



ENTERGY

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James J. Fisicaro
Director
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October 26, 1995

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 9523-01 and 9523-02

File Nos.: G9.5, G15.4.1

RBF1-95-0254
RBG-42096

Gentlemen:

NRC Inspection Report 50-458/95-23 cited two violations. Entergy Operations, Inc., hereby submits its replies to Notices of Violation 9523-01 and 9523-02 (Attachments A and B, respectively).

We share your concern with the identified issues. As we have discussed in earlier meetings, we have taken great efforts to emphasize the importance of complete and accurate communication in every aspect of personnel interface. In addition, we have also focused significant resources on improving site procedures and emphasizing the importance of following written guidance.

We recognize the significance of the issues that you have identified. As discussed in the attached replies to the Notices of Violation, we have taken immediate and comprehensive actions to resolve these concerns.

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Replies to Notices of Violation 9523-01 and 9523-02

October 26, 1995

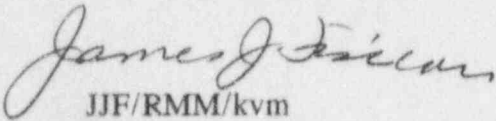
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Should you have any questions, please contact Mr. David N. Lorfing at (504) 381-4157.

Sincerely,



JJF/RMM/kvm

attachments

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ATTACHMENT A

REPLY TO NOTICE OF VIOLATION 50-458/9523-01

VIOLATION

Technical Specification 6.8.1 states, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Appendix A of Regulatory Guide 1.33, paragraph 4.w states, in part, that written procedures should be established covering the operation of safety-related onsite emergency power sources, e.g., diesel generators.

Operations Policy 19, "Restoration/Maintenance of System/Component Operability Through use of Manual Action in Place of Automatic Action," Revision 0, states, in part, that the assignment of a dedicated operator for manual action is not acceptable without written procedural guidance.

Contrary to the above, on August 31, 1995, the licensee's plant modification and construction department installed and designated an individual to manually remove plastic overspray protection from the Division II diesel generator without written procedural guidance. The plastic had been installed on the Division II diesel generator's cooling air vents to prevent damage from paint overspray. Consequently, the licensed operators were unaware that manual action was necessary for the diesel generator to perform its automatic safety function.

REASONS FOR THE VIOLATION

Entergy Operations, Inc., (EOI) admits this violation. The root cause was determined to be less than adequate communications during the pre-job walkdown, job preparation and discussion with the Work Management Center (WMC) personnel, in that the Plant Modification and Construction (PM&C) Foreman did not adequately communicate that the air intake vents for the generator would be covered during the painting activity. As a result, administrative requirements, i.e., Operations Policy 19, were not implemented to generate written guidelines for contingency operation of the diesel generator.

On August 31, 1995, the PM&C Foreman received permission from personnel in the Work Management Center to paint in the Division II Diesel Generator Room. Prior to starting work the painters were briefed by their Foreman on the precautions to be taken when performing this work as part of the pre-job briefing. The Foreman identified the potential for paint overspray getting into the generator during painting and took what he perceived to be the necessary actions to protect the generator. He instructed the painters to cover the air intakes on the generator and to remove the covering if the engine started or as soon as the painting was completed. However, this precaution was not described in the written precautions distributed to the painters and was not communicated to the Operations staff. Without

knowledge of the specific activities being performed, i.e., covering the intakes, Operations staff did not implement the proper contingencies as required by procedures/policies.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

Upon identification of the problem, Operations personnel in the Main Control Room were notified, painting activities were halted, and the coverings were immediately removed. A subsequent engineering assessment concluded that the Division II Diesel Generator was operable during the time (about one hour) that the ventilation intakes were covered. This evaluation was based on the measures that were in place to ensure that the covers were immediately removed if the Diesel Generator started.

The precautions to be taken when painting in the Diesel Generator Room were revised on August 31, 1995, to include contingencies for covering the generator air intakes.

A meeting was held on September 1, 1995, with the painters and Foremen to review this issue and lessons learned. Painters working in the Division II Diesel Generator Room and Fuel Building were briefed prior to starting work in the respective areas.

An accountability and counseling session was held with the individuals involved.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

A Painting Impact Walkdown checklist has been developed to be used during walkdowns with the painters and Operations personnel prior to the start of modification activities which will include painting. This checklist will be used to identify safety related equipment in the area and to ensure that appropriate precautions are taken with respect to the equipment. In addition, procedure PMC-22-002, "Modification Installation," was revised to address all PM&C pre-job walkdowns.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

An engineering assessment concluded that the Division II Diesel Generator was operable during the time (about one hour) that the ventilation intakes were covered due to the measures that were in place. Full compliance was achieved upon removal of the covering from the generator. Additional actions, described above, have been taken to further assure compliance in the future.

ATTACHMENT B

REPLY TO A NOTICE OF VIOLATION 50-458/9523-02

VIOLATION

Technical Specification 6.8.1 states, 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.

There were two examples where written procedures were not properly implemented:

1. Appendix A of Regulatory Guide 1.33, paragraph 9.a states, in part, that maintenance that can affect the performance of safety-related equipment should be performed in accordance with written procedures, documented instructions or drawings appropriate to the circumstances.

Maintenance Work Order R218051, Work Instruction IV.I, directs the removal of the pilot tube on Diesel Generator A forward air start solenoid operated Valve 1EGA*SOVY11A.

Contrary to the above, on August 16, 1995, the mechanic proceeded with the removal of the pilot tube on Diesel Generator A rear air start solenoid operated Valve 1EGA*SOVX11A, until stopped by his foreman. Consequently, the incorrect tubing connection was loosened by approximately one turn.

2. Appendix A of Regulatory Guide 1.33, paragraph I recommends written procedures covering safety-related administrative activities.

River Bend Nuclear Procedure RBNP-030, "Initiation and Processing of Condition Reports," Revision 7, Section 5.1, requires a condition report to be initiated when performance of activities on the wrong equipment because of personnel error is identified.

Contrary to the above, from August 16 to August 18, 1995, a condition report was not initiated to document the error in Example I above, until prompted by the NRC inspector. Consequently, the unauthorized work was not evaluated prior to declaring the diesel generator operable on August 17, 1995.

REASON FOR THE VIOLATION

Entergy admits this violation. The root causes and contributing causes for each example are discussed below.

Example 1: Maintenance Performed on Wrong Valve

The root cause for the mechanical repairman starting to work on the wrong valve was determined to be an insufficient degree of attention to detail. Contributing causes were determined to be perceived pressure to complete the task and nervousness due to the number and stature of the observers.

Example 2: Failure to Initiate Condition Report

The root cause for not initiating a CR for this type of personnel error was a lack of adequate communication of management expectations as well as a misunderstanding of management expectations as documented in RBNP-030, "Initiation and Processing of Condition Reports", Revision 7, Section 5.1.

The guidelines for identification of conditions to be reported include, in part, "performance of activities on the wrong equipment (e.g., wrong unit or train)." This phrasing implies that it is only applicable to work which impacts multiple divisions or trains. In applying this guidance to the mechanical repairman actions on the rear air start valve, the mechanical repairman and supervisor were swayed by several factors. First, the rear air start solenoid valve was tagged out at the time. Further, the mechanical repairman and the supervisor noted, based upon their own experience, that the rear air start valve compression fitting was not significantly disturbed and did not warrant further evaluation. The mechanical repairman is experienced with this type of pilot tube compression fitting and was easily able to confidently restore it to its initial condition. The supervisor also reasoned that the mechanical repairman actions would not degrade the integrity of the compression fitting since there are no torquing requirements for this fitting and the operational leak test (OLT) would be satisfied by the post maintenance operational test.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Example 1: Maintenance Performed on Wrong Valve

An accountability and counseling session was held with the individual involved. Also, an accountability and training session on this issue was held with mechanical maintenance personnel.

Example 2: Failure to Initiate Condition Report

The Supervisor initiated CR 95-0833 on August 18, 1995.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

River Bend Nuclear Procedure RBNP-030, "Initiation and Processing of Condition Reports," includes guidelines for identification of conditions to be reported. These guidelines state, in part, "Performance of activities on the wrong equipment (e.g., wrong unit or train)" should be identified on a CR. These guidelines will be changed to remove the ambiguity in the CR initiation guidelines at the next revision. The revised wording will be "Performance of activities on the wrong equipment." With the examples removed, this guideline will not be construed as applicable only to work which impacts multiple divisions or trains. In addition, training will be conducted to convey management expectations with respect to the initiation of a CR as a result of performance of activities on the wrong equipment.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Supervisor identified the error immediately and stopped work. He then directed work to the correct valve. Full compliance was achieved upon completion of post maintenance testing of the diesel and subsequent initiation of CR 95-0833 on August 18, 1995. The additional actions described above will further assure compliance in the future.