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

November 11, 1996

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

Subject: River Bend Station - Unit 1
License No. NPF-47
Docket No. 50-458
Replies to Notices of Violation 9612-01 and 9612-02

File Nos.: G9.5, G15.4.1

RBF1-96-0410
RBG-43339

Gentlemen:

On June 12, 1996, the NRC issued Inspection Report 50-458/96-12. Included in the report were three apparent violations, being considered for escalated enforcement. After a predecisional enforcement conference on June 26, 1996, to discuss the apparent violations, Supplement 1 to Inspection Report 50-458/96-12 was issued on October 11, 1996, containing two Level IV violations. Entergy Operations, Inc., hereby submits its replies to Notices of Violation 9612-01 and 9612-02 (Attachments A and B, respectively).

Should you have any questions, please contact Mr. David N. Lorfing at (504) 381-4157.

Sincerely,

Rick J. King

RJK/WJF/kvm
attachments

IE01

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
U.S. Nuclear Regulatory Commission
M/S OWFN 13-H-15
Washington, DC 20555

ATTACHMENT A

REPLY TO NOTICE OF VIOLATION 50-458/9612-01

VIOLATION

Technical Specification 5.4.1.a states, in part, that written procedures shall be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33. "Quality Assurance Program Requirements (Operations)," Revision 2, February 1978. Appendix A of Regulatory Guide 1.33, Item 4.a. states, in part, that procedures should cover operation of the nuclear steam supply system (vessel and recirculating system).

Technical Specification 3.3.5.1 requires that the emergency core cooling system instrumentation for each Function in Table 3.3.5.1-1, "Emergency Core Cooling System Instrumentation," shall be OPERABLE. Table 3.3.5.1-1 Function 1.b, "Low Pressure Coolant Injection-A (LPCI) and Low Pressure Core Spray (LPCS) Subsystems" requires for Modes 1, 2, and 3 two operable Drywell Pressure - High instruments.

Procedure SOP-0001, "Nuclear Boiler Instrumentation," Revision 5, Attachment 2 (Instrument and Valve Lineup), requires Valve A4-B21*N094E, Drywell Pressure Transmitter 1B21*PTN094E isolation, to be open for the Drywell Pressure Transmitter 1B21*PTN094E to be operable.

Contrary to the above, on February 14, 1996, while in Mode 1, instrument and control technicians found Valve A4-B21*N094E closed when it should have been open. This rendered Drywell Pressure Transmitter lB21*PTN094E inoperable in Mode 1 when Technical Specifications required the instrument channel to be operable.

REASONS FOR THE VIOLATION

Entergy Operations, Inc., (EOI) admits this violation. Supplement 1 to LER 96-008 was issued on April 10, 1996 (RBG-42782), and documents the investigation, root cause, and corrective actions for this event. The investigation per LER 96-008 reflects instrument failure identification by an operator at 1303 on February 14, 1996. A Limiting Condition for Operation (LCO) was entered, a Maintenance Action Item was initiated, valve A4-B21*N094E was identified as being in the closed position, the valve was opened and the LCO was cleared by 2103 on February 14, 1996. On February 15, 1996, a Significant Event Response Team (SERT) was formed to investigate this event. After their investigation, the SERT concluded that the cause of this event was indeterminate. However, the most probable cause was the valve being intentionally closed by someone who was directed by procedure to close another valve. LER 96-008 also identifies that this event was determined not to have a significant impact on safe plant operation.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

LER 96-008 identifies immediate corrective actions which included restoring the transmitter to service, verifying the Nuclear Boiler Instrumentation line-up, performing a High Pressure Core Spray instrumentation valve line-up, performing a verification of approximately 2,650 accessible safety-related instrumentation valves, and performing a verification of selected non-instrument valve and electrical line-ups.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

In addition to other ongoing program enhancements which are a part of River Bend's corrective action program, LER 96-008 also identifies the use of a natural work team to review mispositioning events and line-ups for improvement areas.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved at 2103 on February 14, 1996, after valve A4-B21*N094E had been re-opened and the LCO cleared.

ATTACHMENT B

REPLY TO A NOTICE OF VIOLATION 50-458/9612-02

VIOLATION

10 CFR Part 50, Appendix B, Criterion III, "Design Control," states, in part, that design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews or the performance of suitable checking processes.

Contrary to the above, following a valid start failure of the Division II Emergency Diesel Generator (EDG) on May 8, 1994, the licensee installed an inadequately designed EDG modification. The modification consisted of a K-1 relay pilot light on the EDG exciter cabinet and the design of the modification was inadequate because the modification permitted sufficient current to be passed through the K-1 relay pilot light to cause heat to build up in the exciter cabinet. As a result of this heat buildup over time, the EDG field flash relay failed on February 14, 1996, which rendered the EDG inoperable.

REASON FOR THE VIOLATION

Entergy Operations, Inc., (EOI) admits this violation. LER 96-009 was issued on March 14, 1996 (RBG-42620), and documents the investigation, root cause, and corrective actions for this issue. After the investigation by a multi-discipline team, two root causes were identified in LER 96-009. The first root cause was an incorrect engineering assumption for the maximum temperature reached during an excitation cabinet overheating event which resulted in less-than-adequate corrective actions. The second root cause was technical errors in the surveillance procedures which resulted in simultaneous latch and reset signals to the K-1 relay. Contributing factors included less-than-adequate technical reviews of design analysis/change implementation and untimely completion of a previous corrective action. In addition, this event was complicated by the overspeed trip that resulted from less-than-adequate guidance on setting the diesel's mechanical governor. LER 96-009 contains substantially more discussion of the investigation and causes for this event and also notes that, since the other two diesel generators were available, this event was of minimum safety significance.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

LER 96-009 corrective actions include replacement of the failed field flash relay, replacement of the K-1 relay, and readjustment of the mechanical governor speed setting on the Division II diesel. An in-depth evaluation was also performed on the effects of maximum temperature in the cabinet during the January 29th event.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The corrective actions identified in LER 96-009 include the performance of a detailed review of surveillance procedures and preventive maintenance tasks associated with the diesel generator control circuitry to identify conditions which may simultaneously energize both the latch and reset coils. LER 96-009 also notes that the field flash ready light will be changed out to one that has a higher resistive value and that engineering will receive "case study" training on this event to highlight lessons learned. A review of the process for granting corrective action extensions reviewed for possible improvements is also included in the LER 96-009 corrective actions.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

EOI is in full compliance.