ENTERGY

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A4.05
QA

December 4, 1992

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
NRC Inspection Report 92-23
Reply to Notice of Violation

Gentlemen:

In accordance with 10CFR2.201, Entergy Operations, Inc. hereby submits in Attachment 1 the response to the violations identified in Appendix A of the subject Inspection Report.

In addition, your inspection report expressed concern over Violation 9223-03 in view of a similar violation identified in July, 1992. Although Entergy Operations, Inc. believes that the root causes of these two violations are unrelated, we share your concern. As a result, we have implemented or plan to implement corrective actions to increase worker's awareness of the importance of maintaining radiological postings. Furthermore, we have formed a Quality Action Team (QAT) to improve radiological posting processes.

If you have any questions concerning this response, please contact C.J. Thomas at (504) 739-6531.

Very truly yours,

R.F. Burski

RFB/CJT/ssf
Attachment
cc: J.L. Milhoan (NRC Region IV), D.L. Wigginton (NRC-NRR), R.B. McGehee, N.S. Reynolds, NRC Resident Inspectors Office

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ATTACHMENT 1

ENTERGY OPERATIONS, INC. RESPONSE TO THE VIOLATIONS IDENTIFIED IN APPENDIX A OF INSPECTION REPORT 92-23

VIOLATION NO. 9223-01

Technical Specification 6.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Section 1 of Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, requires safety-related activities to be covered by written procedures, which include erecting scaffolds in the proximity of safety-related equipment.

Attachment 9.1 of Nuclear Operations Construction Procedure NOCP-207, Revision 4, "Erecting Scaffold," requires an engineering evaluation to be performed if a scaffold is built over equipment, valves, or piping or if installed within 1 inch of adjacent equipment.

Contrary to the above, on September 16, 1992, the inspectors found Scaffold No. 12551 installed directly over, and within 1/16 inch of, the safety-related motor operator for safety injection flow control Valve SI-226A. An engineering evaluation was not done, calling to question the seismic qualification and, therefore, the operability of high pressure safety injection Train A.

RESPONSE

(1) Reason for the Violation

Entergy Operations, Inc. admits this violation and believes that the root cause was personnel error in completing the Scaffold Request Form (Attachment 9.1 of NOCP-207) for Scaffold No. 12551.

Two mistakes were made when completing the Scaffold Request Form (SRF) for Scaffold No. 12551. First, the Construction Foreman who supervised erection of Scaffold No. 12551 incorrectly answered NO to the question that asks if the scaffold is installed with a $\leq$ one-inch gap from adjacent equipment. Second, the Nuclear Operations Construction Supervisor (NOCS)/Designee who reviewed the SRF did not forward it to the Field Engineer for an engineering evaluation although the Construction Foreman had answered YES to the question that asks if the scaffold is installed over equipment, valves, or

piping. According to the SRF, if any answer to these questions is YES, and the scaffold is built in any room/area identified by Attachment 9.5, then the SRF must be forwarded to the Field Engineer for an engineering evaluation. Since Scaffold No. 12551 was installed directly over, and within 1/16 inch of the motor operator for Valve SI-226A, and was located in an area identified by Attachment 9.5, then a posterection engineering evaluation should have been performed.

A contributing cause of this event involves the instructions for forwarding applicable SRFs to the Field Engineer for a posterection engineering evaluation. These instructions are only provided at the bottom of the SRF and not in the body of NOCP-207. This condition may obscure the instructions and allow them to be overlooked by the NOCS/Designee.

It should be noted that this violation was identified 2 days prior to the Refuel 5 Outage. At that time, a large number of pre-outage scaffolds were being erected and only one person was designated as the NOCS/Designee responsible for reviewing all SRFs. This person failed to forward the SRF for Scaffold No. 12551 to the Field Engineer for a posterection engineering evaluation. Moreover, while implementing corrective measures for the violation, Nuclear Operations Construction (NOC) discovered that the NOCS/Designee also failed to forward additional SRFs to the Field Engineer.

(2) Corrective Steps That Have Been Taken and the Results Achieved

Scaffold No. 12551 was dismantled on September 16, 1992. This was accomplished on the same day the NRC Resident Inspector communicated the event to NOC. On September 18, 1992, NOC completed training appropriate scaffold personnel on this event and on those requirements in NOCP-207 that relate to completing the SRF.

Additionally, NOC performed a review of approximately 600 scaffold records on file. This review revealed that 101 scaffolds were erected with only pre-erection evaluations even though their completed SRFs indicated that posterection evaluations were required. As a result, NOC walked down and performed a posterection evaluation on the scaffolds to ascertain if they were installed per NOCP-207. The walkdowns revealed that 2 of the 101 scaffolds did not meet procedure requirements. These scaffolds were promptly reconfigured. The remaining scaffolds were verified to be installed per NOCP-207. These actions were completed by September 30, 1992.

(3) Corrective Steps Which Will Be Taken to Avoid Further Violations

The body of NOCP-207 will be revised to incorporate instructions for forwarding applicable SRFs to Field Engineering for posterection engineering evaluations. Furthermore, the SRF will be human factored to provide additional assurance that these instructions are not overlooked.

(4) Date When Full Compliance Will Be Achieved

Full compliance will be achieved by March 31, 1993.

VIOLATION NO. 9223-02

Technical Specification 6.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Section 1.1 of Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, requires that the Plant Fire Protection Program be covered by written procedures.

Section 6.4 of Fire Protection Procedure FP-001-017, Revision 8, "Transient Combustibles and Designated Storage Areas," requires, in part, that the packing materials from equipment or supplies unpacked in a safety-related area be removed from the safety-related area immediately following the unpacking and that untreated combustible packing materials not be left unattended during lunch breaks, shift changes, or similar periods.

Contrary to the above, on October 6, 1992, the inspector found untreated wood pallets and cardboard boxes, used to pack the new batteries, in the space outside the AB switchgear cage where the battery rooms are located. The inspector noted that there was no one around to watch the material and that the material appeared to be staged for removal. When the inspector returned to the area the next morning, 14 hours later, the combustible materials were still staged and, again, the material was unattended.

RESPONSE

(1) Reason for the Violation

Entergy Operations, Inc. admits this violation and believes that the root cause was inappropriate action in that personnel involved with Design Change (DC) 3362 failed to recognize and adhere to the requirements of FP-001-017.

DC 3362, "Station Battery Replacement," was implemented during the Refuel 5 Outage to replace Station Battery 3AB-S with a new battery of a similar type and capacity and to upgrade Station Batteries 3A-S and 3B-S. Implementation of this DC required that several plant departments identify and adhere to those requirements applicable to their assigned tasks. However, this was not done.

(2) Corrective Steps That Have Been Taken and the Results Achieved

On October 7, 1992, the untreated wooden pallets and cardboard boxes were removed from the area outside the AB switchgear cage. Subsequent to removing these combustible materials, work controls were established to ensure continued compliance with the requirements of FP-001-017. On October 15, 1992, a Transient Combustibles Permit was generated and a continuous fire watch was assigned to keep watch over the combustibles brought into the area to facilitate installation of the new 3B-S Battery.

On October 16, 1992, Quality Notice QA-92-120 was generated to document this condition adverse to quality. Furthermore, the Maintenance Superintendent discussed the need for timely initiation of corrective action documents with his direct reports during a staff meeting on November 17, 1992.

(3) Corrective Steps Which Will Be Taken to Avoid Further Violations

Four specific actions are planned to prevent recurrence. First, this event will be discussed with Maintenance and Modification & Construction personnel during group meetings to ensure that similar conditions are promptly recognized and appropriate actions taken. Second, this event will be discussed during site wide safety meetings to accentuate lessons learned. Third, FP-001-017 will be reviewed to provide additional assurance that the procedure contains sufficient guidance to ensure that fire protection requirements are clearly defined. Finally, Quality Notice QA-92-120 will be distributed to selected management personnel to remind them of the need to initiate corrective action documentation when the situation is appropriate or as circumstances dictate.

(4) Date When Full Compliance Will Be Achieved

Full compliance will be achieved by February 26, 1993.

VIOLATION NO. 9223-03

Technical Specification 6.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Section 7.e.(4) of Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, requires that radiation protection procedures be established for contamination control.

Section 5.3.2 of Administrative Procedure HP-001-219, "Radiological Posting Requirements," requires that each radiation area be posted with a sign or signs bearing the radiation symbol and the words: CAUTION RADIATION AREA.

Contrary to the above:

1. On October 6, 1992, the inspector determined that the boundary chain for a radiation controlled area posting for the Post Accident Sampling Point Skid on the +21-foot level of the reactor auxiliary building was down and, therefore, did not clearly demarcate the radiation controlled area.

2. On October 8, 1992, the inspector determined that a radiation area posting on the -35-foot level in the northwest corner of the fuel handling building was not properly posted in that the area could be entered or material removed without seeing the posting.

RESPONSE

(1) Reason for the Violation

Entergy Operations, Inc. admits this violation.

On November 13, 1992, a Quality Action Team (QAT) was formed to respond to this violation and to improve radiological posting processes. The team, comprised of employees who are directly involved with radiological posting processes, determined that the root causes of the two conditions cited are not related.

The QAT determined that the root cause of the first condition (e.g., downed radiation controlled area boundary chain) is an inadequate procedure in that UNT-005-022, "RCA Access Control," does not provide instructions to radiation workers relative to maintaining radiological boundaries.

For the second condition (improper posting), the QAT determined that the root cause was a non-conservative assumption when posting the area. It was assumed that the area shelving could function as a physical boundary adequate to prevent inadvertent entry into this radiation area/hot particle storage area. This is understandable considering that it is unlikely that workers would try to crawl through the shelving to gain access into the area.

(2) Corrective Steps that Have Been Taken and the Results Achieved

The NRC Resident Inspector restored the boundary chain for the radiation controlled area posting for the Post Accident Sampling System Skid. Additionally, on November 12 and 17, 1992, Health Physics technicians walked down other areas of the plant to identify similar problems with radiological boundaries. During the walkdowns on November 12, 1992, two compromised boundaries (e.g., radiological ropes on the floor) were identified in the Fuel Handling Building. These boundaries were immediately restored. No other instances of downed boundaries were identified. Furthermore, this event was discussed at the November Safety Meetings and a memorandum was issued from the Plant Manager to plant workers to increase worker's awareness of the importance of maintaining radiological boundaries.

The radiation area posting on the -35-foot level in the northwest corner of the fuel handling building was properly posted to prevent inadvertent entry. A radiological rope was extended across the open area of shelving with a radiological posting describing the area.

(3) Corrective Steps Which Will Be Taken to Avoid Further Violations

Four specific actions are planned to prevent recurrence. First, "NP 005-022 will be revised to provide instructions to radiation workers relative to maintaining radiological boundaries/postings. Next, General Employee Training will be revised to provide additional information on the importance of maintaining radiological boundaries/postings. Third, this event will be discussed with the staff Health Physics technicians during the December departmental meeting. Finally, Health Physics will revise HP-001-219 to include additional guidance on what constitutes appropriate posting.

(4) Date When Full Compliance Will Be Achieved

Full compliance will be achieved by March 31, 1993.