactor Auxiliary Building which also may not have the required weep holes. The results of this evaluation indicate that Waterford 3 does not have generic moisture problems with terminal boxes in the Reactor Auxiliary Building.

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

Several additional corrective actions will be taken to avoid further violations of this type in the future. The controlled documentation, drawings, and technical manual affected by the addition of the vent port covers will be updated. New vent port covers will be installed as required. The Materials Management Information System (MMIS) will be updated to add a note to the information in this data base which

will indicate that the exhaust vent port covers are required to be installed on the solenoid valves. This information will subsequently be printed on the issuing ticket when replacement solenoid valves are obtained from the warehouse. Calibration Procedure MI-005-490 "Emergency Diesel Generator Control System Calibration and Maintenance" will be revised to address vent port covers.

As a result of the evaluation performed by Design Engineering, no further actions regarding weep holes are required for terminal boxes previously installed in the Reactor Auxiliary Building. The Box Details Drawing (1564-B353) Sheet 2 which requires all boxes to have weep holes has been posted with a Document Revision Notice (DRN). This DRN allows terminal boxes to be installed without weep holes if supported by an engineering evaluation.

(4) Date When Full Compliance Will Be Achieved

All corrective actions associated with the Emergency Diesel Generator solenoid valve vent port covers will be completed August 30, 1995, with the exception of the replacement of the exhaust vent port cover for the Emergency Diesel Generator (EDG) B overspeed trip solenoid valve. This exhaust vent port cover will be replaced during the next EDG B component outage or during the Refuel 7 outage, whichever occurs first.

All corrective actions associated with the missing weep holes in terminal boxes in the Reactor Auxiliary Building have been completed.

VIOLATION NO. 9513-07

C. 10CFR Part 50, Appendix B, Criterion V (Instructions, Procedures, and Drawings) requires that 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.

Station Procedure UNT-006-011 (Condition Report), Revision 0, dated January 15, 1993, and Revision 2, dated February 24, 1995, require that any individual working at Waterford shall initiate a Condition Report upon identification of an adverse condition.

Contrary to the above, as of March 17, 1995, the following adverse conditions were identified by individuals working at Waterford, and a Condition Report was not initiated:

- (1) On March 15, 1995, a pipe cap, required by Station Drawing 4305-6635, Revision 4, was identified to be missing from the tail piece of emergency feedwater Pump A suction root Valve EFW-MV-108 A.
- (2) Work Authorization, WA 01121725 (CI 288569), dated March 14, 1994, identified loose and missing feed ring bolts and nuts in Steam Generator No. 1. The Work Authorization noted that the same problem was observed in March 1991.
- (3) Work Authorization, WA 01121767 (CI 290045), dated March 15, 1994, identified the wrong material installed on Safety Injection Tank 2A Outlet Check Valve SI-MV-330.
- (4) EDG Air Receiver Check Valve EGA-MV-136 A was identified as having excessive leakage during in-service testing on February 12 and April 4, 1994 (CI 284499 and 290569).

This is a Severity Level IV violation (Supplement 1) (382/9513-07).

RESPONSE

(1) Reason for the Violation

Entergy Operations Inc. admits this violation and believes that the root cause for example one (1) cited in this violation is a procedural deficiency in that Administrative Procedure UNT-006-011, "Condition Report," is unclear because it implies that a CR is necessary for all identified drawing discrepancies regardless of the affect on actual configuration of the plant. Although shown on many

drawings, pipe caps downstream of valves are generally not considered by Waterford 3 to be part of plant configuration and, hence, when missing, do not represent conditions adverse to quality. Pipe caps are primarily installed for maintenance/housekeeping as well as miscellaneous testing purposes and do not affect the operation of the associated piping.

The intent of the CAP concerning drawing discrepancies is to identify and correct those which affect the configuration of the plant. Those minor drawing discrepancies which do not meet this threshold may be addressed without a CR being generated to investigate. Other mechanisms have been utilized in the past to identify and appropriately address pipe cap issues. A CR would be appropriate, however, to address an adverse trend regarding such conditions as minor drawing discrepancies. This is supported by CR 94-0923 which was generated in September, 1994 as a result of the identification of an adverse trend against pipe caps, not an individual instance.

Waterford agrees with the NRC's assessment that examples two (2), three (3), and four (4), cited in this violation should not normally be cited. Waterford 3 identified these conditions prior to the corrective action program upgrade, which became effective June 1, 1994. Prior to that date, the CAP did not require a CR for these examples. They were, however, appropriately identified and corrected via Waterford 3's work control program. These types of events would be tracked by a Condition Report under the current corrective action program.

Based on the above, Waterford 3 does not believe that this violation represents a less than full understanding of the intent of the CAP by plant operators. Waterford 3 feels that expectations for generating CR's when appropriate are being met.

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

In example one (1), upon condition identification, the Shift Supervisor immediately directed that the pipe cap be replaced and the system engineer verified that the caps were in place on the suction and discharge root valves for all Emergency Feedwater pumps. As a result of the inspector's concern, Condition Report 95-191 was written to document and track further corrective actions related to this event.

Subsequently, Condition Report 95-191 was administratively closed to the above mentioned Condition Report (CR 94-923) to track the generic concerns associated with the installation of pipe caps.

It is believed that no further corrective actions are required for the older conditions identified in examples (2), (3), and (4), in that specific corrective actions for each example have been completed and should a similar condition occur in the future, the current corrective action program requirements would necessitate the issuance of a Condition Report.

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

Corrective actions are still in progress to address the adverse trend involving pipe caps per CR 94-923.

UNT-006-011, "Condition Report," will be revised to provide clearer guidance on the scope of drawing discrepancies that affect actual plant configuration.

(4) Date When Full Compliance Will Be Achieved

Waterford 3 will be in full compliance when UNT-006-011 is revised to provide clarification as described above. This action will be completed by August 31, 1995.