



**Entergy  
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**D. F. Packer**  
General Manager  
Plant Operations  
Waterford 3

W3F1-93-0107  
A4.05  
QA

January 15, 1993

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-92-017-00 for Waterford Steam Electric Station Unit 3. This Licensee Event Report is submitted in accordance with 10CFR50.73(a)(2)(i)(B).

Very truly yours,

D.F. Packer  
General Manager - Plant Operations

DFP/TWG/ssf  
Attachment

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

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# LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNB 7714, U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545-0001), AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Waterford Steam Electric Station Unit 3

DOCKET NUMBER (2)

05000 382

PAGE (3)

1 OF 6

TITLE (4)

Failure To Track Repair Causes Tech Spec Action Requirement Time Limit To Be Exceeded

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
12	17	92	92	017	00	01	15	93	N/A	05000
									FACILITY NAME	DOCKET NUMBER
									N/A	05000
									FACILITY NAME	DOCKET NUMBER
									N/A	05000

  

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more) (11)								
POWER LEVEL (10)	100	20.402(b)			20.405(c)			50.73(a)(2)(iv)		73.71(b)
		20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)		73.71(c)
		20.405(a)(1)(ii)			50.36(c)(2)			50.73(a)(2)(vii)		OTHER
		20.405(a)(1)(iii)			X 50.73(a)(2)(i)			50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iv)			50.73(a)(2)(ii)			50.73(a)(2)(viii)(B)		
20.405(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(x)				

LICENSEE CONTACT FOR THIS LER (12)

NAME

D.W. Vinci, Operations Superintendent

TELEPHONE NUMBER (include Area Code)

(504) 464-3178

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS

SUPPLEMENTAL REPORT EXPECTED (14)

\*ES (if yes, complete EXPECTED SUBMISSION DATE)

X NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

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

Waterford 3 was at 100% power when work commenced to adjust the packing on a normally closed containment isolation valve. Technical Specifications (TS) required the valve to be returned to operable status or the affected penetration isolated within 4 hours. However, the allowed outage time expired with the valve still not operable. No other compensatory action was taken.

The root cause of this event is inappropriate action by the Control Room Supervisor because he failed to utilize available administrative controls to ensure that the maintenance complied with TS requirements. As a result, the valve maintenance was not effectively tracked and the non-compliance with TS's was not recognized. Corrective action will include training for both Operations and Maintenance personnel.

Since PSL-204 was later tested satisfactorily, the valve would have performed its required function; therefore, this event did not threaten the health or safety of the public or plant personnel. A similar event is described in LER 91-015.

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

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNSB 7714), 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.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Waterford Steam Electric Station Unit 3	05000 382	92	017	00	2 OF 6

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

**REPORTABLE OCCURRENCE**

On December 15, 1992, Waterford 3 was operating at 100% power. At 1300, work commenced to tighten the packing on Pressurizer Surge Line Sample Outside Containment Isolation Valve PSL-204. As a containment isolation valve, PSL-204 is governed by Technical Specification (TS) 3/4.6.3. "Containment Isolation Valves." TS 3.6.3 requires that inoperable containment isolation valves be returned to service or the affected penetration isolated within four hours. TS 3.6.3 further requires that a stroke time test be performed on affected valves before the valves are returned to service.

The PSL-204 packing adjustment was completed in four hours. However, the required stroke time test was not performed within that time nor was any other compensatory measure allowed by TS 3.6.3 taken. Therefore, Waterford 3 operated with an inoperable containment isolation valve and without taking compensatory measures for a period of time longer than allowed by Technical Specifications. Operation prohibited by Technical Specifications is reportable as an LER in accordance with 10CFR50.73(a)(2)(i)(B).

**INITIAL CONDITIONS**

Plant Power:	100%
Mode:	1
Procedures Being Performed Specific to this Event:	None
Technical Specification LCO's in Effect Specific to this Event:	None
Major Equipment Out of Service Specific to this Event:	None

LICENSEE EVENT REPORT (LER)  
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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (8)			PAGE (3)
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Waterford Steam Electric Station Unit 3	05000 382	92	017	00	3 OF 6

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

**EVENT SEQUENCE**

On December 15, 1992 the Waterford 3 Control Room Supervisor (CRS) gave mechanical maintenance personnel permission to commence Work Authorization (WA) 01104103 to adjust the packing on PSL-204. Work commenced, however, PSL-204 was not entered in the "Equipment Out of Service" (EOS) log as required by Administrative Procedure OP-100-010, "Equipment Out of Service." OP-100-010 provides guidance for the documentation of the removal from and restoration to service of Quality/Safety-Related equipment. OP-100-010 specifically states that whenever packing is adjusted on ASME Section XI valves, a Quality/Safety-Related EOS Checklist should be completed before removal of a component from service when possible or as soon as possible thereafter. Since PSL-204 is an ASME Section XI component, the CRS should have ensured that the valve was entered in the EOS log.

Because PSL-204 was not entered in the EOS log, it was not entered in the station log as inoperable, the TS 3.6.3. Limiting Condition for Operation was not entered, and the Control Room staff (other than the Control Room Supervisor) was not aware of the status of PSL-204. As a result, the progress of the work on PSL-204 was not being tracked to ensure continued compliance with Technical Specification requirements.

The PSL-204 packing adjustment was completed in four hours. However, the required stroke time test was not performed within that time nor was any other compensatory measure allowed by TS 3.6.3 taken. As a result, Waterford 3 was operating in a condition prohibited by Technical Specifications beginning at 1700 on December 15, 1992.

The discrepancy with the PSL-204 repair was noted during a review of the work package on December 17, 1992. A stroke time test was performed immediately in accordance with OP-903-032, "Quarterly IST Valve Tests," and PSL-204 was declared

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

operable, thus restoring compliance with Technical Specification requirements.

### CAUSAL FACTORS

The root cause of this event is inappropriate action by the Control Room Supervisor because he failed to utilize available administrative controls to ensure that the maintenance complied with TS requirements. Specifically, the CRS did not ensure that PSL-204 was entered in the EOS log when the valve was removed from service for the packing adjustment. Because PSL-204 was not entered in the EOS log, it was also not entered in the station log as inoperable, the TS 3.6.3. Limiting Condition for Operation was not entered, and the Control Room staff was not aware of the status of PSL-204. As a result, the progress of the work on PSL-204 was not being tracked to ensure continued compliance with Technical Specification requirements. If this valve would have been entered in the EOS log, the shift would have been more able to track time constraints associated with placing the valve out of service.

### IMMEDIATE CORRECTIVE MEASURES

A stroke time test in accordance with OP-903-032 was satisfactorily completed and PSL-204 was declared operable on December 17, 1992.

Secondly, the Control Room Supervisor involved with this event has been debriefed in accordance with the Improving Human Performance (IHP) Program.

### ACTIONS TO PREVENT RECURRENCE

This event will be added to the Operations Department required reading program. Also, a discussion of this event and the administrative requirements associated with maintenance on Technical Specification components will be added to the operators' requalification program.

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

Second, the Operations Department will conduct seminars on this event with Maintenance Department personnel. While not responsible for this event, a discussion of the sensitivity involved in performing maintenance on Technical Specification components is expected to improve communication between Operations and Maintenance personnel in this important area.

Corrective action associated with this event will be completed by May 5, 1993.

**SAFETY SIGNIFICANCE**

This event posed no risk to the health and safety of the public. The Pressurizer Surge Line Sample Inside Containment Isolation Valve PSL-203 could have isolated the containment penetration had that been necessary. Also, since PSL-204 was later tested satisfactorily, the valve would have performed its required function; therefore, this event posed no risk to the health or safety of either the public or plant personnel.

**SIMILAR EVENTS**

LER 91-015 is a recent example of an event in which Technical Specification requirements were not satisfied because of a failure to comply the requirements of OP-100-010, "Equipment Out of Service." As in the event described above,

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required stroke testing of a containment isolation valve was not performed as required by Technical Specifications after work was performed on the valve packing. Similarly, the root causes of the two events were the same: in both cases the Control Room Supervisor did not initiate an Equipment Out of Service checklist to assist him in identifying constraints on the maintenance. Corrective action for the earlier event included a debrief of the responsible Control Room Supervisor and adding the event to the Operations Department required reading program. Although those corrective actions will also be taken for this event, the formal training described for Operations personnel is expected to address any knowledge-based deficiencies in this area.