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

DEC 23 1994

Entergy Operations, Inc.
ATTN: John R. McGaha, Vice President -
Operations, River Bend Station
P.O. Box 220
St. Francisville, Louisiana 70775

SUBJECT: NRC INSPECTION REPORT 50-458/94-19

Thank you for your letter of December 9, 1994, in response to our letter and Notice of Violation dated November 10, 1994. 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. Bill Beach, Director
Division of Reactor Projects

Docket: 50-458
License: NPF-47

cc:
Entergy Operations, Inc.
ATTN: Harold W. Keiser, Executive Vice
President and Chief Operating Officer
P.O. Box 31995
Jackson, Mississippi 39286-1995

Entergy Operations, Inc.
ATTN: Jerrold G. Dewease, Vice President
Operations Support
P.O. Box 31995
Jackson, Mississippi 39286-1995

Entergy Operations, Inc.
ATTN: Michael B. Sellman, General Manager
Plant Operations
P.O. Box 220
St. Francisville, Louisiana 70775

Entergy Operations, Inc.
ATTN: James J. Fisicaro, Director
Nuclear Safety
River Bend Station
P.O. Box 220
St. Francisville, Louisiana 70775

Wise, Carter, Child & Caraway
ATTN: Robert B. McGehee, Esq.
P.O. Box 651
Jackson, Mississippi 39205

Winston & Strawn
ATTN: Mark J. Wetterhahn, Esq.
1401 L Street, N.W.
Washington, D.C. 20005-3502

Entergy Operations, Inc.
ATTN: Otto P. Bulich, Manager
Nuclear Licensing
P.O. Box 220
St. Francisville, Louisiana 70775

The Honorable Richard P. Ieyoub
Attorney General
P.O. Box 94095
Baton Rouge, Louisiana 70804-9095

H. Anne Plettinger
3456 Villa Rose Drive
Baton Rouge, Louisiana 70806

President of West Feliciana
Police Jury
P.O. Box 1921
St. Francisville, Louisiana 70775

Cajun Electric Power Coop. Inc.
ATTN: Philip G. Harris
10719 Airline Highway
P.O. Box 15540
Baton Rouge, Louisiana 70895

William H. Spell, Administrator
Radiation Protection Division
P.O. Box 82135
Baton Rouge, Louisiana 70884-2135

bcc to DMB (IE01)

bcc distrib. by RIV:

L. J. Callan
Branch Chief (DRP/D)
Project Engineer (DRP/D)
MIS System
RIV File
Senior Resident Inspector (Cooper)
Resident Inspector
Leah Tremper (OC/LFDCB, MS: TWFN 9E10)
Senior Resident Inspector (Grand Gulf)
DRSS-FIPB
Branch Chief (DRP/TSS)

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bcc to DMB (IE01)

bcc distrib. by RIV:

L. J. Callan
Branch Chief (DRP/D)
Project Engineer (DRP/D)
MIS System
RIV File
Senior Resident Inspector (Cooper)
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GAPick;cm	CAVanDenburgh	ABBeach			
12/21/94	12/22/94	12/23/94			

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ENTERGY

Entergy Operations, Inc.
River Bend Station
5485 US Highway 61
PO Box 220
St Francisville, LA 70775
(504) 336-6225
FAX (504) 635-5068

JAMES J. FISICARO
Director
Nuclear Safety

December 9, 1994

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

Subject: River Bend Station - Unit 1
Docket No. 50-458
License No. NPF-47
Reply to Notices of Violation Described in
Inspection Report 50-458/94-19, dated November 9, 1994

File No.: G9.5, G15.4.1

RBG-41096
RBF1-94-0116

Gentlemen:

Pursuant to 10CFR2.201, attached is Entergy Operations, Inc.'s response to the notices of violation described in NRC Inspection Report (IR) 50-458/94-19.

In the Inspection Report, the Staff expressed concerns regarding four violations. The violations basically dealt with the failure to properly control maintenance activities and one equipment tagging issue. Entergy is committed to making improvements in these areas and has develop specific corrective actions for each issue as described in the attached responses to these violations. In addition, programmatic initiatives which have previously been documented in RBS's Long Term Performance Improvement Plan are also being implemented. RBS management believes that these actions will serve to effectively resolve these issues.

Should you have any questions, please contact Mr. T. W. Gates at (504) 381-4866.

Sincerely,

James J. Fisicaro

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

NRC Resident Inspector
P.O. Box 1051
St. Francisville, LA 70775

Mr. D.L. Wigginton
U.S. Nuclear Regulatory Commission
Mail Stop O13-H-3
Washington, DC 20555

Reply to Notice of Violation
94-19-01

VIOLATION

Technical Specification 6.8.1.c requires, in part, that written procedures shall be implemented covering refueling operations.

Maintenance Work Order P574322 referenced the vendor manual for the refueling bridge, which contained the appropriate information to obtain the part identification number for replacement refueling mast cables.

Contrary to the above, on June 15, 1994, licensee personnel failed to follow Maintenance Work Order P574322 in that they did not use the part identification number specified by the referenced vendor manual to requisition the correct cables. Consequently, the personnel installed the incorrect cables.

REASON FOR THE VIOLATION

Entergy Operations, Inc. admits this violation and believes the reason for the violation was that contract personnel evidently used the wrong vendor manual when identifying the part number for the replacement cables. A review of the warehouse requisition ticket written by the contractor indicated that the cables requisitioned were designed for the fuel handling platform and not for the refueling platform. The correct vendor manual was referenced in the work order; however, the part number used in the requisition matched the part number provided in the fuel handling platform manual and not the number provided in the refueling platform manual. The error appears to be the result of inattention to detail by the contractor and failure to recognize that differences in the cable lengths existed between the fuel handling platform and refueling platform cranes at River Bend Station (RBS). A Task Force was initiated at RBS immediately following this event and the following contributing causes were also identified:

- The refueling platform and the fuel handling platform are nearly identical except that the refueling platform has a longer mast, and consequently needs a longer cable. The cables for these pieces of equipment are similar and the length differences are not readily apparent.

- The maintenance procedure was determined to be inadequate in that it did not require a check of the cable length before cable installation.

- Materials Management System database description lacked sufficient detail in that it did not specify the length of these similar cables.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The immediate corrective actions were to requisition and install the proper cables. Following the installation of the correct cables, post-maintenance testing was performed which verified that the correct cables had been installed.

Following these immediate corrective actions, the Materials Management System database was enhanced by revising the descriptions of the subject cables to include the specific cable lengths This action should serve to heighten the awareness of this attribute.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATION

The following long term correctives have been identified and will be implemented:

- Maintenance Lifting Procedures (MLP) 7506, "Refueling Platform" and MLP 7504, "Fuel Handling Platform" will be revised to include provisions which will ensure that the correct cables are used and their lengths verified.

- Evaluate the Polar Crane and the Turbine Building Bridge crane and their associated maintenance procedures for susceptibility to installing a cable of the incorrect length.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved when the correct cables were installed and verified. This was accomplished in approximately two days after the identification of this condition. The long-term corrective actions described above will be completed by September 7, 1995.

Reply to Notice of Violation
94-19-03

VIOLATION

Technical Specification 6.8.1.a requires, in part, that written procedures shall be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Appendix A, states, in part, that safety-related activities should be covered by written procedures.

Administrative Procedure ADM-0037, "Equipment Identification and Labeling," Revision 6, stated, in part, that all personnel must complete a temporary equipment identification tag whenever an unlabeled component is discovered and to stop all work until a temporary equipment identification tag is completed and installed.

Contrary to the above, on September 22, 1994, a danger-hold tag was installed on motor-operated Valve SFT-MOV101 that did not have a plant equipment identification label nor a temporary equipment identification tag.

REASON FOR THE VIOLATION

Entergy Operations, Inc. admits this violation and believes that the reason for this condition was that the policy guidance and management expectations were not well-defined or understood. Specific procedural guidance, applicable to the condition described in this violation, was not provided to plant personnel for determining the adequacy of as-found equipment labels.

An OSP-018 "Operations Accountability Review" was conducted to investigate the plant staff actions and to determine if the actions taken by plant staff were appropriate. In addition, a review of ADM-0027, "Protective Tagging;" ADM-0037; and Operation Policy #004 was conducted to identify the required tasks/actions to be performed. Explicit guidance is provided in both ADM-0037 and Operations Policy #004 for a situation where a component is not labeled, or the label is illegible or inadequate. For these defined situations, the activity in progress is stopped until the component is positively identified to be correct and a proper label attached. In this instance, both the operator hanging the tags and the operator performing the independent verification, verified the component to be correct and determined the existing label to be adequate based upon their understanding of the procedural requirements for labeling.

Before placing the danger tag on SFT-MOV101, Fuel Transfer System Drain Valve, the operator verified he had the proper valve based on his understanding of the requirements of ADM-0027 and the STAR program. The operator could not locate the standard River Bend equipment label; however, he did locate a stainless steel "manufacturer's" tag riveted to the valve yoke with the River Bend component mark number. The operator determined that since

he was familiar with this valve and the Equipment mark number on the stainless steel tag was correct, the label was adequate for tagging purposes.

Contrary to management expectations, neither the operator who placed the danger tag or the independent verifier took immediate action to initiate a Temporary Equipment Identification Tag. They did not believe that the identified labeling was a deficiency that required immediate action. Although one operator did recognize the need to put the valve into the labeling process to ensure a tag was manufactured with the appropriate information (e.g., the noun name of the valve which is included on River Bend generated labels but which was not shown on the vendor's tag) included on the tag. This action was initiated when the NRC resident inspector questioned the adequacy of the existing tag.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

A Temporary Equipment Identification Tag (TEIT) was written and placed on the valve. The issuance of this temporary tag was in accordance with RBS's tagging procedure and provides positive identification of this equipment until a permanent tag can be fabricated and placed. Note that the "positive identification" provided by the TEIT was the same as that provided by the existing tag in that both simply identify the equipment by its mark number. However, this action did initiate the process to fabricate an improved label that will meet the management expectations for RBS's labeling program.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATION

The following corrective actions to preclude recurrence have been identified:

- The definition of "inadequate" labels will be clarified in ADM-0037 and Operations Policy #004. This clarification will specify that an adequate label exists if a component has a legible and secure tag that includes at a minimum the component's mark number. A tag with these attributes will be acceptable for tagging purposes provided that the responsible plant personnel placing the tag has the knowledge to positively identify the subject component.

- Training will be provided to Operations personnel through shift briefings on the clarified definition and policy guidance.

- An inter-office memorandum will be issued to Maintenance, Chemistry, Radwaste, and Engineering that will communicate the clarified definition of an inadequate label and emphasize the requirements for generating label requests.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend Station is in full compliance. The corrective actions described above will be completed by January 25, 1995.

Reply to Notice of Violation
94-19-04

VIOLATION

Technical Specification 6.8.1.c requires, in part, that written procedures shall be maintained covering refueling operations.

Contrary to the above, on September 18, 1994, General Maintenance Procedure GMP-0102, "Reactor Disassembly," Revision 1, was not adequately maintained in that the procedure did not provide instructions as to what criteria must be satisfied prior to placing the containment ventilation back into service. An inadvertent release of radioactive material occurred because of inadequate instructions.

REASON FOR THE VIOLATION

Entergy Operations, Inc. admits this violation and believes the reason for the violation was that the procedure did not conform with the improved format established by the Procedures Upgrade Program and, in addition, it had not received an adequate technical review to ensure completeness. The contamination control instructions in the procedure were located in the precaution section of General Maintenance Procedure (GMP)-0102, "Reactor Disassembly" and not sequenced in the body of the procedure as is being effected by the procedures upgrade project. The procedure failed to clearly identify the responsibilities of personnel performing the contamination control functions. While the procedure did address the securing of containment ventilation before reactor pressure vessel (RPV) internal component lift, it did not provide instructions on restoring containment ventilation after an RPV internal component lift. No contamination control criterion was provided to support the restoration of containment ventilation.

Event and causal factor charting was performed using the TAP ROOT technique to determine these reasons.

Contributing to these procedural deficiencies was an inadequate pre-job briefing. A recommendation by the refuel floor supervisor to perform the pre-job briefing on the radiological lift plan away from the job site was not complied with. The briefing was held at the job site which had a high noise level and an additional complication of some individuals involved in the briefing being restricted to a contaminated zone area.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

Immediately following this event actions were taken to decontaminate the reactor building. This action served to restore this area to the desired ALARA condition. The area HEPA unit was inspected for proper operation to ensure continued filtration of the work area atmosphere. In addition, RP Temporary Instruction 94-0002 was written and issued to address post lift radiological concerns. This temporary instruction included guidance on restoration of ventilation to preclude recurrence.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATION

Regarding the generic implications of RBS procedure quality problems described in this violation, both interim and long-term actions are being implemented as part of the Procedures Upgrade Program as described in RBS's Long Term Performance Improvement Plan. The priorities of the Procedures Upgrade Program are based on the safety significance of a procedure and its impact on the continued safe operation of the plant. As such, the procedural enhancements effected by the Procedure Upgrade Program will be implemented on a schedule commensurate with a procedure's safety significance. Separate from this effort, specific corrective actions will be implemented for the deficiencies identified during this investigation. These specific actions are described below.

- The Reactor Disassembly procedure, GMP-0102, will be revised to properly address the radiological conditions for recommending restart of containment ventilation and the proper sequencing of the contamination control instructions in the procedure.

- RP refuel training (the Reactor Assembly/Disassembly Job Coverage lesson plan) will be enhanced to address air sampling during the RPV disassembly as well as the related ventilation flow paths during the RPV disassembly.

- Training will be conducted on this event with Health Physics shift supervision and RP technicians to emphasize the importance of conducting a proper pre-job brief.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend Station is in full compliance. The specific long-term corrective actions will be completed before the next scheduled refueling outage.

Reply to Notice of Violation
94-19-05

VIOLATION

Technical Specification 6.8.1.a requires, in part, that written procedures shall be established covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Item 9.a, states, in part, that maintenance that can affect the performance of safety-related equipment should be properly preplanned and performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances.

Administrative Procedure ADM-0023, "Conduct of Maintenance," Revision 12, Section 8.1.1, states, in part, that procedures shall be developed to describe the means by which maintenance is performed, controlled, and documented.

Contrary to the above, on two occasions maintenance was performed but not controlled and documented in accordance with established procedures:

1. On September 1, 1994, the inspectors identified four flange nuts missing from the inlet strainer flange on safety-related Penetration Valve Leakage Control System Compressor LSV*C3A without any records to show that the work was controlled or authorized.

2. On September 10, 1994, licensee personnel found the Siltemp cable wrap removed from the solenoid valve cables on Main Steam Safety Relief Valve lB21*RVF041D, which rendered this automatic depressurization valve inoperable from the startup following Refueling Outage 4 in 1992 until the plant was shut down on September 8, 1994. The licensee had established no procedures to reinstall the cable wrap following removal for troubleshooting activities.

REASON FOR THE VIOLATION

Entergy Operations, Inc. admits this violation. The reasons for each example have been investigated and are provided below. Note that additional examples of missing fasteners (similar to example 1) were discussed in Inspection Report 94-19, but were not cited in this violation. Due to the similarity of these uncited examples, information associated with EOI's investigation of this entire issue is provide in this response for completeness.

Example 1

Due to the number of documented occurrences of lost/missing fasteners, plant management took action to commission a Significant Event Response Team (SERT) to review the occurrences, assess the potential root cause(s), initiate immediate corrective actions, if required, and recommend further corrective actions based on the findings. The SERT team has concluded that at least four separate reasons exist that have resulted in the conditions identified.

- **Original Construction Problem**: A number of mechanical systems associated with safety related and non-safety related components were not properly assembled/maintained during the construction and initial startup phases of the plant. As the current efforts to identify materiel condition deficiencies continue, these deficiencies will be identified and corrected. The deficiencies identified in this category have not caused a significant impact to plant reliability or threaten the safe operation of the plant. This is based on the condition of the equipment at time of discovery (not leaking or showing any signs of imminent failure).

- **Work Practices**: Some work practices are not sufficient to ensure maintenance/modification activities result in properly configured mechanical equipment without additional emphasis. It appears one group of individuals (contract personnel) has predominately been involved in the cases identified in this category. No major modifications have been installed during the most recent forced outages and several of the jobs performed by these personnel were worked/reworked during forced outage 94-01 or were inspected by PM&C management. With additional emphasis on verification of proper installation of critical mechanical fasteners, deficiencies identified in this category should be prevented in the future and a threat to plant reliability or safety should not occur.

- **Unknown**: The deficiencies categorized as cause "unknown" should be addressed by the current efforts to identify materiel condition deficiencies. It is likely, however, the items in this category occurred as a result of poor work practices. The deficiencies identified in this category have not cause a significant impact to plant reliability or threaten the safe operation of the plant. This is based on the condition of the equipment at time of discovery (not leaking or showing any signs of imminent failure).

- **Vibration**: The deficiency categorized as vibration appears based on a search of the Maintenance Work Order (MWO) history indicates those fastener problems due to vibration are most commonly found related to the diesel generators or instrument air compressors. This equipment is routinely monitored by System Engineering, Operations and Maintenance personnel. Additional positive locking devices may be required for recurring problems associated with vibration.

The team assembled documentation for each of the issues from 1994. Each of the incidents was categorized as to the general cause (i.e., Poor Work Practices, Vibration, Unknown, Poor Work Instructions, Original Construction Problem). A brief summary of the items discussed in Inspection Report 94-19 follows:

- CR-94-1089 (9/01/94) An NRC inspector reported LSV*C3A suction strainer did not have nuts attached to the bolts holding the strainer on the suction piping. The strainer was still attached to the suction piping flange being held in place apparently due to pinning by the bolts. Investigation did not identify conclusively when or how the nuts were removed or fell off. For four nuts to be removed on this particular system (little vibration and infrequent operation), a deliberate action would be required. At the time of discovery no nuts were found in the area. This SERT team believes the nuts were removed to facilitate installation of a check valve under MR-92-0087. This is based on interviews by members

of the team with those involved in work on the compressor, a review of the MWO which revealed that longer bolts were required when the check valve was installed under the MR, and verification that new bolts were installed prior to the installation of the MR in March. Personnel involved with the MR installation, however, indicated that these bolts were not disturbed during the installation. Categorized as Poor Work Practices (most likely by contract personnel)

- CR-94-1303 (10/08/94) Maintenance personnel identified packing gland stud and nuts missing from RWCU pump B seal purge line vent, WCS*V3009. This was eliminated as an original construction problem in that the valve was recently installed during RF-5 under MR- 93-0116. Documentation associated with the MR indicates the valve was repacked before installation, as it should have been. No indication of any maintenance or further modification work could be found following installation. The valve is normally shut and would not see system pressure of greater than 1000 psig in this configuration since it is a globe valve (pressure is under the seat and the packing is downstream of seats). Had the valve been opened under system pressure, the packing could have blown presenting a personnel safety hazard. The system was vented following completion of the modification during RF-5 but no indications of problems were identified by the operation's personnel performing the venting operation as determined by interview. Some of the missing hardware was identified on the floor of the room beneath some equipment. These were located when personnel working on replacing the missing hardware dropped some of this hardware and in retrieving the replacement hardware located some of the missing parts. This condition was categorized as Poor Work Practices (most likely during installation of the modification by contract personnel).

- CR-94-1305 (10/09/94) One of the nuts was found missing on the discharge flange of 1TME-RV1B, Steam Seal Evaporator Relief Valve. Based on the painted bolt threads, it appears that this nut has never been installed. A search of maintenance history reveals no record of corrective or preventive maintenance. The SERT team concludes this is an item originating at construction of the plant. This condition was categorized as Original Construction Problem.

- CR-94-1296 (10/09/94) Found Reactor Water Clean-Up (RWCU) Pump B seal purge line relief valve 1WCS*RV31B with only 3 stud and nut sets in the inlet 4 bolt flange. This relief valve was installed at the same time as the valve identified by CR-94-1303 above. Records generated during the installation of MR 93-0116 indicate that the flange bolts were all torqued by Modifications. This is a limited access room due to high radiation and very little documented work has occurred in the room since MR installation. Following installation, the system was walked down by an engineer and subsequent to the system operation the relief valve lifted and operations and maintenance personnel attempted to reseat the valve manually. No missing bolt or stud was identified at either time although visibility is not the best in this location. The room was inspected in an attempt to locate the missing hardware. The missing bolt and nut (as verified by heat # markings) were located in a tool box in the RWCU pump room. It is not likely that the bolt vibrated out of position and was later moved to the tool box as the system experiences very little vibration and the room has limited access. Movements of personnel into the room were examined

through review of the records of access for RWPs that are written specifically for work in the room. These failed to identify any further opportunities for work than that previously mentioned. As documented in QC surveillance report 410003 (relief valve testing, 10/09/94), mechanical personnel at the time of discovery indicated that they believed the stud and nuts were never installed. Based on the above the SERT team concludes that the stud and nut were never installed during the installation of the MR. The installation of the relief valve occurred later in time than the bulk of the modification due to delays in delivery of the relief valve, so there may have been some pressure to hurry the installation due to plant conditions. This condition was categorized as Poor Work Practices (most likely during installation of the modification by contract personnel).

One commonalty identified among the condition reports listed above is that those related to modifications involved some of the same contract personnel. Some of these same individuals were also associated with other deficiencies identified during RF-5, such as the backwards installation of the Non-Return Valve and foreign material exclusion problems. Since most of the workers responsible for completion of these activities are no longer employed at RBS, two of the responsible foremen still on site were interviewed. Based on the results of the interviews, no conclusive evidence was established, although some additional areas for training and coaching these individuals were identified. In addition, PM&C is currently developing a new work control process to ensure additional supervisory oversight and inspections are performed in conjunction with the work that is being performed by contract personnel. This process is being developed with the focus on the use of short term contract personnel.

General requirements exist to verify all fasteners are properly installed when performing work at River Bend. Until recently these requirements were stated in the "boiler plate" section of each MWO. However, as this "boiler plate" was cluttering the specific work instructions, it was moved to ADM-0023, "Conduct of Maintenance." The SERT team's review seems to indicate this method of alerting plant personnel to these requirements has not been totally effective even though the requirement to have the generic job step in MWOs has been in place since 1985. A review of previous CRs associated with "missing", "nut", or "bolt" indicates that the most prevalent problem is with electrical/I&C enclosures and covers. As a result, any corrective action taken to address ensuring completion of work activities should apply to all disciplines.

Example 2:

The reason for no procedures being prepared to reinstall the cable wrap following its removal for troubleshooting activities was the existence of conflicting direction in the MWO. The MWO was only intended for troubleshooting activities and a particular step in the MWO required the work order to be returned to planning if additional work was required. However, due to connector replacement instructions also being included in the MWO, the responsible technician apparently did not feel that a separate procedure was required to perform the rework. The specific step in the MWO that required the package to be returned was generic in nature and was subject to broad interpretation. This step led to the technician completing the work and not returning the work package to planning for the appropriate revision.

The involved technician reworked connectors for two SRV's. The rework activity for the F041G was successfully completed and met the appropriate separation requirements. However, the work performed on F041D did not meet these requirements. Review of work activities that occurred prior to RF 4 indicated that cable wrapping had been previously installed on F041D. Therefore it is concluded that the technician removed the wrapping and did not replace it due to inattention to detail. This is a contributing factor to this incident.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The following corrective steps were taken in response to these events:

Example 1

Each of the specific fastener deficiencies identified have been corrected at the component level. The SERT team has performed a concerted effort to evaluate these known occurrences and has assessed the safety significance of each example. These evaluations have concluded that these conditions have not cause a significant impact on plant reliability or threatened safe operation.

The SERT team requested walkdowns to be conducted of selected safety-related systems. As a result several discrepancies were identified and CRs were initiated. RBS is continuing its current zone inspection program that systematically reviews all areas of the plant. This ongoing activity will help in identifying issues from construction, vibration or previous work activities. In addition, plant management has requested that System Engineers and Operations be particularly attentive to identification of missing fasteners when walking down plant systems.

Example 2:

Subsequent to RF 4 a plant administrative procedure was developed and issued to control troubleshooting activities. This procedure provides guidance regarding proper implementation of troubleshooting activities. The missing fire wrap was reinstalled on September 18, 1994. This action reestablished the system's compliance with its design basis.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATION

Example 1

- EOI will further evaluate the findings and conclusions with regard to the apparent performance problems with the crew involved in the modification work discussed in the SERT report and take appropriate action based on the evaluation, including the need to review additional work performed by the people involved.

- The instructions currently used for fastener installation appear to be adequate; however, the work packages currently rely on one worker's signature, a foreman's review and QC. Verification of work performed by contract workers will be increased in the interim

through the assignment of additional supervisory hold points within the work process to identify performance issues beyond those of the single crew identified. The development of standardized installation cards for routine activities such as valve and piping installation is underway.

- EOI will review the current instructions and training for all crafts relative to installation of fasteners.

- Instructions will be provided to plant housekeeping, decontamination and laborer personnel, emphasizing the need to identify to the appropriate supervision any loose fasteners identified during performance of their duties so that appropriate investigation/corrective action can be taken.

- EOI will review the current list of contractors performing work on site to determine if other work groups utilizing contractors should receive additional guidance or training on mechanical fastener installation/standards.

- EOI will review the history of loose fasteners associated with the diesel generators and instrument air compressors to determine if additional locking devices should be added to resolve recurring problems.

Example 2

- Corrective Maintenance Procedure (CMP) -9144, "Main Steam Relief Valve Disassembly, Inspection, Rework and Reassembly," will be revised to incorporate all steps necessary to perform corrective maintenance on the solenoid operated valves associated with the ADS, including steps necessary to check the cable connectors and confirm the proper installation of the cable fire wrap.

- An evaluation of the maintenance planning process will be performed and enhancements implemented as appropriate.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

River Bend Station is in full compliance. The above corrective actions for example 1 will be complete by February 16, 1995. The above corrective actions for example 2 will be complete by June 15, 1995.