

JAN 22 1990

In Reply Refer To:  
Docket: 50-458/89-04

Gulf States Utilities  
ATTN: James C. Deddens  
Senior Vice President (RBNG)  
P.O. Box 220  
St. Francisville, Louisiana 70775

Gentlemen:

Thank you for your letter of December 1, 1989, in response to our letter dated November 1, 1989. As a result of our review and discussions with you in our office on December 15, 1989, we have concluded that your actions were responsive to our concerns. We will review the implementation of your corrective actions during a future inspection.

Sincerely,

Original Signed By:  
Samuel J. Collins

Samuel J. Collins, Director  
Division of Reactor Projects

cc:  
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RIV:C:OPS  
JEGagliardo/lb  
1/19/90

D:DRS  
LJCallan  
1/22/90

AG  
Rwise  
1/22/90

D:DRS  
SJCcollins  
1/22/90

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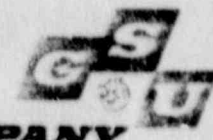
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bcc to DMB (IE01)

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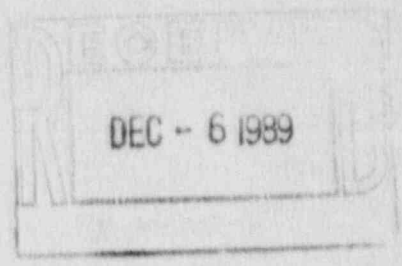


**GULF STATES UTILITIES COMPANY**

RIVER BEND STATION      POST OFF. BOX 220      ST. 1 ANDREVILLE, LOUISIANA 70775  
AREA CODE 804      635 6284      345 8531

December 1, 1989  
RBG-31830  
File Nos. G9.5, G15.4.1

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



Gentlemen:

River Bend Station - Unit 1  
Refer to : Region IV  
Docket No. 50-458/Report 89-04

This letter provides Gulf States Utilities Company's response to Mr. Milhoan's letter of November 1, 1989 regarding administrative requirements for accurately documenting activities. During the maintenance team inspection, two occurrences were identified by inspectors in which documentation did not accurately reflect what had actually occurred.

The first occurrence involved the manner in which the day shift foreman signed on to a clearance for maintenance work carried over from the night shift. The inspector noted that the "Checked and Accepted By" block of Clearance No. RB-1-89-2483 was not filled in by the day shift foreman until after his maintenance crew began working on the defective check valve and that the time entry did not correspond to the time of the signature entry.

The intent of ADM-0027, "Protective Tagging" is for the foreman to check each item and sign the clearance before the work begins, however the procedure language is not specific in this intent. In this case the day shift foreman did, in fact, perform the "check" function at 6:35 a.m. before his crew began work by checking to see that the breaker, which energizes the control switch, and the appropriate isolation valves were in a safe configuration in accordance with the clearance. The foreman failed to sign or "accept" the clearance at that time. When he finally did make the signature entry, he entered the time of performance of the "check" function rather than the "accept" function. The "check" function is the more critical of the two in terms of personnel and equipment safety.

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This individual was immediately removed of all duties as Mechanical Foreman until final investigation of this event was complete. In addition, all work on clearances accepted by this individual was suspended until checked and accepted by another qualified individual. When the investigation revealed that the foreman had performed a safety check of the job before his crew began work, the foreman was restored to full duty status. To emphasize the intent of ADM-0027 for the foreman to perform the check function and to sign for the acceptance of the clearance before working on the equipment, all maintenance foremen will be required to read, by January 15, 1990, CR89-1083 which describes this occurrence. As discussed in GSU's response to Notice of Violation 50-458/8911-01A dated July 7, 1989, several discrepancies in the tagging program at River Bend Station have been identified. A task force was formed and has formulated several recommendations for improvement of this program, including a major revision to ADM-0027. Specific details of the task force findings will be provided in GSU's supplement to Notice of Violation 8811-01A to be submitted December 15, 1989.

The second occurrence involved the completion of the QC Planning Review Checklist for MWO R116231. The inspector noted that the checklist should have been completed by QC before work was started. He further noted that the checklist was only half completed until the MWO was returned to QC for closure review of the completed document package and then no indications appeared as to when it was completed or by whom.

QC's investigation of this instance determined that, while a satisfactory QC review was completed as evidenced by the QC Notification/Review signature on October 18, 1988, the QC reviewer failed to properly complete the QC checklist. The individual who completed the checklist had just been assigned to QC Inspection Planning and his relative unfamiliarity with the QC Planning procedure is felt to have contributed the oversight at that time. When the QC closure review was performed on the MWO, the closure reviewer discovered the checklist had not been completed. After determining that the items which had not been completed were either satisfactory or not applicable, he then elected to complete the checklist. However, this individual failed to note these subsequent actions and the reasoning behind his actions.

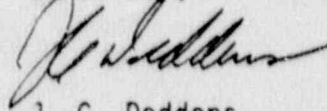
The immediate corrective action was to include on October 5, 1989 the explanatory note which appears in the "Comments" section of the checklist. After investigation of the events surrounding the origin and closure of this checklist, QC has determined that this occurrence resulted from unfamiliarity with the QC Inspection Planning procedure and an oversight on the closure reviewer's part for not appropriately documenting his actions of completing the open checklist items. The NRC inspector reviewed approximately 30 checklists and the QC

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supervisor reviewed in excess of 100 checklists and no additional discrepancies were discovered. This, as well as discussions with the closure reviewer have provided assurance that this occurrence was an isolated case and is not a generic problem within the QC documents or departmental personnel. To prevent recurrence, interdepartmental training on QCI-3.7, "Quality Control Inspection Planning," ADM-0006, "Control of Plans Records," and the information that should be included to accurately document activities was completed on October 31, 1989.

Based upon the investigation and review of these two occurrences, GSU concludes that the incidence of these documentation inadequacies is so infrequent as not to warrant further generic corrective action at this time. Should routine surveillances and audits identify any increased prevalence of inadequacies in the future, appropriate measures will be formulated and implemented.

Sincerely,



J. C. Deddens  
Senior Vice President  
River Bend Nuclear Group

JCD/JEB/LAE/DNL/NRC/TCC/DRD/pg

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