



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV

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ARLINGTON, TEXAS 76011-8064

JAN 24 1997

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

SUBJECT: NRC INSPECTION REPORT 50-382/96-13

Thank you for your letter of January 21, 1997, in response to our letter and Notice of Violation dated December 19, 1996. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

A handwritten signature in cursive script, appearing to read "J. E. Dyer", is written above the typed name.

J. E. Dyer, Director
Division of Reactor Projects

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

cc:
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-3-

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JAN 24 1997

bcc to DMB (IE01)

bcc distrib. by RIV:

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Resident Inspector
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MIS System
RIV File
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GAPick;cm		PHHarrell		JEDyer				
01/24/97		01/24/97		01/24/97				

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JAN 24 1997

bcc to DMB (IE01)

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GAPick;cm	PHHarren	JEDyer					
01/24/97	01/24/97	01/24/97					

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**Entergy
Operations**

Entergy Operations, Inc.

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TS 100-100-6730

W3F1-97-0002

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PR

January 21, 1997

JAN 22

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-38
NRC Inspection Report 50-382/96-13
Reply to Notice of Violation

Gentlemen:

In accordance with 10CFR2.201, Entergy Operations, Inc. hereby submits in Attachment 1 the response to the violations identified in Enclosure 1 of the subject Inspection Report.

Waterford 3 acknowledges the three concerns expressed in the cover letter to the inspection report: (1) operators failed to follow procedures regarding configuration control, (2) operators failed to recognize that the wet cooling tower fans were rendered inoperable during a maintenance activity and failed to enter appropriate Technical Specification (TS) Limiting Conditions for Operation, and (3) review of the Inservice Test (IST) program did not identify the need to perform testing on the dry cooling tower isolation valves which are required to be repositioned during the design basis tornado event.

Regarding the first concern, Waterford 3 has previously identified an increasing trend in the number of human performance violations. Our comprehensive corrective actions to address that trend are detailed in Letter W3F1-96-0213 dated 12/13/96. We believe those corrective actions, in concert with the actions detailed in Attachment 1, will help prevent similar violations from recurring and will improve operator attentiveness.

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Reply to Notice of Violation (IR 96-13)

W3F1-97-0002

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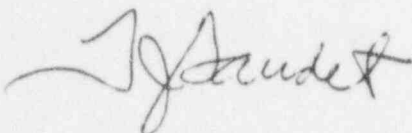
January 21, 1997

In addition to the corrective actions detailed in Attachment 1 for the second concern, we are continuing to implement corrective actions from the FOCUS plan (reference Letter W3F1-96-0130 dated 8/19/96) to improve our performance in the area of TS implementation. These actions include enhancing the procedure process, utilizing assessments as a tool to identify additional improvement opportunities, improving operator awareness of plant conditions prior to approving maintenance activities, and establishing specific guidance concerning the control of work and pre-job briefings to ensure proper Operations oversight. Furthermore, Waterford 3 management has placed significant focus on assuring that the culture and policy for implementing Technical Specifications are conservative from a safety standpoint and comply with regulatory requirements.

Regarding the third concern, the dry cooling tower isolation valves will be added to the IST plan. Furthermore, we are developing a document that details the design basis tornado event. This document should increase the probability that similar conditions, if they exist, are identified and corrected.

Should you have any questions concerning this response, please contact me at (504) 739-6666 or Jeff Thomas at (504) 739-6531.

Very truly yours,



T.J. Gaudet
Acting Director,
Nuclear Safety & Regulatory Affairs

TJG/GCS/tjs
Attachment

cc: E.W. Merschoff (NRC Region IV)
C.P. Patel (NRC-NRR)
R.B. McGehee
N.S. Reynolds
NRC Resident Inspectors Office

ATTACHMENT 1

ENTERGY OPERATIONS, INC. RESPONSE TO THE VIOLATION IDENTIFIED IN
ENCLOSURE 1 OF INSPECTION REPORT 96-13

VIOLATION NO. 9613-01

Technical Specification 6.8.1.a requires, in part, that written procedures shall be implemented covering applicable procedures recommended in Appendix A of Regulatory guide 1.33, Revision 2, February 1978. Appendix A, Section 3, requires that the licensee have procedures for operation of safety related systems.

1. Procedure OP-002-010, "Reactor Auxiliary Building HVAC and Containment Purge," Revision 11, Section 6.6, required that the airborne radioactivity removal system be secured when stopping containment purge.

Contrary to the above, on October 1, 1996, the licensee failed to secure the airborne radioactivity removal system after stopping containment purge. The airborne radioactivity removal system was not secured until observed in the abnormal configuration on October 20, 1996, a period of 19 days.

2. Procedure OP-002-003, "System Operating Procedure - Component Cooling Water System," Revision 10, Section 6.0, "Normal Operations," required that dry cooling tower fan control switches be in the AUTO position.

Contrary to the above, on October 19, 1996, at 3:37 a.m., operators inadvertently placed the Dry Cooling Tower Fan 13-B control switch in the OFF position. The switch remained in the OFF position until observed in the abnormal configuration at 4:40 p.m. on October 20, a period of 36 hours.

3. Procedure OP-903-121, "Safety Systems Quarterly IST Valves Tests," Revision 1, Section 7.2, "Safety Injection Train B," requires that Valve SI139B be closed following inservice testing.

Contrary to the above, on November 19, 1996, at 1:42 a.m., operators failed to close Valve SI-139B following inservice testing. Valve SI-139B was not closed until operators observed the abnormal configuration at 4 p.m. on November 21, 1996, a period of 62 hours.

This is a Severity Level IV violation (Supplement 1). (50-382/9613-01)

RESPONSE

(1) Reason for the Violation

This violation was due to personnel error and inattention to detail in that operators involved with each of the occurrences failed to follow procedures and failed to closely monitor activities that were taking place on the control board. The operators are required to be cognizant of activities on all the control panels and the attention given to the control panels with the incorrect configurations was not adequate. The operations shift turnover on the plant configuration was inadequate in that configuration errors existed over several shifts and were never discussed or identified by the oncoming shifts until 19 days for example 1, 36 hours for example 2 and 62 hours for example 3 of the violation. In addition, Operations supervisory personnel (Control Room Supervisor [CRS] and Shift Superintendent [SS]) did not provide adequate oversight of the activities taking place on the control panels.

Contributing to the failure to follow procedure OP-002-010, "Reactor Auxiliary Building HVAC and Containment Purge," to secure the airborne radioactivity removal system was an inadequate place keeping method in procedure OP-002-010. This procedure does not have sign-offs for each action step delineated. Consequently, steps in the procedure, such as those securing the airborne radioactivity system, may be overlooked due to a sign-off not being required. In addition, Operations supervisory personnel (Control Room Supervisor [CRS] and Shift Superintendent [SS]) did not provide adequate oversight of the activities taking place on the control panels.

Contributing to the failure to follow procedure OP-002-003, "System Operating Procedure- Component Cooling Water System," which requires the Dry Cooling Tower Fan 13-B control switch to be in Auto position was that there is no difference in light indication on the DCT fan control switch when the switch is in auto position compared with the off position. The operators rely on the position of the control knob pointer to determine the position of the control switch. In addition, Operations supervisory personnel did not provide adequate oversight of the activities taking place on the control panels.

Contributing to the failure to follow Section 7.2, "Safety Injection Train B," of procedure OP-903-121, "Safety Systems Quarterly IST Valves Tests," was that the operators, who should have closed valve SI-139 from the control board, were involved with another activity which distracted their attention and caused them to overlook the position of valve SI-139. Even though distractions are a cue to self checking, proper self checking was not done. In addition, Operations supervisory personnel did not provide the proper work environment to minimize these distractions.

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

1. Condition reports 96-1639, 96-1640 and 96-1847 were generated for each one of the self-identified occurrences.
2. All the components were placed in their correct configuration.
3. All the operators involved with the failure to restore the plant to its correct configuration have been counseled.
4. Operations Manager reinforced the operators requirement to perform thorough control board walkdowns.
5. All control room operators are required to sign a new addendum sheet to the shift log indicating completion of control board panel walkdowns.

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

1. The Operations Manager will issue a letter to all Shift Superintendent and Control Room Supervisors which will emphasize the importance of properly prioritizing tasks to avoid excessive operator work load.
2. The Operations Manager will clarify to operations supervisory personnel the expectation that licensed operators have responsibility for monitoring plant controls. The supervisory personnel will convey these expectations to the operations staff.
3. The Operations department will form a team to review and improve, if appropriate, the current method used for shift turnover. A review of the inadequacy of reviewing shift logs will also be performed.
4. A review will be performed on normal operating procedures to determine if the method for place keeping in procedures can be improved.

(4) Date When Full Compliance Will Be Achieved

Waterford 3 is in full compliance. Items 1, 2, and 3 will be completed by 2/28/97 and Item 4 will be completed by 7/1/97.

ATTACHMENT 1

ENTERGY OPERATIONS, INC. RESPONSE TO THE VIOLATION IDENTIFIED IN
ENCLOSURE 1 OF INSPECTION REPORT 96-13

VIOLATION NO. 9613-03

Technical Specification 3.7.4.f requires, in part, that, with more than one wet cooling tower fan inoperable and the outside air temperature greater than 70 degrees F, the dry bulb temperature must be determined at least once every 2 hours.

Contrary to the above, between May 5 and 9, 1996, with more than one wet cooling tower fan inoperable and the outside air temperature greater than 70 degrees F, the licensee did not determine the dry bulb temperature at least once every 2 hours.

This is a Severity Level IV violation (Supplement 1). (50-382/9613-03)

RESPONSE

(1) Reason for the Violation

Entergy Operations admits this violation and believes that the root cause is inadequate work controls in that the method used in the engineering evaluations was not standardized. There was no standard method or process to establish administrative controls for the format, required level of review/approval, and operations interface of the evaluation that was used to document the inoperability of the wet cooling tower fans. Guidance on the use of engineering input to evaluate work that may impact operability of safety related or technical specification equipment was inadequate. As a result, an adequate level of review of the engineering evaluation was not performed and the fact that the wet cooling tower fans would be rendered inoperable while netting was placed around the wet cooling tower basin was not clearly communicated to operations. As a result of operations not being cognizant of the wet cooling tower fans inoperability, the required actions per Technical Specification 3.7.4.f was not performed.

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

1. Condition report 96-729 was generated to document and address this matter.
2. LER 96-005 Revision 0 was issued to report this occurrence.
3. The temporary netting that rendered the fans inoperable was removed.

4. Operations Administrative Procedure OP-100-014, "Technical Specification Compliance," has been revised to require the following:
 - a. If any system, sub-system, or component becomes unable to perform its intended safety function due to surveillance, calibration, or maintenance, then declare that equipment inoperable and enter the appropriate Tech/Spec TRM (Technical Requirements Manual) action.
 - b. If a component is thought to be Inoperable enter the appropriate Tech Spec/TRM action and initiate LCO tracking in accordance with OP-100-010, "Equipment Out of Service."
 - c. The engineering guidance should have at least two signatures on it indicating that a technical review has been performed.
 - d. The engineering guidance must be specifically bounded against any applicable Tech Specs. All engineering guidance parameters must be bounded by Tech Spec parameters, and in all cases, operators will adhere to the Tech Specs.
 - e. The STA should perform a review of the engineering guidance and provide a recommendation to the SS concerning the adequacy of the guidance.
5. Plant Administrative Procedure UNT 007-053 "Engineering Work Authorization," has been revised to specify the following:
 - a. An engineering input will not be used to make operability determinations for technical specifications or safety related equipment, nor will it be used to implement configuration changes.
 - b. All nonconformance conditions are addressed by Corrective Action Site Directive, W2.501.
 - c. Engineering inputs are only used to facilitate work such as bolting, torquing, gasketing, material condition improvements, troubleshooting and venting requirements.
 - d. All engineering inputs require a technical reviewer signature.

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

The Engineering Request process will replace the Problem Evaluation/Information Request (PEIR) for the purpose of engineering evaluations.

(4) Date When Full Compliance Will Be Achieved

Waterford 3 is currently in full compliance. The above corrective action will be completed by 9/30/97.

ATTACHMENT 1

ENTERGY OPERATIONS, INC. RESPONSE TO THE VIOLATION IDENTIFIED IN
ENCLOSURE 1 OF INSPECTION REPORT 96-13

VIOLATION NO. 9613-04

10 CFR 50.55a(g) requires, in part, that inservice testing to verify operational readiness of pumps and valves whose function is required for safety be accomplished in accordance with Section XI of the ASME Boiler and Pressure Vessel Code.

Contrary to the above, as of October 29, 1996, the licensee failed to verify the operational readiness of certain valves whose function is required for safety in accordance with Section XI of the ASME Boiler and Pressure Vessel Code. Specifically, the licensee failed to perform testing which ensured the operational readiness of manually operated dry cooling tower isolation valves used to maintain the safety function of the ultimate heat sink during the design basis tornado event.

This is a Severity Level IV violation (Supplement 1). (50-382/9613-04)

RESPONSE

(1) Reason for the Violation

The root cause of this violation is believed to be insufficiently explicit design-basis tornado event documentation. The documentation was not specific enough to readily allow the IST plan reviewers to conclude that the Dry Cooling Tower inlet and outlet valves had a safety function and should be included in the IST program for testing. These valves were not included in the IST plan during initial IST plan development, during the IST design basis document (DBD 24) review, or during the current (although not completed) review of all ASME Class 1, 2, and 3 valves.

A contributing cause for this violation was that the reviewer did not examine all of the available design basis tornado event documentation during the current IST plan review process. It is believed that had the reviewer examined the calculation related to the design basis tornado event, he would have concluded that the Dry Cooling Tower inlet and outlet valves should have been in the IST plan.

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

The Dry Cooling Tower manual inlet and outlet valves were successfully tested per IST requirements on 12/7/96.

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

1. The Dry Cooling Tower Manual inlet and outlet valves will be included in the IST program.
2. A review of the design basis tornado event will be performed and the design basis documents will be revised, as necessary, based on the results of the review.
3. The IST basis document will be reviewed by the appropriate design engineering disciplines in support of the development of the IST plan for the second ten interval.

(4) Date When Full Compliance Will Be Achieved

Waterford 3 is in full compliance. Item 1 will be completed by 1/31/97, Item 2 will be completed by 8/31/97 and item 3 will be completed by 12/1/97.