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Waterford 3

W3F1-95-0212
A4.05
PR

January 8, 1996

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
Reporting of Licensee Event Report

Gentlemen:

Attached is Licensee Event Report Number LER-95-006-00 for Waterford Steam Electric Station Unit 3. This Licensee Event Report is submitted in accordance with 10CFR50.73(a)(2)(i)(B).

Very truly yours,

D.R. Keuter
General Manager
Plant Operations

DRK/RJM/tmm
Attachment

cc: L.J. Callan, NRC Region IV
C.P. Patel, NRC-NRR
D.F. Packer
J.T. Wheelock - INPO Records Center
R.B. McGehee
N.S. Reynolds
NRC Resident Inspectors Office
Administrator - LRPD

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LICENSEE EVENT REPORT (LER)

(See reverse for required number of
digits/characters for each block)ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY
INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE
INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY.
FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND
RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION,
WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-
0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Waterford Steam Electric Station Unit 3

DOCKET NUMBER (2)

05000 382

PAGE (3)

1 OF 12

TITLE (4)

Failure to Provide Backup Overcurrent Protection Due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
12	07	95	95	-- 006	-- 00	01	08	96	N/A	05000
									N/A	05000
OPERATING MODE (9)		1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)							
POWER LEVEL (10)		100	20.2201(b)		20.2203(a)(2)(v)		<input checked="" type="checkbox"/>		50.73(a)(2)(i)	50.73(a)(2)(viii)
			20.2203(a)(1)		20.2203(a)(3)(i)				50.73(a)(2)(ii)	50.73(a)(2)(x)
			20.2203(a)(2)(i)		20.2203(a)(3)(ii)				50.73(a)(2)(iii)	73.71
			20.2203(a)(2)(ii)		20.2203(a)(4)				50.73(a)(2)(iv)	OTHER
			20.2203(a)(2)(iii)		50.36(c)(1)				50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)		50.36(c)(2)				50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
G.S. Matharu, Supervisor, Electrical Engineering	(504) 739-6258

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	<input checked="" type="checkbox"/>				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On December 07, 1995, it was determined that two electrical alternating current (AC) circuits which use containment electrical penetrations did not have backup overcurrent protection as required by the Technical Specifications. While promptly investigating this condition, it was discovered that the primary breakers for the same two circuits had not been tested within 60 months as required by the Technical Specifications. The principal root cause for these two distinct but interrelated events was personnel error. The immediate corrective actions were to install backup overcurrent protection for these circuits and to test the two breakers. The health and safety of the public were not compromised during this event.

**REQUIRED NUMBER OF DIGITS/CHARACTERS
FOR EACH BLOCK**

BLOCK NUMBER	NUMBER OF DIGITS/CHARACTERS	TITLE
1	UP TO 46	FACILITY NAME
2	8 TOTAL 3 IN ADDITION TO 05000	DOCKET NUMBER
3	VARIES	PAGE NUMBER
4	UP TO 76	TITLE
5	6 TOTAL 2 PER BLOCK	EVENT DATE
6	7 TOTAL 2 FOR YEAR 3 FOR SEQUENTIAL NUMBER 2 FOR REVISION NUMBER	LER NUMBER
7	6 TOTAL 2 PER BLOCK	REPORT DATE
8	UP TO 18 -- FACILITY NAME 8 TOTAL -- DOCKET NUMBER 3 IN ADDITION TO 05000	OTHER FACILITIES INVOLVED
9	1	OPERATING MODE
10	3	POWER LEVEL
11	1 CHECK BOX THAT APPLIES	REQUIREMENTS OF 10 CFR
12	UP TO 50 FOR NAME 14 FOR TELEPHONE	LICENSEE CONTACT
13	CAUSE VARIES 2 FOR SYSTEM 4 FOR COMPONENT 4 FOR MANUFACTURER NPRDS VARIES	EACH COMPONENT FAILURE
14	1 CHECK BOX THAT APPLIES	SUPPLEMENTAL REPORT EXPECTED
15	6 TOTAL 2 PER BLOCK	EXPECTED SUBMISSION DATE

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REPORTABLE OCCURRENCE

Circuit #32 in PDP 360SA and circuit #32 in PDP 361SB use containment penetrations 141 and 142, respectively. Technical Specification 3.8.4.1 requires that circuits using containment penetrations (EIIS Identifier PEN) have primary and backup overcurrent protection. A Design Change, implemented in April 1988, utilized these two circuits which did not have backup overcurrent protection. The fact that circuit #32 in PDP 360SA and circuit #32 in PDP 361SB did not have backup overcurrent protection is a condition prohibited by Technical Specification 3.8.4.1. Therefore, this condition is reportable as a Licensee Event Report (LER) pursuant to 50.73(a)(2)(i)(B), "any operation or condition prohibited by Technical Specifications."

After the implementation of the design change, the preventative maintenance tasks for the maintenance and testing of the primary breakers, HRAEBKR60A-32 and HRAEBKR61B-32 (EIIS Identifier IK-52), should have been generated. This task was overlooked, and thus the required testing and maintenance of the breakers was not performed. Technical Specification 4.8.4.1 (b) requires that overcurrent protection devices be subjected to an inspection and preventive maintenance in accordance with procedures at least once per 60 months. The breakers were last tested in April 1988, and thus the failure to test the breakers within the 60 months is a condition prohibited by Technical Specifications. Therefore, this condition is reportable as an LER pursuant to 50.73(a)(2)(i)(B), "any operation or condition prohibited by Technical Specifications."

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INITIAL CONDITIONS

The following were the initial conditions just prior to the discovery of the reportable conditions:

Plant Power	100%
Mode	1
Procedures Being Implemented Specific to This Event	None
Technical Specification LCOs Specific to This Event	None
Major Equipment Out of Service Specific to This Event	None

EVENT DESCRIPTION

As a result of a review of the Technical Requirements Manual (TRM), a controlled document which incorporates the requirements removed from the Technical Specifications, and further investigation, plant personnel determined on December 07, 1995, that circuits #32 in PDP 360SA and #32 in PDP 361SB did not have backup overcurrent protection. These two circuits use containment electrical penetrations 141 and 142. The two circuits feed isolation and sample valves for containment hydrogen analyzers A and B. Condition Report 95-1282 was written on December 07, 1995 to document this condition.

A Station Modification Package (SMP) SMP-983 was implemented in April 1988 to install a new Hydrogen Analyzer System. A minor change to SMP-983 was implemented by Design Change Package Change (DCPC) DCPC 983-19. DCPC 983-19, in error, allowed the use of circuits which did not have backup overcurrent protection. This condition has existed since the implementation of DCPC 983-19.

Technical Specification Action 3.8.4.1.a.1 requires that with one or more of the containment penetration overcurrent protection devices not operable, the protective overcurrent device should be restored to operable status or the

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circuit should be deenergized within 72 hours. Pursuant to this Technical Specification action statement, circuit # 32 in PDP 360SA and circuit # 32 in PDP 361SB were deenergized as required. This action in turn made the hydrogen analyzers A and B inoperable since the sample valves for the hydrogen analyzers are powered from these circuits. Technical Specification 3.6.4.1 for the hydrogen analyzers was entered when the circuits were deenergized. Technical Specification Action 3.6.4.1.b requires that with two hydrogen analyzers not operable, restoration of at least one hydrogen analyzer is required within 72 hours, or the plant is required to be in Hot Standby within the next 6 hours. Under WA 01143182, backup overcurrent protection was provided for these two circuits by installing 15 amp fuses in series with the 20 amp breakers for circuit # 32 in PDP 360SA and circuit # 32 in PDP 361SB. The backup overcurrent protection was implemented within 72 hours, and the circuits and the Hydrogen Analyzer System were returned to service.

As a result of the discovery of the foregoing condition and further investigation, plant personnel determined that the task cards for the maintenance and testing of the primary breakers, HRAEBKR60A-32 and HRAEBKR61B-32, were not generated. Thus the required testing and maintenance of the breakers had not been performed. Technical Specification 4.8.4.1 (b) requires that overcurrent protection devices be subjected to an inspection and preventive maintenance in accordance with procedures at least once per 60 months. The breakers were last tested in April 1988. Under WA 01143182, the two primary breakers were tested and demonstrated operable on December 08, 1995, prior to returning the circuits and the Hydrogen Analyzer System to service.

CAUSAL FACTORS

There were two distinct but interrelated events. The first event was the use of circuits which did not have backup overcurrent protection, and the second

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event was the failure to perform the required testing and maintenance for the primary breakers. The causal factors for these two events are discussed separately.

1. Use Of Circuits Which Did Not Have Overcurrent Protection

The root cause for the use of circuits which did not have backup overcurrent protection was personnel error in that the Architect Engineer (AE) personnel and a Waterford 3 engineer failed to perform an adequate review of DCPC 983-19. Further, the Waterford 3 engineer indicated he was unaware of the Technical Specification requirement for overcurrent protection of penetrations at the time he reviewed DCPC 983-19.

The design documents for DCPC 983-19 were developed, reviewed, and approved by the AE, Ebasco Services Inc. DCPC 983-19 was also reviewed and approved by a Waterford 3 action engineer. DCPC 983-19 was implemented in order to power the new Hydrogen Analyzer sample valves that were being installed in the plant from different circuits. The circuits originally designated for use, circuit #43 in PDP 394SA and circuit #43 in PDP 395SB, did not have adequately rated breakers for use with the Hydrogen Analyzer sample valves. The DCPC allowed the relocation of the power feed for the Hydrogen Analyzer sample valves from circuit #43 in PDP 394SA and circuit #43 in PDP 395SB, which had backup overcurrent protection, to circuit #32 in PDP 360SA and circuit #32 in PDP 361SB which did not have backup overcurrent protection. The design change process for the DCPC as documented in Procedure PE-002-006, Revision 9, Change 1, required a determination of the impact of the minor change on the FSAR and regulatory requirements and also precluded such a change from proceeding if the evaluations in the original SMP, including the SMP 10CFR50.59 evaluation, were impacted. However, the Waterford 3 action engineer failed to identify the impact. The change

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was viewed and assessed as a minor change which simply changed a power source from one safety-related circuit to another safety-related circuit. The AE personnel and the Waterford 3 action engineer failed to take into consideration that circuit #32 in PDP 360SA and circuit #32 in PDP 361SB were fed through containment penetrations 141 and 142 which required double protection, that is, breaker and breaker or breaker and fuse combination.

DCPC 983-19 was developed and implemented under a procedure which has now been abolished, Procedure PE-002-006, Revision 9, Change 1. This procedure did not require Waterford 3 interdisciplinary reviews, independent reviews, nor supervisory reviews for minor changes to approved SMPs.

Further discussions with the Waterford 3 action engineer for DCPC 983-19 established that he was unaware, at the time DCPC 983-19 was implemented, of the requirements of Technical Specification 3.8.4.1 or of the requirement in general that double protection is required for containment electrical penetrations.

2. Failure To Test The Primary Breakers

The root cause for the failure to perform maintenance and testing of the primary breakers was the failure of design personnel to specify adequate instructions in DCPC 983-19 for the planner to establish repetitive tasks to test the primary breakers. The planner, his supervisor, and the Technical Specification Coordinator missed an opportunity to correct the problem in that they did not question whether new task cards should have been generated for the breakers in circuit #32 in PDP 360SA and circuit #32 in PDP 361SB.

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As discussed in item 1. of this LER, the AE personnel and the Waterford 3 action engineer, failed to recognize and identify the significance of the impact of DCPC 983-19. The DCPC design change process precluded the change from proceeding if regulatory requirements, the FSAR, or the evaluations in the original SMP were impacted. Had the significance of the change been recognized, Waterford 3 personnel would have been required to use the SMP change process and to specify the total impact of the change, including the disposition of task cards.

After the implementation of DCPC 983-19, the task cards for the primary breakers, HRAEBKR94A-43 and HRAEBKR95B-43, for circuit #43 in 394SA and circuit #43 in PDP 395SB were deleted. There were no task cards generated for breaker HRAEBKR60A-32 in circuit #32 in 360SA and breaker HRAEBKR61B-32 in circuit #32 in PDP 361SB, the to which the Hydrogen Analyzer sample valves were connected. The cognizant planner was verbally instructed, he does not recall by whom, to process the paper work for the deletion of the task cards. The processing of the paper work for the deletion of the task cards was done by the planner in accordance with Procedure UNT-005-012, Revision 0, Change 1. The processing required the planner to line through the task card, writing "Task Deletion," to obtain supervisory approval, and to forward the change to the Technical Specification Coordinator. The procedure did not require the planner to provide justification for the deletion of a task covered by the Technical Specifications. The task cards marked for deletion were then reviewed by the Technical Specification Coordinator, and the deletion was made by the Technical Specification Coordinator in the Station Information Management System (SIMS).

The task cards for equipment covered by Technical Specifications are marked with the designation "ST." This designation should have provided an indication to the planner, his supervisor, and the Technical Specification Coordinator that a further review was required. Thus, the

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planner, his supervisor, and the Technical Specification Coordinator missed an opportunity to correct the problem in that they did not question whether new task cards should have been generated for the breakers in circuit #32 in PDP 360SA and circuit #32 in PDP 361SB.

IMMEDIATE CORRECTIVE MEASURES

Backup overcurrent protection for circuit #32 in PDP 360SA and circuit #32 in PDP 361SB was provided under WA 01143182 on December 08, 1995. 15 amp fuses were added in series with the 20 amp breakers for circuit #32 in PDP 360SA and circuit #32 in PDP 361SB.

The primary breakers, HRAEBKR60A-32 and HRAEBKR61B-32, were tested and demonstrated operable on December 08, 1995. Task cards #021711 and #021712 were generated on December 11, 1995 to ensure testing and maintenance of these breakers in accordance with Waterford 3 procedures.

The design documents affected by the installation of the backup overcurrent protection were identified in WA 01143182, and the affected design documents, except drawing 5817-8099, have been revised. The procedure for the maintenance and testing of the primary circuit breakers, Procedure ME-003-315, Revision 8, was also revised and approved.

ACTIONS TO PREVENT RECURRENCE

A similar event was reported to the NRC on February 25, 1988 in LER 87-026-01. LER 87-026-01 found backup overcurrent protection missing for the circuits for two Chemical and Volume Control (CVC) valves (EIIS Identifier CB-ISV) and for a Control Element Drive Mechanism (CEDM) cooling coil water shutoff valve (EIIS Identifier CD-CCL-SHV-33).

Followup action for the event described in LER 87-026-01 included a check of all other penetrations requiring backup overcurrent protection. This in depth

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review verified that all penetrations requiring backup overcurrent protection contained this protection. The verification was accomplished using two separate methods. One method involved verifying Technical Specification table 3-8.1 against the control wiring diagrams, B424 series drawings. The other method used the Penetration List, B316 series drawings, to ensure Technical Specification table 3-8.1 was correct. Both methods resulted in the same list of circuits requiring backup overcurrent protection. The circuits discussed in this LER were modified subsequent to the reviews which were performed for LER 87-026-01.

Since the occurrence of this event, significant changes have been implemented for the design change control process, and significant training has been administered to Waterford 3 technical staff.

Some specific changes relevant to this occurrence are the following:
The DCPC process has been abolished. The procedures for design package development and 10CFR50.59 safety evaluations have been significantly enhanced.

Procedure NOECP-303, section 2.2, specifically requires that the affected document list shall include a list of all operations and maintenance department procedures, and repetitive tasks affected by the design change. The design change closeout checklist, item 11., requires that all repetitive tasks be modified as applicable. Procedure NOECP-303 clearly delineates the responsibility of engineering personnel for engineering instructions to contain sufficient detail to ensure that installation organizations and individuals (e.g. Planning and Scheduling and Work Group Planners, etc.) understand how the modification must be installed and the affects the installation can have on the plant.

Site Procedure No. W4.102, sections 6.8.4 and 6.8.4.1, require that prior to operational acceptance, the Operations Superintendent or designee must verify

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that required surveillances that impact design change affected equipment operability have been performed and that surveillances required for continued operation are identified and tracked.

A minor design change requires an evaluation to determine if the original 10CFR50.59 evaluation is impacted. A change that impacts the Technical Specifications is a major change. A major change will require a detailed 10CFR50.59 safety evaluation and review by the impacted discipline, Design Review Committee (a panel comprised of Design Engineering Supervisors), and the Plant Operations Review Committee (PORC). A design change receives independent review by the preparer's supervisor and manager. The 10CFR50.59 safety screening specifically requires a determination to be made whether the Technical Specifications or Operating License are impacted. A detailed safety evaluation is required should the safety screening determine the Technical Specifications or Operating License are impacted.

Some of the training that is provided to Waterford 3 technical staff is the following: Plant Systems Training, Technical Specification Training, Safety Evaluation Training, Station Information Management Systems Training, Final Safety Analysis Report Training, NOECP and Plant Procedures, and Design Change Process Training.

The actions that will be implemented in the future include the following:

1. The TRM will be revised to reflect the actual configuration in the plant as implemented by WA 01143182.
2. The procedure for the addition and deletion of task cards, UNT-007-004, will be revised to require that justification be provided for all tasks cards being generated or removed for equipment covered by the Technical Specifications.

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3. LER-95-006-00 will be reviewed with planners that have the ability to generate or delete tasks cards for equipment covered by the Technical Specifications for lessons learned.
4. LER-95-006-00 will be included in the Engineering Support Personnel (ESP) training for engineering personnel for lessons learned.
5. Drawing 5817-8099 will be revised.

SAFETY SIGNIFICANCE

Backup overcurrent protection is required for containment electrical penetrations by Technical Specification 3.8.4.1. The backup overcurrent protection ensures the containment penetration physical integrity is not impaired in the event of an electrical fault inside containment and the failure of one electrical device to interrupt and isolate the fault.

The two 20 amp primary breakers, HRAEBKR60A-32 and HRAEBKR61B-32, were tested on December 08, 1995 in accordance with Procedure ME-003-315, and the two breakers successfully passed the operability criteria of the procedure. The breakers were tested at 300% of the breaker rating. Although the test for each breaker included only one trip point, the test results indicate that other test points should also be well within the thermal capability of the penetrations.

Thus, since the primary breakers were operable, containment penetrations 141 and 142 would not have been impaired had there been a fault in either of these two circuits during the short time they would have been energized. Thus, containment integrity was maintained.

The health and safety of the public were not compromised.

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SIMILAR EVENTS

A similar event was reported to the NRC on February 25, 1988 in LER 87-026-01. LER 87-026-01 found backup overcurrent protection missing for the circuits for two Chemical and Volume Control (CVC) valves and for a Control Element Drive Mechanism (CEDM) cooling coil water shutoff valve.