



Entergy

Entergy Operations, Inc.
River Bend Station
5485 U. S. Highway 61
P.O. Box 220
St. Francisville, LA 70775
Tel 504 336 6225
Fax 504 635 5068

Rick J. King
Director
Nuclear Safety & Regulatory Affairs

October 10, 1996

U.S. Nuclear Regulatory Commission
Document Control Desk
Mail Stop PI-37
Washington, DC 20555-0001

Subject: Response to Apparent Violations in IR 50-458/96-026
River Bend Station
License No. NPF-47
Docket No. 50-458

File Nos.: G9.5, G15.4.1

RBG-43295
RBF1-96-0359

Ladies and Gentlemen:

Please find attached Entergy Operations, Inc.'s (EOI) response to the apparent violations described in NRC Inspection Report (IR) 96-026. The apparent violations were a result of EOI's identification of missed surveillance testing as required by the River Bend Station (RBS) Technical Specifications (TS).

The surveillance testing performance issues identified in IR 96-026 are receiving a significant level of management focus and oversight. As presented at the September 18, 1996 NRC/RBS Long Term Performance Improvement Plan (LTPIP) meeting, significant and overall improvement has been achieved at RBS. Program reviews conducted in the surveillance testing area indicated some improvements; however, continuing assessments show that additional improvements are necessary to meet EOI expectations.

In May 1996, surveillance program weaknesses were identified during a Quality Assurance Surveillance. These issues were documented in our corrective action program and comprehensive improvement initiatives were underway prior to identification of the subject apparent violations. Some of these initiatives were, in part, an evaluation of program controls, establishment of a new oversight position in system engineering, and plans to benchmark our

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surveillance program with other sites. Although the initiatives identified in May 1996 may not have identified the previous occurrences described in IR 96-026, we believe these initiatives would have prevented recurrence of issues similar to those described in IR 96-026. However, upon identification of the recent performance issues, the action plan was accelerated and additional resources were focused on the surveillance testing program to yield immediate results.

As noted in IR 96-026, on July 19, 1996 during a review of the Division I station service battery performance discharge data, system engineering identified the condition discussed in apparent violation 96026-01. Subsequent to a request for enforcement discretion, the plant was shutdown to perform the required test. While shutdown, additional corrective action review efforts identified the additional apparent violations described in your report.

Following self-identification of the Division I station service battery condition, a Significant Event Response Team (SERT) performed an immediate and thorough program review, including an evaluation of the combination of the identified issues. The team performed a root cause analysis and recommended extensive corrective actions to prevent recurrence. These corrective actions strengthen the previously established action plan and address the scope of plant safety and performance, including improved communication of management expectations, emphasis on accuracy and accountability, and improved training.

Immediate actions included a review of TS surveillance tests with an 18-month or greater frequency requiring performance during cold shutdown conditions. This initial scope was completed prior to plant start-up to identify and resolve potential issues that could impose additional unnecessary plant transients (i.e. shutdown). Additional procedure reviews are ongoing. It was through this initial comprehensive, exhaustive review effort that the additional surveillance testing issues were identified. The surveillance program is continuing to receive focused attention to ensure that the long term actions are effectively resolving the issues. Additional reviews and program enhancements will ensure that the program improvements meet EOI expectations. For each issue, conservative actions were taken to immediately confirm equipment operability. Based on successful test results, these issues had no actual safety significance.

In response to IR 96-026, we have reviewed the identified issues against the criteria provided in NUREG-1600, "General Statement of Policy and Procedures for NRC Enforcement Actions", and believe there is adequate justification for imposition of one severity level IV violation (Refer to Attachment G). This is based on 1) the issues being self-identified, 2) immediate and comprehensive corrective actions, 3) lack of actual safety significance, 4) unwillfullness, 5) RBS management's awareness of the significance of the recent issues, and 6) the significant attention applied to the Surveillance Testing program prior to the identification of the subject apparent violations.

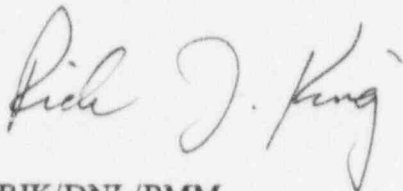
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RBS management understands the significance of the performance issues cited in the IR and have identified the underlying causes and programmatic weaknesses that are responsible for the apparent violations. Our corrective action program has been effective in conjunction with our performance monitoring and critical assessment practices. As demonstrated by our identification of weaknesses in the surveillance program in May 1996, our self-critical culture is capable of identifying and resolving important performance issues.

Response to each specific apparent violation is contained in Attachments A through E. Attachment F contains a summary of the generic corrective actions and Attachment G provides our enforcement perspective and regulatory/safety significance conclusions for these issues.

Should you have any questions regarding the attached information, please contact Mr. David Lorfing of my staff at (504) 381-4157.

Sincerely,



PJK/DNL/RMM
attachments

cc: U. S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011

NRC Sr. Resident Inspector
P. O. Box 1050
St. Francisville, LA 70775

David Wigginton
NRR Project Manager
U. S. Nuclear Regulatory Commission
NRR Mail Stop 13-H-3, One White Flint North
11555 Rockville Pike
Rockville, MD 20852

BEFORE THE
UNITED STATES NUCLEAR REGULATORY COMMISSION

LICENSE NO. NPF-47

DOCKET NO. 50-458

IN THE MATTER OF

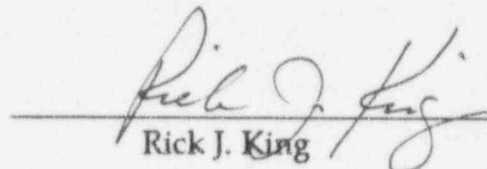
ENTERGY GULF STATES, INC

CAJUN ELECTRIC POWER COOPERATIVE AND

ENTERGY OPERATIONS, INC.

AFFIRMATION

I, Rick J. King, state that I am Director - Nuclear Safety & Regulatory Affairs of Entergy Operations, Inc., at River Bend Station; that on behalf of Entergy Operations, Inc., I am authorized by Entergy Operations, Inc., to sign and file with the Nuclear Regulatory Commission, this response to Inspection Report 50-458/96-026; that I signed this letter as Director - Nuclear Safety & Regulatory Affairs at River Bend Station of Entergy Operations, Inc.; and that the statements made and the matters set forth herein are true and correct to the best of my knowledge, information, and belief.

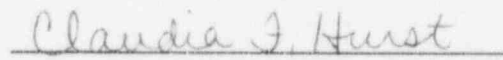


Rick J. King

STATE OF LOUISIANA
PARISH OF WEST FELICIANA

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the Parish and State above named, this 10th day of October, 1996.

(SEAL)



Claudia F. Hurst
Notary Public

My commission expires with life

ATTACHMENT A

REPLY TO NOTICE OF APPARENT VIOLATION 50-458/96026-01

Violation

The inspector reviewed the Condition Report that identified issues with the surveillance test data for the Division I battery. The previous performance of Procedure STP-350-1700 was completed under the requirements of the original Technical Specification, during RFO 5. On May 22, 1994, the original requirement of Technical Specification 4.8.4.8 was that the surveillance periodicity for the performance discharge test be decreased from 60 to 18 months if the capacity decreased at least 10 percent from the average capacity of the previous performance discharge tests. During performance of Procedure STP-350-1700 in RFO 5, the Division I battery capacity was 97 percent, as compared to an average capacity of the previous tests of 110 percent. Therefore, the discharge test should have been performed during RFO 6 because it became overdue on April 7, 1996, when the 18 month plus 25 percent period expired.

The failure to perform a surveillance test within the periodicity specified by TS SR 3.8.4.8 is a failure to comply with the requirements of TS SR 3.0.1 and is an apparent violation (50-458/96026-01).

Reasons for the Violation

Entergy Operations, Inc. (EOI) has determined the root causes for the Division I Station Service Battery missed surveillance to be:

- Surveillance test personnel had less than adequate understanding of the test acceptance criteria.
- An inappropriate change was made in the surveillance test procedure and a review of test results did not detect the error.

On July 10, 1996, RBS discovered that surveillance test procedure (STP) STP-305-1700, "Division I Station Service Battery Performance Discharge Test", was not performed within its Technical Specification (TS) 3.8.4.8 required frequency of 18 months. A battery capacity degradation of greater than 10 percent had been indicated during the last performance in May, 1994. The requirement to increase test frequency to 18 months should have been identified at that time.

Investigation of the event revealed that performing and supervising personnel for STP-305-1700 did not adequately understand the acceptance criteria. The test acceptance criteria was stated in the STP; however, the electrical maintenance supervisors signing the acceptance criteria and accepting the test results were unaware that the battery capacity, as determined by

this test, can exceed 100 percent. The battery capacity determined in the two previous tests was 113 percent (1989) and 108 percent (1984). These results were not used to determine the battery capacity degradation. The acceptance was based on degradation from 100 percent capacity.

During the previous procedure revision, a step requiring the performer to review previous performance tests and include a copy of the previous performance test data was removed. This change, in addition to the misunderstanding of the acceptance test criteria, contributed to the event in that the previous test results were not used to determine the battery capacity degradation.

It was noted in IR 96-026, Section M1.2.c, that the cause was, in part, due to an inadequate post-test review by the system engineer. At the time of the test performance, there was no procedural requirement for the system engineer to perform a post-test review. Because of recent initiatives, additional reviews of completed STPs are now performed.

Safety Significance

A battery performance discharge test was performed on July 17, 1996, confirming that the Division I station service batteries had ample capacity to satisfy design basis requirements and were capable of performing the intended safety functions. As a result, the failure to test the batteries on an increased frequency had no safety significance.

Corrective Steps That Have Been Taken and the Results Achieved

Procedure STP-305-1700 was successfully performed on July 17, 1996. This procedure was also revised to provide a detailed verification of acceptance criteria.

An accountability session was held with personnel involved in the approval of the May, 1994 STP-305-1700 test performance.

As a result of initiatives identified in May, 1996, a new position was added to the System Engineering staff to provide oversight of the surveillance testing program. As a result of this issue, the scope and expectations of this position were enhanced to provide the appropriate level of oversight.

Corrective Steps That Will Be Taken to Avoid Further Violations

A matrix will be developed for surveillance requirements that are subject to frequency changes based, in part, on degradation. These results will be incorporated into the STP performance review process.

The procedure change process will be evaluated for improvements to ensure an adequate basis exists for making procedural changes. In addition, the expectations for procedural adherence and compliance will be reinforced to site personnel.

Additional generic corrective actions are provided in Attachment F of this letter.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on July 17, 1996 when procedure STP-305-1700 was successfully completed. Tests results determined the Division I electrical distribution system had remained operable.

ATTACHMENT B

REPLY TO NOTICE OF APPARENT VIOLATION 50-458/96026-02

Violation

On July 13, during a review of completed surveillance test data, the licensee found that the battery service discharge test, required by Technical Specification Surveillance Requirement 3.8.4.7 for the Division III battery, had been missed. Technical Specification Surveillance Requirement 3.8.4.7 allows taking credit for the battery performance discharge test, specified in Technical Specification Surveillance Requirement 3.8.4.8, to meet the provisions of the battery service discharge test once in a 60-month period. Because the licensee took credit for the performance discharge test to meet Technical Specification Surveillance Requirement 3.8.4.7 during RFO 5, the once per 60-month exception could not be used again during RFO 6, which it was. As a result, the test specified by Technical Specification Surveillance Requirement 3.8.4.7 should have been completed during RFO 6 and it was not.

The failure to perform a surveillance test within the frequency specified by Technical Specification Surveillance Requirement 3.8.4.7 is a failure to comply with the requirements of Technical Specification Surveillance Requirement 3.0.1 and is an apparent violation (50-458/96026-02).

Reasons for the Violation

Entergy Operations, Inc. (EOI) has determined the root causes for the Division III Station Service Battery Missed Surveillance to be:

- Incorrect assumptions made by Surveillance test personnel and their failure to consult Technical Specifications regarding the required battery testing, and
- Insufficient guidance in the STP program administrative procedure about alternate credit for surveillance tests.

On January 9, 1996, STP-203-1702, "Division III Battery Performance Discharge Test", was performed in place of STP-203-1608, "Division III Battery Service Discharge Test". This incorrect substitution resulted from an incorrect assumption made by the departmental test coordinator. The departmental test coordinator responsible for testing the batteries incorrectly assumed that information obtained from Licensing concerning testing the batteries during Refueling Outage 5 (RF-5) was still applicable during RF-6. There was no procedure guidance for crediting alternate surveillances and the coordinator did not verify the assumption.

This test substitution was discussed on several occasions prior to the outage. This included discussions with the system engineer who incorrectly understood that the five year performance discharge test had not been completed in RF-5. Therefore, he thought the five year performance discharge test needed to be performed during RF-6 to meet the two year acceptance test requirement as recommended by IEEE-450. Both the system engineer and test coordinator failed to verify their assumptions and recognize the deviation from the Technical Specification requirement.

Safety Significance

The battery service discharge test was completed satisfactorily by July 18, 1996, demonstrating capability of the Division III station service battery. This confirmed that the Division III battery was capable of performing its intended safety function; therefore, this missed surveillance had no safety significance.

Corrective Steps That Have Been Taken and the Results Achieved

The battery service test, STP-203-1608, was successfully performed on July 18, 1996, which confirmed operability of the Division III station service battery.

An accountability session was held with personnel involved with the substitution of STP-203-1608 with STP-203-1702.

Corrective Steps That Will Be Taken to Avoid Further Violations

Procedure ADM-0015, "Station Surveillance Testing Program", will be revised to add direction for alternate credit for STP surveillances.

Additional generic corrective actions are provided in Attachment F of this letter.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on July 18, 1996 when procedure STP-203-1608 was successfully completed. Tests results determined that the Division III electrical distribution system had remained operable.

ATTACHMENT C

REPLY TO NOTICE OF APPARENT VIOLATION 50-458/96026-03 and 96026-04

Violations

96026-03

On July 13, during a review of completed surveillance test procedures, the licensee identified that Procedure STP-057-7204 was inadequately performed. Technical Specification surveillance requirement 3.6.5.2.5 requires, every 18 months, that the licensee verify, from an initial pressure of 75 psig, that the drywell airlock seal pneumatic system pressure does not decay at a rate equivalent to greater than 0.65 psig for a period of 24 hours.

The failure to perform a surveillance test within the frequency specified by Technical Specification 3.6.5.2.5 is a failure to comply with the requirements of Technical Specification surveillance requirement 3.0.1 and is an apparent violation (50-458/96026-03).

96026-04

On July 13, the licensee identified that Surveillance Test Procedure STP-057-7205 was inadequately performed. Technical Specification surveillance requirement 3.6.5.1.2 requires, every 18 months, that the licensee verify, from an initial pressure of 75 psig, that the drywell combination equipment hatch/personnel door seal pneumatic system pressure does not decay at a rate equivalent to greater than 0.67 psig for a period of 24 hours.

The failure to perform a surveillance test within the frequency specified by TS SR 3.6.5.1.2 is a failure to comply with the requirements of Technical Specification surveillance requirement 3.0.1 and is an apparent violation (50-458/96026-04).

Reasons for the Violation

Entergy Operations, Inc. (EOI) has determined the root causes for the Drywell Airlock Leak Rate Test issues to be:

- Test personnel did not clearly understand the acceptance criteria of the procedure.
- Procedures were unclear on technical details.
- Pre-job briefing and training was not provided when the tasks had changed significantly in the revised procedures.
- Review of surveillance test results did not detect the errors.

On July 13, 1996, during a review of surveillance procedures, it was identified that local leak rate tests performed in February 1996, for STP-057-7204, "Drywell Personnel Airlock Door Seal Air System", and STP-057-7205, "Drywell Equipment Hatch/Personnel Door Seal Pneumatic System test", should have been performed for a 24-hour period but instead were terminated after eight hours. Procedural requirements allow the tests to be terminated at the eight-hour period if the leak rate has stabilized and is below the TS value. In both cases the as-left eight-hour pressure drop test met the Technical Specification requirement; however, the leak rates indicated a slight increase between the four and eight hour periods.

Subsequent reviews of the two procedures revealed that the requirement to proceed with the test for 24 hours was included in the procedure and was similar to the methodology of the containment airlocks seal air system drop test; however, the STP data sheet did not contain the new calculation for the rate of change of leakage subsequent to the four and eight hour readings.

In IR 96-026, Sections M1.4.b and M1.5.b, the report noted that the mechanics had never before performed the procedure. To clarify, this was the first time this particular revision of the procedure had been performed; however, the mechanics involved with the test had performed previous revisions and were considered to be experienced in this area.

In IR 96-026, Section M1.4.b, the report noted instances where the inner airlock door inflatable seal was replaced "to reduce leakage". This inflatable seal did not leak but was removed and replaced due to the discovery of a surface blister found while troubleshooting the leaking fittings.

Safety Significance

96026-03

On July 20, 1996, the tests were successfully completed for each of the four seal air systems on the drywell airlock. A review of as-left data taken during RF-6 for the drywell airlock concluded that three of the four seals had remained operable. The design basis of the drywell airlock minimum seal air pressure is to prevent drywell bypass leakage created during a design basis accident (DBA) or a high energy line break (HELB) inside the drywell, from increasing containment temperature/pressure above its design values. Furthermore, the drywell airlock is required to provide leak-tight performance for 30 days following an initiating event. One inflatable seal, pressurized to at least the calculated minimum allowed pressure, is required to maintain acceptable leakage during a DBA or HELB. The other three redundant seals provide personnel access functional capability and allow performance of airlock door integrity testing. Since three drywell airlock door seals remained operable after RF-6, the Drywell Airlock remained capable of performing its intended safety function, despite the failure to perform the STP properly. As a result, this event was of little safety significance.

On July 19, 1996, an as-found performance of STP-057-7205 "Drywell Combination Equipment Hatch/Personnel Door Seal Pneumatic System 18 Month Leak Rate Test", was successfully completed on both seal air systems. This confirmed that the previous incomplete as-left performance of the STP-057-7205 in February, 1996 did not have any safety impact.

Corrective Steps That Have Been Taken and the Results Achieved

Procedures STP-057-7204 and 7205 were successfully performed on July 20 and 19, 1996, respectively.

An evaluation of the training methodology was performed to ensure success during performance of procedures such as STP-057-7204 and 07205. The evaluation concluded that the methodology is patterned after INPO 85-006, "Principles of Training System Development", and meets the requirements of 10CFR50.120, "Training and Qualification of Nuclear Power Plant Personnel". This methodology is currently utilized for I&C technician training/qualification to perform STPs. However, Mechanical Maintenance does not currently participate in this specific training program. Instead, an overview of STPs are presented during fundamentals training.

Accountability sessions were held with responsible individuals to discuss this issue, including expectations for proper review and approval of test results, procedure verifications, pre-job briefings, and training for surveillances being performed for the first time after a change in test methodology.

Corrective Steps That Will Be Taken to Avoid Further Violations

An evaluation will be performed of the drywell airlock and equipment hatch test criteria. This evaluation should provide an improved method for performing the tests, specifically providing guidance for collecting trend data. The procedures will be revised accordingly.

STP training methodology currently used for I&C maintenance will be implemented as part of the qualification for Mechanical Maintenance, which does not currently have a separate qualification area for performing STPs.

Additional generic corrective actions are provided in Attachment F of this letter.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on July 20, 1996, when procedures STP-057-7205 and 7204 were successfully completed.

ATTACHMENT D

REPLY TO NOTICE OF APPARENT VIOLATION 50-458/96026-05

Violation

On July 15, during a review of completed surveillance test procedures, the licensee identified that the prefilters in the Standby Gas Treatment, Control Room Fresh Air, and Fuel Building Ventilation systems had not been pressure drop tested, as required by Technical Specification 5.5.7.d. The requirement to test the prefilters was not identified by the licensee when the Improved Standard TS were implemented.

The failure to perform a surveillance test within the frequency specified by TS 5.5.7.d is a failure to comply with the requirements of TS SR 3.0.1 and is an apparent violation (50-458/96026-05).

Reasons for the Violation

Entergy Operations, Inc. (EOI) has determined the root causes for not including prefilters in the HVAC testing to be:

- Reviewers of the Technical Specification (TS) amendment submittal package failed to identify the wording change in NUREG 1434 during development of the Improved Technical Specification (ITS).
- Reviewers of the NRC approved license amendment failed to identify the unintended wording change.
- Revised procedures did not properly incorporate the TS change.

During a surveillance test review, it was identified that the STPs for testing the Standby Gas Treatment System (SGTS), Fuel Building Ventilation System (FBVS), and Control Room Fresh Air System (CRFAS) did not meet the requirement of TS Section 5.5.7.d. The TS states, "Demonstrate for each of the ESF systems that the pressure drop across the combined HEPA filters, the prefilters, and the charcoal adsorbers is less than the value specified below when tested in accordance with Regulatory Guide 1.52, Revision 2 and ANSI N510-1989 at the system flow rate specified below $\pm 10\%$ ". This wording was established during development of Improved Technical Specifications (ITS) and NUREG-1434, "Standard Technical Specifications - General Electric Plants, BWR/6". Neither the ITS submittal nor the NRC's Safety Evaluation Report (SER) identified such testing as being a new or more restrictive requirement. Discussion with the individuals involved with the ITS development, both at RBS and other BWR-6's, confirmed this position. Upon further investigation, it was discovered that neither Regulatory Guide 1.52 "Design, Testing, and Maintenance Criteria for

Engineered-Safety-Feature Atmosphere Cleanup System Air Filtration and Adsorption Units of Light-Water-Cooled Nuclear Power Plants", nor ANSI N510-1989, "Testing of Nuclear Air Cleaning Systems", require prefilter pressure drop testing.

Investigation revealed that review personnel failed to notice the NUREG-1434 wording had differed from the previous TS surveillance requirement wording. This wording difference was not detected during the review of the NRC approved license amendment.

The prefilter pressure drop measurement requirement remained in ITS and was later incorporated into the "Purpose" section of two of the three applicable surveillance procedures. However, since it was not recognized that the ITS wording constituted a change of intent, the appropriate revisions to the performance and acceptance criteria sections did not occur. As a result, the applicable pre-filter tests were not performed.

Safety Significance

There were no safety implications associated with not including the prefilters in the pressure drop calculations. The prefilters were inadvertently added to the discussion in TS Section 5.5.7.d during development of NUREG-1434 and ITS. There is no technical basis that requires including the prefilters in the pressure drop calculation which was added by the NRC during the ITS process. It was neither an original testing requirement nor part of Regulatory Guide 1.52, Revision 2, or ANSI N510-1989. The latest testing, performed on July 17, 1996, conducted with the prefilter pressure drop added to the overall pressure drop of the filter train met the Technical Specifications acceptance criteria. The satisfactory test performance demonstrated that the filter trains were capable of performing their intended safety functions.

Corrective Steps That Have Been Taken and the Results Achieved

STP-406-0601, STP-403-0601, and STP-402-4501 were completed by July 17, 1996, confirming equipment operability. These procedures were revised to incorporate the required pre-filter testing prior to test performance.

Corrective Steps That Will Be Taken to Avoid Further Violations

Accountability sessions are being held with the applicable procedure writers performing procedure validation and verification to emphasize the completeness of procedure implementation and attention to detail. These sessions are expected to be completed by October 31, 1996.

Additional generic corrective actions are provided in Attachment F of this letter.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on July 17, 1996, when procedures STP-406-0601, STP-403-0601, and STP-402-4501 were successfully completed. Test results determined the filter trains had remained operable.

ATTACHMENT E

REPLY TO NOTICE OF APPARENT VIOLATION 50-458/96026-06

Violation

During a licensee review, it was identified that leak rate test history for Valve SWP-MOV503A was mistakenly designated as as-found [sic] valve leakage from RFO 5 instead of as-left [sic] leakage. The licensee performed corrective maintenance on Valve SWP-MOV503A to correct known seat leakage without performing as-found testing. Following the maintenance, the licensee satisfactorily leak rate tested valve. Based on the satisfactory test results from RFO 4 coupled with the belief that as-found local leak rate testing for Valve SWP-MOV503A was also satisfactory, the licensee determined that Valve SWP-MOV503A had two consecutive satisfactory leak rate tests. The licensee changed the frequency for the local leak rate test of Valve SWP-MOV503A to 5 years, when the frequency should have remained at 2 years.

The failure to perform a surveillance test within the frequency specified by TS SR 3.6.1.1.1 is a failure to comply with the requirements of TS SR 3.0.1 and is an apparent violation (50-458/96026-06).

Reasons for the Violation

Entergy Operations, Inc. (EOI) has determined the root causes for the inappropriately deferred LLRT valve test to be:

- Incorrect data entry in the surveillance test procedure, and
- Surveillance test result reviews did not detect errors.

While reviewing procedure STP-256-3828, "Service Water Return Valve Leak Rate Test", for valve SWP-MOV503A, it was identified that during the last performance of the test during RF-5, the as-left valve leakage was incorrectly entered into the procedure data sheet as as-found leakage. The investigation revealed that the incorrectly designated as-found leakage was recorded after valve maintenance and that the actual as-found leakage exceeded the performance acceptance criteria. Procedure ADM-0015 provides guidance to change the frequency of this leak test to five years after successful completion of two consecutive tests. Based on the incorrect data entry during RF-5 and successful test results during RF-4, the test frequency was changed to five years.

Safety Significance

The leak rate test was successfully performed on July 16, 1996, demonstrating that the valve remained operable and capable of performing its intended safety function. As a result, this issue was of no safety significance.

Corrective Steps That Have Been Taken and the Results Achieved

An accountability session was conducted with LLRT program personnel to emphasize expectations for accurate data entry, and complete and accurate technical reviews.

Corrective Steps That Will Be Taken to Avoid Further Violations

Data sheets will be developed to record the complete history of "as-found" and "as-left" leak rate test results for valves in the LLRT program.

Additional generic corrective actions are provided in Attachment F of this letter.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on July 16, 1996, when procedure STP-256-3828 was successfully completed. Test results confirmed the valve had remained operable.

ATTACHMENT F
REPLY TO NOTICE OF APPARENT VIOLATIONS 50-458/96026

GENERIC CORRECTIVE ACTIONS

Immediate actions included a review of TS surveillance tests with an 18 month or greater frequency requiring cold shutdown. It was through this comprehensive, exhaustive review effort that the additional surveillance testing issues were uncovered. For each issue, conservative actions were taken to immediately confirm equipment operability. Based on successful test results, these issues were of no safety significance.

Additional actions were implemented to prevent recurrence of similar performance problems. These corrective actions, in part, are:

1. Perform a sample review of surveillance procedures which meet the following criteria. This review is expected to be completed by January 15, 1997, and includes:
 - a) Surveillance procedures with test frequency greater than quarterly,
 - b) Surveillances not included in the previous review, and
 - c) Surveillances scheduled to be performed during Modes 1, 2, or 3.
2. QA will perform a follow-up assessment of the surveillance program actions associated with this condition report to ensure appropriate implementation. This assessment is expected to be completed by March 15, 1997.
3. Validate the TS-STP cross reference matrix. This effort is expected to be completed by March 15, 1997.
4. Develop appropriate TS and TS bases training to enhance knowledge of supervisors and key technical personnel. This will include Operations, Maintenance, Outage Management, and Engineering Support personnel. This program is expected to be completed by March 15, 1997.

5. Departmental "All Hands" meetings are being conducted to communicate and encourage the following. These meetings are underway and are expected to be completed by October 30, 1996.
 - a) Importance of Ownership/Quality,
 - b) Importance of step-by-step performance of surveillance procedures,
 - c) Implications of surveillance errors,
 - d) Questioning Attitude, and
 - e) Assurance that appropriate technical inputs are utilized in decision making process.

Additional program initiatives are also being implemented. These actions are being presented as enhancements and are not considered commitments.

The following actions, in part, were developed as a result of program weaknesses identified as a result of a May 1996 QA surveillance.

1. A new position was established in system engineering and filled on August 21, 1996. This position will provide oversight of the surveillance testing program in the following areas:
 - a) Development of new procedures,
 - b) Maintenance of STP/TS cross-reference matrix,
 - c) Review of license basis changes to ensure continued surveillance compliance, and
 - d) STP performance, test exceptions and frequency tolerance evaluations.
2. Enhance current program by benchmarking and comparison of the RBS program with other sites, evaluate procedure format, and establish departmental leads.
3. Evaluate current staffing levels to ensure that the necessary resources are available to implement and maintain effective program oversight.
4. A Surveillance Program Self-Assessment will be performed to provide additional insight to areas that can be improved.
5. A survey of industry Best Practices will be performed for further enhancement of our improvement initiatives.

The following program initiatives, in part, were added as a result of our recent investigations. They are:

1. Conduct an effectiveness review of a sampling of safety evaluation screenings for surveillance procedures.
2. The adequacy of the current qualification/training matrix for STP performance was evaluated. As a result, general classroom training and on-the-job-training is being developed. The maintenance training qualification matrices will reflect these changes when developed.
3. Evaluate the effectiveness of procedure verification and validation.
4. Supervisor training workshops on "site policy" for applying disciplinary actions related to procedural compliance issues has been completed.
5. Focus additional management observations on the performance of surveillance tests. Observing management should be knowledgeable of the system and its related TS. The observations should include the adequacy of the pre-job briefing, personnel knowledge of the test, test performance, and the documentation and review process.

ATTACHMENT G
REPLY TO NOTICE OF APPARENT VIOLATIONS 50-458/96026

REGULATORY ENFORCEMENT PERSPECTIVE

In response to your report, we have reviewed the identified issues against the criteria provided in NUREG-1600, "General Statement of Policy and Procedures for NRC Enforcement Actions", and believe that there is adequate justification for imposition of a severity level IV violation. This is based on 1) the issues being self-identified, 2) immediate and comprehensive corrective actions, 3) lack of actual safety significance, 4) unwillfulness, 5) RBS management's awareness of the significance of the recent issues, and 6) the significant attention applied to the Surveillance Testing program.

Self-Identification

On July 19, 1996, during a battery life extension initiative for the Division I station service battery, system engineering reviewed battery performance documentation and identified the condition discussed in apparent violation 96026-01. Because of acceptable battery performance this condition was not self-revealing and considered to be self-identified. Additional corrective action review efforts resulting from the initial concern, identified the additional apparent violations described in your report.

Immediate and Comprehensive Corrective Actions

Upon self-identification that the surveillance test for the Division I battery was not performed when required, immediate and aggressive actions were implemented to ensure continued safe operation of RBS. Subsequent to a request for enforcement discretion which was submitted within 24 hours of condition identification, the plant was shutdown to perform the required surveillance test (the enforcement discretion was denied based on the condition being avoidable and insufficient data to justify continued operation). In addition, a Significant Event Response Team (SERT) was immediately formed to perform an immediate and thorough program review, including an evaluation of the combination of identified issues. Immediate corrective actions were completed prior to plant start-up. The review scope included TS surveillance tests with an 18 month or greater frequency requiring cold shutdown. It was through this review, which consisted of several thousand man-hours of review effort, that the additional surveillance testing issues were uncovered. For each issue, conservative actions were taken to immediately confirm equipment operability.

In addition to the immediate focus, the team performed a root cause analysis and developed extensive corrective actions to strengthen the previously established action plan. Refer to Attachment F for details of these initiatives. The enhanced plan addresses the entire scope of plant safety and performance from improved communication of management expectations, added resources, emphasis on accuracy

and accountability, and improved training. These actions are discussed in detail for each of the apparent violations and in Attachments A through E.

Lack of Actual Safety Significance

As reported in Licensee Event Report (LER) 96-014-00, dated August 9, 1996, and discussed in the preceding attachments, each of the missed or deficient surveillance tests were re-performed with successful results confirming that the associated equipment had remained operable and capable of fulfilling the intended safety function. Based on successful test results, these issues had no actual safety significance.

Unwillfulness

An extensive root cause evaluation did not identify any evidence indicating the issues were a result of any willful actions.

No Severity Level III Violations Issued Within the Last Two Years

No severity level III regulatory violations have been issued to RBS over the past two years.

RBS Management's Awareness of the Significance of the Recent Issues

RBS management understands the significance of the performance issues cited in IR 96-026 and are highly aware of the underlying causes and weaknesses that are responsible for the apparent violations. As you noted in your report, RBS management took immediate and comprehensive actions to address a self-identified performance issue.

Prior to the identification of the apparent violations discussed in IR 96-026, surveillance area weaknesses had been identified by a Quality Assurance Surveillance. These issues were documented in our corrective action program and improvement initiatives were underway. Although the identified actions may not have identified the previous occurrences described in IR 96-026, we believe these improvements would have prevented recurrence of similar issues. Upon identification of the recent performance issues, the action plan was accelerated and additional resources were focused on the surveillance testing program to yield immediate results.

Summary

The NUREG guidance states that the purpose of aggregating violations to a higher severity level is to focus the licensee's attention on fundamental underlying causes. In addition, a severity level III violation implies cause for "significant regulatory concern". As noted in the NRC's report, RBS management took immediate and comprehensive actions to address a self-identified performance issue. Additional instances were identified through exhaustive research consisting of several thousand man-hours of review. RBS management has played an integral part in the root cause determination and the development of the corrective action plan to ensure that the underlying causes were appropriately identified and that the action plan was complete and properly focused. We believe our corrective action program is effective and that in conjunction with our performance monitoring and self critical assessment practices, our surveillance testing program will achieve the expected results. As demonstrated by our identification of the performance issues in May 1996, our self-critical culture is capable of identifying and resolving important performance issues.

For the reasons provide above, we propose that the issues cited in IR 96-026 meet the NUREG-1600 criteria as a severity level IV violation with six examples. However, if your review determines that a severity level III violation is warranted, we believe that there is adequate justification to nullify any associated civil penalty. Per NUREG-1600 guidance, the civil penalty should be suppressed because 1) this was not a willful violation, 2) RBS has received no severity level III violations within the past two years, and 3) credit should be given for self-identification and immediate and comprehensive corrective actions that were taken.

Our corrective actions indicate that the appropriate focus has been applied and that the actions we are taking will effectively address the underlying causes. Based on the safety significance of the identified issues and our immediate, focused attention to resolve the problems, we believe there is no necessity to aggregate the identified issues into a severity level III violation.