ENTERGY

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April 28, 1995

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Stop P1-37
Washington, D.C. 20555

Subject: Reply to Notice of Violation IR 95-11
River Bend Station - Unit 1/Docket No. 50-458

File No.: G9.5, G15.4.1

RBG-41475
RBF1-95-0106

Gentlemen:

Pursuant 10CFR2.201, please find Entergy Operation's response to the notice of violation described in NRC Inspection Report (IR) 95-11. This inspection was performed by W.F. Smith, M.M. Biamonte, and M.E. Murphy during March 7, 1995 through March 10, 1995 to obtain an understanding of the circumstances surrounding the inappropriate positioning by licensed operators of a remote shutdown transfer switch to the "emergency" position on February 28, 1995.

For clarification, this switch is one of many switches that must be repositioned to transfer control room functions to the Remote Shutdown Panel. This particular transfer switch affects only a few of the components (primarily in the service water system) for which control can be transferred to the Remote Shutdown Panel.

In the inspection report, you raised concerns regarding the inadequate work instructions associated with the safety-related preventive maintenance activity. River Bend Station management has recognized that weaknesses exist in certain processes which have resulted in inadequate work instructions and has already taken significant steps to strengthen this area. As discussed in our response to IR 50-458/95-01, we are working diligently to reduce challenges to the plant that result from inadequate work instructions. As discussed herein, we have increased our focus in the area of preventive maintenance. We are confident that our short term actions in this area, combined with

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the broad-based preventive maintenance program initiatives described in the Long Term Performance Improvement Plan (LTPIP), will effectively resolve this weakness.

You also expressed concerns regarding the performance of the operators involved in this event. We acknowledge that in certain aspects of this event the operators did not perform at a high level consistent with management expectations. Nevertheless, as we discussed at our meeting on April 10, 1995, we are confident that the station's licensed operators are, without exception, highly competent and fully capable of meeting the challenges of ensuring safe plant operation while our improvement efforts continue.

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

Sincerely,

Donald R Dahonne for JJF

JJF/jr
attachment

cc: U.S. Nuclear Regulatory Commission
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ATTACHMENT A

REPLY TO NOTICE OF VIOLATION IR 458/9511-01

VIOLATION

Technical Specification 6.8.1.1 states, in part, that written procedures shall be established and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Appendix A of Regulatory Guide 1.33, Paragraph 9.a states, in part, that maintenance that can affect the performance of safety-related equipment should be properly preplanned in accordance with written procedures, documented instructions or drawings appropriate to the circumstances.

Contrary to the above, on February 28,1995, Preventive Maintenance Work Order P579376 was not appropriately preplanned. Consequently, the instructions misled the technicians and the operators to believe that placing remote shutdown transfer Switch 43-1SWPN15 in the "emergency" position was authorized; however, the document did not contain a step to place the switch in that position, nor did it include any precautions or information regarding impact on plant operations.

REASON FOR THE VIOLATION

Entergy Operations concurs with this violation. The reason for this violation was that a note in the PM which provided the methodology for task accomplishment was removed during the last PM revision in November 1993. This oversight was due to an inadequate review of the risks/consequences associated with the procedure revision.

During this revision, a note which stated, "*Do not move Remote Shutdown Transfer Switch to perform this PM. 1SWP*PC32A1 is to be tested by injecting a mA signal at the appropriate SRU input leads and checking the output of 1SWP*PC32A1,*" was removed from the PM. This same note had been added in an earlier revision as the result of a lesson learned on a previous performance, and even though it was classified as a note, actually described the methodology by which the task was performed. Consequently, the preparer of this revision did not adequately review the risk/consequences associated with the removal of this note during the PM revision.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

To address the issue of PM adequacy, Maintenance supervision is screening Preventive Maintenance tasks prior to releasing the packages to the workers to determine if there is the potential for plant impact. If any component manipulations are required, then an impact statement will be added prior to the review of the PM by Operations In addition, the maintenance group at River Bend that issues PM's is currently screening PM's prior to issuance of packages to the maintenance shops for work. This review is also a review for impact, and PM's that do not have one will be revised to include an impact statement prior to scheduling the task.

A PM Reviewer's Checklist has been developed to ensure consistent review criteria and to provide a statement addressing impact. This checklist will help ensure an SRO review of the impact statement and any operational requirements associated with the PM.

Condition Report (CR) 95-0181 was initiated to investigate the event.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

The circumstances and the human factors concerns associated with this violation will be discussed with maintenance department personnel to make them aware of problems with the packages until such time as the PM packages have been upgraded to address the concerns.

Further evaluation of the events and concerns regarding PM tasks associated with this violation are being conducted. This evaluation will be appropriately documented with corrective actions assigned for any problem areas. This evaluation will address:

1. providing detailed job steps that address component manipulations,
2. level and depth of review for revisions,
3. review criteria,
4. formally defining the "impact statement."

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend Station is in full compliance. PM reviews that are presently in place ensure continued compliance, while the detailed evaluation of the PM program and resulting corrective actions will prevent future occurrences. The estimated completion date for the corrective actions associated with this violation is February 1, 1997.

ATTACHMENT B

REPLY TO NOTICE OF VIOLATION IR 458/9511-02

VIOLATION

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

Appendix A of Regulatory Guide 1.33 states, in part, that authorities and responsibilities for safe operation should be covered by written administrative procedures, as well as procedures covering operation of safety-related systems.

Contrary to the above, there were four examples where procedures prescribing safe operation of the plant were not properly implemented:

1. Administrative Procedure ADM-0022, "Conduct of Operations", Revision 18, Paragraph 3.2.10.1 holds the Work Control Supervisor responsible for assisting the on-shift Control Room Supervisor in coordination of shift activities.

   Contrary to the above, on February 28,1995, the Work Control Supervisor failed to fulfill the above responsibility, in that he released Preventive Maintenance Work Order P579376 for implementation without an adequate review to determine plant impact. Consequently a work item requiring system configurations inappropriate for current plant conditions was not screened out.

2. Procedure ADM-0022, "Conduct of Operations," Revision 18, Paragraph 3.2.3.5 holds the Control Room Supervisor responsible to coordinate and supervise the activities of the Nuclear Control Operators with other operations and plant personnel to achieve safe, reliable and efficient unit operation.

   Contrary to the above, on February 28,1995, the Control Room Supervisor failed to fulfill the above responsibility, in that he did not provide adequate specific criteria defining what conditions would be acceptable to position remote shutdown transfer Switch 43-1SWPN15, when he delegated the review of applicable procedures to the Nuclear Control Operators.

3. Procedure ADM-0022, "Conduct of Operations," Revision 18, Section 5.8.8, requires communications between operating personnel to be clear and concise, utilizing repeat-backs or written direction whenever possible.

   Contrary to the above, on February 28,1995, the control building operator communicated with the unit operator in an informal manner and without repeat-back, regarding the positioning of remote shutdown transfer Switch 43-1SWPN15. Consequently, transfer Switch 43-1SWPN15 was prematurely positioned to "emergency," causing an inadvertent cross-connect of safety-related service water with the non-safety chilled water system.

4. System Operating Procedure SOP-0027, "Remote Shutdown System," Revision 10, Section 5.0, NOTE, requires all operations from the remote shutdown panel to be in accordance with Abnormal Operating Procedure AOP-0031, "Shutdown from Outside Control Room," or applicable surveillance test procedures.

   Contrary to the above, on February 28, 1995, the control building operator manipulated remote shutdown transfer Switch 43-1SWPN15 in support of Preventive Maintenance Work Order P579376.

REASON FOR THE VIOLATION

Entergy Operations concurs with this violation. The reasons for the improper implementation of plant procedures have been determined as follows:

Example 1: Improper Implementation of ADM-0022 (Failure of Work Center Supervisor to assist the Control Room Supervisor in coordination of shift activities)

The Work Control Supervisor released Preventive Maintenance Work Order P579376 for implementation without an adequate review to determine plant impact.

The root cause of this example of the violation was inadequate communication between the WMC SRO and the technician who was to perform the task. Specifically, pertinent information was not transmitted to the WMC SRO by the technician who was to perform the PM task because the technician anticipated that a more detailed review would be performed later. Additionally, the WMC SRO was not familiar enough with the format of the loop calibration report used to perform the task to readily identify all of the actions required to perform the task.

Example 2: Improper Implementation of ADM-0022, "Conduct of Operations," (Failure of Control Room Supervisor to coordinate activities)

Regarding performance of Preventive Maintenance Work Order P579376, the Control Room Supervisor did not provide adequate specific criteria defining what conditions would be acceptable to position remote shutdown transfer Switch 43-1SWPN15 before delegating the review of applicable procedures to the Nuclear Control Operators.

The root cause of this example of the violation is that the Control Room Supervisor inappropriately characterized the task as a simple, straight-forward evolution and failed to provide the specific operating guidance necessary to adequately control this evolution. As a result, the operating crew failed to conduct a pre-job briefing or take other steps to assign individual responsibilities and identify specific criteria which would allow the evolution to proceed. As a result, the investigation of plant impact was not completed prior to moving the switch.

Example 3: Improper Implementation of ADM-0022 (Informal communications)

Regarding performance of Preventive Maintenance Work Order P579376, the control building operator communicated with the unit operator in an informal manner and without repeat-back regarding the positioning of remote shutdown transfer Switch 43-1SWPN15.

The root cause of this communication problem was cognitive personnel error by the control building operator because he incorrectly assumed that a general statement made by the control room operator authorized switch manipulation. As a result, the remote transfer switch was repositioned without informing the control room beforehand.

Example 4: Improper Implementation of SOP-0027 (Failure to operate remote shutdown panel in accordance with Abnormal Operating Procedure AOP-0031)

During the performance of Preventive Maintenance Work Order P579376, the control building operator manipulated remote shutdown transfer Switch 43-1SWPN15 contrary to procedural requirements.

The root cause for this example of the violation was inadequate communication between the control building operator and the I&C technicians assigned to perform the task. Specifically, the control building operator recognized that the transfer switch manipulation could be performed only as specified in the applicable surveillance test procedure or the associated abnormal operating procedure. However, he failed to confirm that the preventive maintenance work package included the appropriate procedure to govern repositioning of the switch.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Trainees were removed from shift until they had received additional training on individual responsibilities and communication policies. The training was conducted by the Training department and has been reinforced through meetings with the Operations Superintendent.

The Operations Superintendent has briefed the Shift Superintendents to ensure they are reinforcing the operations communication policy and management expectations for control of licensed duties.

Standard Operating Procedure (SOP) - 0027 was revised such that the note prohibiting manipulation of the transfer switch unless in accordance with Abnormal Operating Procedure (AOP) - 003, or an applicable Surveillance Test Procedure was put in the Precautions and Limitations section of the procedure.

Three SRO's were assigned to randomly monitor gaitronics communication from 3/16/95 through 3/30/95 to ensure that management expectations and published policy are being satisfied.

Condition Report (CR) 95-0181 was initiated to investigate the event.

A detailed account of this event, the root cause determination, and the corrective actions were discussed with the operating crews during Human Performance Workshops. This event was used as an example while discussing pre-job briefings, communications requirements, use of plant procedures, and conservative decision making. In addition, the groups discussed how to recognize complex evolutions and when an evolution should be stopped.

An all-employee letter was issued by the Vice President-Operations addressing Human Performance Achievements and Expectations. This letter addressed recent human performance errors and stressed the need for heightened awareness, good teamwork, and questioning attitudes.

The Long Term Performance Improvement Plan (LTPIP) specifically addresses human performance problems at River Bend and contains initiatives that are presently in progress for improving human performance at River Bend.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

A practical role playing exercise for SRO's will be formulated to strengthen their skills in evaluations of work packages and troubleshooting plans. This exercise will be incorporated into the training schedule for SRO's.

A case study based on this event will be prepared for presentation to operations personnel to help develop decision making, supervisory/oversight, and team skills.

The Independent Safety Engineering Group at River Bend Station will monitor control room work load/activities and provide a report on findings regarding amounts of work vs. ability to review packages in detail in the main control room.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend Station is in full compliance. The estimated completion date for the corrective actions associated with this violation is October 31, 1995.