Entergy Operations

Entergy Operations, Inc.
P.O. Box B
Killona, LA 70066
Tel 504-464-3120

D. R. Keuter
General Manager
Plant Operations
Waterford 3

W3F1-95-0155
A4.05
PR

October 5, 1995

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
Reporting of Licensee Event Report

Gentlemen:

Attached is Licensee Event Report Number LER-95-004-00 for Waterford Steam Electric Station Unit 3. This Licensee Event Report is submitted in accordance with 10CFR50.73(a)(2)(i) and 10CFR50.36(c)(2).

Very truly yours,

D.R. Keuter
General Manager
Plant Operations

DRK/DFL/tjs
Attachment

cc: L.J. Callan, NRC Region IV
C.P. Patel, NRC-NRR
G.L. Florreich
J.T. Wheelock - INPO Records Center
R.B. McGehee
N.S. Reynolds
NRC Resident Inspectors Office
Administrator - LRPD

IE22
1/1

NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Waterford Steam Electric Station Unit 3	05000 382	1 OF 8

TITLE (4)

Noncompliance With T.S. Surveillance Requirements Due to An Inadequate Procedure

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
09	07	95	95	004	00	10	05	95	N/A	05000
									FACILITY NAME: N/A	DOCKET NUMBER: 05000

OPERATING MODE (9)	1
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(2)(v)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)
	20.2203(a)(1)		20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
	20.2203(a)(2)(ii)		20.2203(a)(4)	50.73(a)(2)(iv)	OTHER
	20.2203(a)(2)(iii)		50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iv)	X	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
D.W. Vinci, Licensing Manager	(504) 739-6370

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 7, 1995, Waterford 3 operations personnel discovered the failure to perform Technical Specification (TS) Surveillance Requirement 4.3.3.6 for a number of Regulatory Guide (RG) 1.97 containment isolation valve position indicators. This surveillance requirement demonstrates the operability of various post accident monitoring instrument channels. Upon identification, TS 3.3.3.6 Action was immediately entered and the checks on the identified valves were performed satisfactorily. The most probable root cause was inadequate communication and technical verification resulting in an inadequate procedure. Corrective actions include a procedure revision to comply with TS 4.3.3.6 as well as a complete review of TS compliance for RG 1.97 instruments. Timeliness of corrective actions will also be addressed from a generic standpoint. This event did not compromise the health and safety of the public.

REQUIRED NUMBER OF DIGITS/CHARACTERS FOR EACH BLOCK

BLOCK NUMBER	NUMBER OF DIGITS/CHARACTERS	TITLE
1	UP TO 46	FACILITY NAME
2	8 TOTAL 3 IN ADDITION TO 05000	DOCKET NUMBER
3	VARIES	PAGE NUMBER
4	UP TO 76	TITLE
5	6 TOTAL 2 PER BLOCK	EVENT DATE
6	7 TOTAL 2 FOR YEAR 3 FOR SEQUENTIAL NUMBER 2 FOR REVISION NUMBER	LER NUMBER
7	6 TOTAL 2 PER BLOCK	REPORT DATE
8	UP TO 18 -- FACILITY NAME 8 TOTAL -- DOCKET NUMBER 3 IN ADDITION TO 05000	OTHER FACILITIES INVOLVED
9	1	OPERATING MODE
10	3	POWER LEVEL
11	1 CHECK BOX THAT APPLIES	REQUIREMENTS OF 10 CFR
12	UP TO 50 FOR NAME 14 FOR TELEPHONE	LICENSEE CONTACT
13	CAUSE VARIES 2 FOR SYSTEM 4 FOR COMPONENT 4 FOR MANUFACTURER NPRDS VARIES	EACH COMPONENT FAILURE
14	1 CHECK BOX THAT APPLIES	SUPPLEMENTAL REPORT EXPECTED
15	6 TOTAL 2 PER BLOCK	EXPECTED SUBMISSION DATE

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Waterford Steam Electric Station Unit 3	05000 382	95	-- 004	-- 00	2 OF 8

TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

REPORTABLE OCCURRENCE

This event constitutes a failure to meet the operability requirements of Technical Specification (TS) 3.3.3.6. This event is reportable as an operation prohibited by Technical Specifications pursuant to 10CFR50.73(a)(2)(i)(B) and 10CFR50.36(c)(2).

INITIAL CONDITIONS

At the time this condition was identified, Waterford 3 was operating at approximately 100 percent power in Operational Mode 1 (Power Operation). No procedures were being performed specific to this event nor was any major equipment out of service specific to this event.

EVENT DESCRIPTION

On October 17, 1983, Waterford 3 surveillance procedure OP-903-013, "Monthly Channel Checks," was revised (Revision 1) to include accident monitoring instrumentation channel checks. The purpose of the checks is to satisfy TS surveillance requirement 4.3.3.6 which requires a monthly check of specified accident monitoring instrumentation (EIIS identifier IP), including RG 1.97 category 1 containment isolation valve position indications (EIIS identifier IP-ISV-ZI). A component-specific list of the required indications, however, is not listed in the TS. Per this revision to OP-903-013, a list of containment isolation valves (EIIS identifier JM-ISV) was included to satisfy this portion of the checks. The list, however, failed to include all category 1 containment isolation valves as required to meet TS requirements. Hence, OP-903-013 would fail to ensure the operability requirements of TS 3.3.3.6 were met.

Previous to OP-903-013 Rev.1, on July 6, 1983, Waterford 3 submitted to the NRC a report describing implementation of Regulatory Guide (RG) 1.97 Revision 2. This report included a list of Waterford 3 instrumentation required to meet the requirements of RG 1.97, including category 1 containment isolation valve position indications. The list did not specifically list each position indicator but made a general reference to include all. Subsequent to this submittal, on August 3, 1983, Waterford 3 submitted to the NRC, per their request, a list of all category 1 and 2 post accident monitoring equipment installed or expected to be installed prior to plant operation. This list included an attachment which listed category 1 containment isolation valve position indicators by component.

On February 28, 1991, Waterford 3 submitted to the NRC implementation of RG 1.97 Revision 3. This submittal, unlike the Rev. 2 submittal, listed all category 1 containment isolation valve position indicators by component. This list was generated by ABB Impell Corporation and provided to Waterford 3 under contract for submittal to the NRC. The entire list of RG 1.97 Revision 3 accident monitoring instrumentation was then incorporated into the Waterford 3 Final Safety Analysis Report (FSAR) as Table 7.5-3. This change to the FSAR received a 10CFR50.59 safety evaluation as well as a Licensing Document Change Request (LDCR) which was distributed for a cross-departmental review. However, the pre-existing inadequacies of OP-903-013 were not identified during these reviews.

On December 5, 1993, a condition report (CR-93-0294) was written to document that two category 1 containment isolation valves, Containment Atmospheric Purge (CAP; EIIS identifier BK) valves CAP-102 and CAP-205, were not being tested for position indication per OP-903-013. The response to this CR concluded that the two CAP valves are not containment isolation valves and should not have been included in the RG 1.97 Rev.3 submittal. One of the corrective actions generated per this CR to address generic

concerns was to revise OP-903-013 to include a complete review of the RG 1.97 Rev.3 submittal for the isolation valves. This action was identified by the Design Engineering I&C group without an estimated completion date. On July 14, 1994, Quality Assurance (QA) performed a Corrective Action Evaluation of CR-93-0294 which inadvertently omitted this outstanding action. Design Engineering was aware that the action remained open for completion and requested Operations department support on the item. However, neither Design Engineering nor QA ensured the actions were formally reassigned to Operations for subsequent action.

On May 3, 1995, QA assigned action to Operations to review and update OP-903-013 for containment isolation valves in order to close CR-93-0294. On September 7, 1995, during the performance of this corrective action, it was first discovered that a number of RG 1.97 category 1 containment isolation valves were not included in OP-903-013. The valves include the following: Containment Atmospheric Purge valves CAP-103, 104, 203, and 204 (EIIS identifier BK-ISV); Containment Atmospheric Release valves CAR-200B and 202B (EIIS identifier BK-ISV); Emergency Feedwater valves EFW-223A&B, 224A&B, 228A&B, and 229A&B (EIIS identifier BA-ISV); Component Cooling Water valves CC-641, 710, and 713 (EIIS identifier CC-ISV); Main Steam valves MS-124A&B (EIIS identifier SB-ISV); Main Feedwater valves FW-184A&B (EIIS identifier SJ-ISV); Safety Injection valves SI-602A&B (EIIS identifier BQ-ISV); and Secondary Sampling valves SSL-301A&B (EIIS identifier KN-ISV).

A condition report (CR-95-0758) was immediately generated for this discovery and brought to the control room. TS 3.3.3.6 action was entered immediately and within 15 minutes the position indications for the containment isolation valves listed in CR-95-0758 were checked to be satisfactory. It should be noted that CR-95-0758 originally identified 64 valves which appeared to be missing from OP-903-013. A subsequent review

of the RG 1.97 Rev.3 submittal indicated that only 25 (listed above) of the 64 valves are considered category 1 and are required to be in OP-903-013.

CAUSAL FACTORS

A Root Cause Analysis Team formed to investigate this condition identified the causal factors discussed below.

The most probable causes of this condition were inadequate inter-departmental communications and inadequate technical verification during the inclusion of containment isolation valve position indications into OP-903-013, Rev.1. Due to the lack of documentation, it is unclear as to where the original list of valves which was included in OP-903-013 was obtained. It is speculated that the author of OP-903-013, Rev.1 was provided with an incomplete list which was not adequately verified. The development or major revision to a procedure that implements TS surveillance requirements such as this should receive input from the various subject matter experts. The August, 1983 submittal of category 1 and 2 components indicates that the requirements of RG 1.97 were understood by the offsite engineering support group. This understanding, however, does not appear to have been communicated to the Waterford 3 Operations department. Hence, the list of containment isolation valves included in OP-903-013 for position identification checks was incomplete and resulted in a failure to meet TS 3.3.3.6 requirements.

An opportunity to identify the inadequacies of OP-903-013 was missed during the RG 1.97 Rev.3 submittal and FSAR update in 1991. Since the change involved the addition of a component list to the FSAR and not a physical change in the plant, it was concluded that no operating procedures would be affected. The FSAR change did not have a direct affect on OP-903-013 (the scope of category 1 valves did not increase), however, it did provide an

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Waterford Steam Electric Station Unit 3	05000 382	95	-- 004	-- 00	6 OF 8

TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

opportunity to verify correct implementation of TS with regard to the change. After reviewing the depth, scope, and purpose of this potential opportunity, it can be concluded that no corrective actions related to the reviews are necessary.

Another opportunity to identify the deficient OP-903-013 occurred with the assignment of corrective action from CR-93-0294. Although the implementation of this action eventually led to the discovery of the condition, it is considered to have been untimely. Several causes have been identified as contributing to this untimeliness. First, as mentioned earlier, there was no initial due date established to revise OP-903-013 to include a review of the RG 1.97 submittal. Secondly, the tracking of this action by QA is considered to have been lacking. This is partially due to QA focusing on the acceptance of the CAP valve evaluation (which was the original scope of the CR) and a low urgency disposition resulting from the evaluation (the CAP valves were not needed for TS compliance). Thirdly, there was inadequate communications from the Design Engineering and QA departments to the Operations department regarding corrective action responsibility. An unclear scope of the action (level of procedure review necessary) to be performed is considered to have contributed to these inadequate communications.

IMMEDIATE CORRECTIVE MEASURES

Upon discovery of this condition, a condition report (CR-95-0758) was immediately generated and brought to the control room. TS 3.3.3.6 action was entered immediately and within 15 minutes the position indications for the containment isolation valves listed in CR-95-0758 were checked to be satisfactory.

ACTIONS TO PREVENT RECURRENCE

Procedure OP-903-013 will be revised to include the missing valves identified. A note has been added to the next scheduled Work Authorization Task which implements OP-903-013, to hold until the valves have been added.

Design Engineering and Operations, with the support of Licensing, will perform a complete review of the Waterford 3 Technical Specifications for compliance with regard to RG 1.97 instrumentation.

Design Engineering will perform a re-verification of the RG 1.97 Rev.3 submittal for the selection of category 1 containment isolation valves to ensure its correctness.

With regard to the root cause of inadequate communication and technical verification during revision 1 to OP-903-013, no corrective actions are considered necessary. The existing controls of Waterford 3 procedure changes should preclude this type of event from occurring. Operations Dept. Procedure OI-019-000, "Operations Procedure Administrative Group," has since been developed and recently revised to improve the review process of operating procedures. This procedure emphasizes multiple reviews for Operations procedure changes and, due to recent review process improvements, has been successful in identifying procedure inadequacies.

With regard to the untimely corrective action associated with CR-93-0294, a condition report (CR-95-0750) has recently been issued to address the timeliness of corrective actions from a generic standpoint. This event has been included in the scope of this generic CR for review. It should also be noted that procedure UNT-006-011, "Condition Report," was recently revised to clarify the requirement for the originator of the corrective action plan to ensure responsible groups are cognizant of their assigned actions and due dates.

SAFETY SIGNIFICANCE

This event did not compromise the health and safety of the public. The purpose of TS surveillance 4.3.3.6 is to ensure the operability of certain instrumentation required following an accident as recommended in RG 1.97. When this condition was discovered, the operability of the subject containment isolation valve position indicators was verified to be satisfactory. In addition, the ability of the subject containment isolation valves to perform their safety function is not affected by the operability of the respective position indicators.

SIMILAR EVENTS

A review of LERs dating back to 1992 revealed four LERs that document failures to perform TS required surveillances due to surveillance procedures not fully implementing TS surveillance requirements: LERs 92-004, 94-003, 94-005 and 94-012. None of these LERs involved surveillances associated with RG 1.97 accident monitoring instrumentation.