



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

September 23, 1996

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
M/S P1-37
Washington, DC 20555-0001

Subject: Reply to a Notices of Violation 50-458/96-13
River Bend Station - Unit I
License No. NPF-47
Docket No. 50-458

File Nos.: G9.5, G15.4.1

RBG-43252
RBF1-96-0357

Gentlemen:

Pursuant to the provisions of 10CFR2.201, attached is the Entergy Operations Inc. response to the notice of violations described in NRC Inspection Report (IR) 96-13. The subject violations address a problem with the implementation of an Inservice Testing Program (IST) procedure and an instance where a high radiation area was not posted as required.

The IST issue that is the subject of this violation is one of several issues identified that involve various aspects of the IST program. A comprehensive evaluation of these issues has been conducted by RBS management. An action plan has also been issued to facilitate rapid improvements within the program. Some of the enhancements and program adjustments identified by this action plan are as follows:

9609270204 960923
PDR ADOCK 05000458
Q PDR

IE 01/1

Reply to Notices of Violation 50-458/96-13

September 23, 1996

RBG-43252

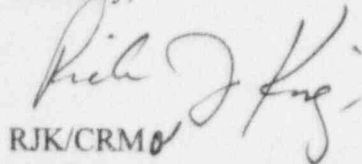
RBF1-96-0357

Page 2 of 2

- More experienced engineers and operators assigned to IST
- IST Test Director present in field during testing
- Hands-on gauge installation training
- Pre-test and post-test briefings
- Procedure review to ensure appropriate level of detail
- IST procedure validation not performed by an IST expert
- Note added to pump test procedures to allow stoppage for troubleshooting
- Engineering Programs to perform a one-time validation of pump test procedures by observing successful performance
- Increased management observations in the area of IST

Should you have any questions regarding the attached information, please contact Mr. David Lorring of my staff at (504) 381-4157.

Sincerely,



RJK/CRMO
attachments

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

ATTACHMENT A

REPLY TO NOTICE OF VIOLATION 50-458/9613-01

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 8.b.(2)(j) states, in part, that specific procedures for emergency core cooling system tests are applicable. Step 7.10.3 of Surveillance Test Procedure STP-204-6304, "Division II RHR Quarterly Valve Operability Test," Revision 10, stated, "Connect a 0-100 psig test gauge to the air actuator pressure regulator for 1E12*AOVFO98."

Contrary to the above, on July 29, 1996, Procedure STP-204-6304 was not properly implemented in that an operator disconnected air tubing between the air actuator and the solenoid air control valve in preparation for connecting a test gauge, instead of connecting the test gauge to the air actuator pressure regulator for Valve 1E12*AOVFO98.

Reasons for the Violation:

The reason for this violation was misinterpretation of procedural guidance. During the performance of a quarterly valve operability test, the operators were unsure of where to install a pressure gauge due in part, to their knowledge level of the test, and the level of detail provided in the procedure for the installation of the test gauge. Instead of stopping work, the operators made an assumption concerning gauge placement and disconnected an air line down stream of the regulator in preparation for installing the test rig when it arrived at the test location. The actual test connection was the pressure port on the regulator itself. The operators did not involve the IST Coordinator, the Operations Shift Superintendent (OSS) or the Control Room Supervisor (CRS). Station procedures are clear that the OSS/CRS are to be consulted if there are questions concerning the performance of surveillance procedures.

Corrective Actions That Have Been Taken:

The operator was instructed to reconnect the air supply line and connect the pressure gauge to the pressure regulator. Retest requirements, due to this air supply line being disconnected, were verified. Once the air supply line was reconnected and the gauge properly installed, the test was completed satisfactorily including a leak test of the air supply line with the line pressurized.

Operations department personnel have been instructed to notify the OSS / CRS when they have questions concerning the performance of surveillance tests. The operators performing the procedure were counseled on the importance of the OSS/CRS's role in the interpretation of procedural steps.

Corrective Actions That Will Be Taken to Avoid Further Violations:

Further management level accountability sessions will be held for the operators involved with this event. This action will be completed by September 24, 1996.

The procedure step in question states that the gauge was to be installed at the pressure regulator. The procedure did not specify where on the pressure regulator to install the gauge or that an existing gauge had to be removed to allow installation. This is the only inservice test that uses the pressure sensing port on a pressure regulator as a test connection. The procedure step will be clarified prior to the next performance of the test.

Date When Full Compliance Will Be Achieved:

Full compliance was achieved on July 29, 1996, when the air supply line was connected and the test was completed satisfactorily.

ATTACHMENT B

REPLY TO A NOTICE OF VIOLATION 50-458/9613-02

Violation:

Technical Specification 5.7.1 states, in part, that each high radiation area in which the intensity of radiation is greater than 100 mR/hr but less than 1000 mR/hr shall be barricaded and conspicuously posted as a high radiation area.

Section 6.3 of Radiation Protection Procedure RPP-0005, "Posting of Radiological Controlled Areas," Revision 10, required, in part, that areas accessible to individuals in which radiation levels could result in an individual receiving a deep dose equivalent in excess of 100 mR in 1 hour at 12 inches shall be conspicuously posted as a high radiation area, shall have radiological barriers and boundaries established, and shall have a sign posted resembling a stop sign that states, "TECH SPEC MONITORING REQUIRED BEYOND THIS POINT."

Contrary to the above, on May 21, 1996, an area in which radiation levels exceeded 100 mR/hr was not posted as a high radiation area in that a filter assembly was loaded on a flat bed trailer in the radwaste building truck bay, allowing personnel access, to a high radiation area that was not posted and barricaded until May 27.

Reasons for the Violation:

The reason for this violation was that the Radiation Protection technician did not follow basic radiation protection work practices for surveying and posting high radiation areas. Initial survey information obtained on the empty flatbed truck by a Radiation Protection technician did not reveal a high radiation area. The technician did not climb up on the filter after it was loaded on the flatbed truck and conduct a survey. He estimated that the workers would not be exposed to a radiation field of 100 mrem/hr or greater based on his initial survey.

The technician did not discover the high radiation area while the workers were on the filter assembly disconnecting the rigging from the crane. The high radiation area was found by a different Radiation Protection technician on May 27, 1996. It was then realized that the workers that disconnected the rigging most likely had their heads in a high radiation area for a short period of time.

Corrective Actions That Have Been Taken:

Upon discovery, RP personnel posted the truck bay as a "high radiation area." The condition report response and related issues were discussed with RP personnel during an RP department information meeting on June 18, 1996. A dose assessment was performed for the workers exposed during the incident (highest dose for this event was estimated to be 50 mR). The RP technician was counseled on expectations and the actions he should have taken. A talking paper was developed for RP supervisors / foremen to use in reinforcing posting requirements and expectations. An employee newsletter was issued, discussing posting requirements and expectations. Continuing training is scheduled for RP personnel on observation techniques and the detrimental impacts of complacency during job performance.

The expectations for posting equipment in the truck bay located adjacent to the resin liner shield wall were reiterated to the RP technicians. The importance of implementing this policy was also stressed.

Corrective Actions That Will Be Taken to Avoid Further Violations:

Corrective actions associated with this violation have been completed.

Date When Full Compliance Will Be Achieved:

Full compliance was achieved when the truck bay area was properly surveyed and posted.