UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

December 26, 1996

EA 96-255

Michael B. Sellman, Vice President
Operations - Waterford
Entergy Operations, Inc.
P.O. Box B
Killona, Louisiana 70066

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - $50,000
(NRC Inspection Report Nos. 50-382/96-09 and /96-20)

Dear Mr. Sellman:

This refers to the predecisional enforcement conference conducted on November 20, 1996, with you and members of your staff in the NRC Region IV office in Arlington, Texas. The conference was held to discuss the circumstances surrounding three apparent violations discussed in the subject inspection reports. These apparent violations were identified to your staff during a telephonic exit meeting on October 9, 1996. The inspection reports were issued on July 24, 1996 (96-09) and October 24, 1996 (96-20).

Based on the information developed during the inspection and the information that you provided at the conference, the NRC has determined that violations of NRC requirements occurred. These violations are cited in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) and the circumstances surrounding them were described in detail in the subject inspection reports.

Violation I in the attached Notice involves the actual design configuration of the containment vacuum relief (CVR) system being different from that described in the Waterford 3 Final Safety Analysis Report (FSAR). The required written safety evaluation to substantiate that the change did not involve an unreviewed safety question was never performed. Specifically, the CVR instrument lines did not terminate at a location within the controlled ventilation area system (CVAS) (or within any other filtration system) as described in the response to FSAR Question 480.36. As a result of the erroneous information, valves CVR 302A(B) and 402A(B) were inadequately tested to ensure they fulfilled the containment isolation function in accordance with General Design Criterion 56.

When appropriately tested in July 1996, valves CVR 302A(B) and CVR 402A(B) failed to close. Thus, containment isolation would not have been adequate in the event of a design basis event. Due to its design, the failure of CVR 402A(B) had the potential to result in both control room dose limits and offsite dose limits being exceeded during a design basis loss-of-coolant

accident. Therefore, this violation is classified in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600, as a Severity Level III violation.

Violation II.A in the Notice, involves a failure to promptly evaluate and correct known discrepancies in the IST program. The circumstances surrounding this violation involved known discrepancies between an Inservice Testing (IST) Design Basis Document (DBD-024), issued in March 1994, and the IST plan in existence at the time. In May 1994, Entergy formed an IST Plan Task Force to resolve these discrepancies and to determine if the IST plan met all ASME Code requirements. In November 1994, the task force issued its final report stating that the addition of the 39 valves to the IST plan would be "enhancements" and that the company was in compliance with applicable requirements without the addition of these 39 additional valves. This determination was incorrect and the valves were not added to the IST plan. It was not until about December 1995, that this condition adverse to quality was identified, when Waterford 3 personnel began identifying that these valves should be included in the IST program and began developing a schedule for reviewing the discrepancies.

At the pre-decisional enforcement conference, Entergy personnel stated that the root causes for this violation involved: (1) the inappropriate assigning of responsibility for the IST program to the shift technical advisors (STA), (2) the perception that management was not receptive to additional testing, (3) inadequate and ineffective corrective action tracking, (4) inadequate coordination between the IST bases document and the IST plan, (5) inadequate guidance concerning how long DBD open items may remain open, and (6) the failure to enter in the corrective action program the subsequent items identified in an earlier review. At the conference, your staff stated that there was no safety significance associated with the identified plan discrepancies, and that the violation should be classified at Severity Level IV. We agree that, except for the CVR 402A(B) valves discussed in Violation I, the consequences of this violation, with the valves in their as-found condition, would have been minimal. However, these IST issues involve known discrepancies in the IST program that were not addressed in a timely manner and, as a result, a large number of valves were not being tested to assure they would perform their safety function. Therefore, this violation has been categorized in accordance with the Enforcement Policy at Severity Level III.

In accordance with the Enforcement Policy, a civil penalty of $50,000 is considered for a Severity Level III violation. Because your facility has been the subject of escalated enforcement actions within the last 2 years[1], the NRC considered whether credit was warranted for *Identification* and *Corrective*

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[1] EA 96-025 issued on March 25, 1996, involved a $50,000 civil penalty for a failure to implement effective actions to preclude repetition of a significant condition adverse to quality.

Action in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. In reviewing the *Identification* factor for Violation I, NRC noted an important missed opportunity to earlier identification of the violation. This occurred during the review of Condition Report CR-96-0272, initiated March 1, 1996, involving the operability of certain valves, including CVR-302A(B). Also, during several discussions with NRC inspectors through July 20, your staff continued to depend on the erroneous information in the FSAR and stated the intent to remove the valves from the inservice test (IST) program. Although we recognize that your staff ultimately identified the FSAR discrepancy associated with the CVR 302A(B) and 402A(B) valves, NRC has determined that it was unlikely that your staff would have identified this violation absent NRC's involvement. Therefore, the NRC has determined that credit for the *Identification* factor is not warranted for Violation I. As to Violation II, the NRC has determined that credit for the *Identification* factor is warranted because Entergy identified the problem.

In evaluating the *Corrective Action* factor, the NRC has determined that credit is warranted for both Violation I and II because the corrective actions to these violations were sufficiently prompt and comprehensive. Corrective actions for Violation I included: (1) promptly replacing and retesting failed valves, (2) performing a root cause analysis, (3) isolating and administratively controlling the non-essential lines until a plant modification and license amendment could be implemented, (4) promptly submitting a license amendment request, (5) reviewing other containment penetrations for similar problems, and (6) implementing a FSAR fidelity assessment. The corrective action for Violation II included: (1) developing a schedule to resolve the discrepancies between the IST plan and the DBD, (2) testing the valves which had not been previously tested or which had been inadequately tested, (3) controlling changes to the IST plan with the DBD by procedure, and (4) comprehensively reviewing the ASME valves and current IST plan to facilitate development of a second 120-month interval plan.

At the predecisional enforcement conference, your staff asserted that the NRC should exercise discretion for Violation I because it was an old design issue. After careful consideration, we have determined that, because of the NRC's involvement in the identification of the violation, this problem was not identified by a voluntary initiative on Entergy's part (Entergy was moving to remove the CVR 302A(B) valves from the IST program until NRC's questioning, and most likely would not have identified the same problem with CVR 402A(B)). As such, the exercise of discretion is not warranted in this case.

Therefore, to emphasize the importance of ensuring that the plant is operated in accordance with its FSAR and the importance of prompt identification of non-conforming conditions, I have been authorized, after consultation with the Director, Office of Enforcement, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the base amount of $50,000 for the Severity Level III violation discussed in Section I of the Notice. In addition to encourage your efforts to identify and correct problems and noncompliances, I have also been authorized to issue a Severity Level III violation without a civil penalty, for the Severity Level III violation

described in Section II.A of the Notice. However, significant violations of this nature could, in the future, result in a civil penalty.

The third violation, discussed in Section II.B of the Notice, involved a failure to fully close a containment spray valve. Entergy personnel identified this condition in November 1995, promptly corrected it, and performed an operability determination of the Containment Spray System. During discussions concerning IST issues in March 1996, design engineering personnel realized that the earlier operability evaluation did not consider backleakage to the refueling water storage pool. This realization demonstrated a good questioning attitude by plant staff. Using very conservative calculations, Entergy postulated the consequences of the condition to be that Control Room thyroid dose limits would be exceeded. However, a more realistic analysis, including a review of the plant's routine monitoring program, showed that Control Room thyroid dose problems would have been identified before dose limits would have been exceeded. Given the circumstances of the violation, the NRC determined that this violation is appropriately classified at Severity Level IV.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

Sincerely,

L. J. Callan
Regional Administrator

Docket No. 50-382
License No. NPF-38

Enclosure: Notice of Violation and
Proposed Imposition of Civil Penalty

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