

SEP 26 1988

In Reply Refer To:
Docket: 50-382/88-13

Louisiana Power & Light Company
ATTN: J. G. Dewease, Senior Vice President
Nuclear Operations
317 Baronne Street
New Orleans, Louisiana 70160

Gentlemen:

Thank you for your letter of August 17, 1988, in response to our letter and Notice of Violation dated July 18, 1988. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

Original Signed By:

L. J. CALLAN

L. J. Callan, Director
Division of Reactor Projects

cc:
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Louisiana Power & Light Company

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Louisiana Power & Light Company
ATTN: R. F. Burski, Acting Manager
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Louisiana Radiation Control Program Director

bcc to DMB (IE01)

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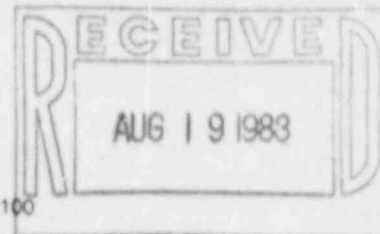
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August 17, 1988

W3P88-1270
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QA

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 88-13

In accordance with 10CFR Part 2.201, Louisiana Power & Light hereby submits in Attachment 1 the responses to the Violations identified in Appendix A of the subject Inspection Report.

If you have any questions concerning these responses, please contact L.W. Laughlin, Site Licensing Support, at (504) 464-3499.

Very truly yours,

R.F. Burski
Manager
Nuclear Safety & Regulatory Affairs

RFB:TJG:ssf

Attachment

cc: R.D. Martin, NRC Region IV
J.A. Calvo, NRC-NRR
D.L. Wigginton, NRC-NRR
NRC Resident Inspectors Office
E.L. Blake
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ATTACHMENT 1

LP&L Responses to Violations Identified in Appendix A
of Inspection Report 88-13

A. VIOLATION NO. 8813-01

Inadequate Maintenance Work Instructions

Technical Specification 6.8.1.a requires written procedures to be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33 requires procedures appropriate to the circumstances for performing maintenance on safety-related equipment.

Procedure UNT-7-005, Revision 2, "Cleanliness Control," is an approved procedure that requires cleanliness control requirements to be established when opening emergency diesel generator air systems.

Contrary to the above, on May 11, 1988, control air valves were manipulated, the starter system disconnected, and the start air system actuated using work instructions that were not appropriate in that they did not include these tasks and they did not require the implementation of cleanliness controls.

This is a Severity Level IV violation.

RESPONSE

LP&L acknowledges that this incident was a Violation of the guidelines of Regulatory Guide 1.33 in that the work instructions for replacing control air interface check valve EGA-421B were not detailed enough relative to the circumstances.

(1) Reason For The Violation

The requirements for dispositioning a condition as "Troubleshoot" when the failure mechanism or the reason for a degraded condition cannot be detected easily are provided in Plant Operations Administrative Procedure UNT-05-015, "Work Authorization Preparation and Implementation". Since specific guidance for determining where to differentiate between troubleshooting and rework is not provided in the procedure, a conscientious decision has to be made by maintenance personnel when in the field performing routine maintenance under a specific work authorization. Because troubleshooting involves a logical sequence of events which is determined by the outcome of a

previous step or action, specific troubleshooting instructions are difficult to write in the planning process. In this incident, the extent of work after valve replacement was not known or defined at the time, so a statement to troubleshoot was included on the work authorization in accordance with UNT-05-015.

The responsibilities and criteria for cleaning fluid systems and associated components are provided in Plant Administrative Procedure UNT-07-005, "Cleanliness Control". This procedure, which is based on the guidance provided in Regulatory Guide 1.37 (Quality Assurance Requirements for Cleaning of Fluid Systems and Associated Components of Water-Cooled Nuclear Power Plants) and ANSI N45.2.1-1973 (Cleaning of Fluid Systems and Associated Components for Nuclear Power Plants) is written primarily to address fluid systems. Although the diesel generator air system is listed as a Class "C" cleanliness system in the attachment of UNT-07-005, the procedure does not realistically address maintaining cleanliness in such an instrument and control system. The inspection criteria detailed in the procedure are not adequate for an instrument systems of such a small size. Therefore, maintenance personnel had the impression that the procedure did not apply, as was the case cited in this inspection.

(2) Corrective Actions That Have Been Taken

Since the occurrence of this incident, a Maintenance Directive (No. 28) entitled, "Troubleshooting" was developed to provide guidance on writing troubleshoot instructions and establishing limitations on what can and cannot be done in the field on work authorizations dispositioned as "Troubleshoot". The directive instructs Maintenance personnel to contact their supervisor for clarification if it becomes questionable as to whether or not a certain activity is allowed under troubleshoot authority. The directive also points out that troubleshooting does not allow deviation from procedural requirements and that complete and accurate documentation of all steps and actions taken as well as observations noted is imperative.

With regard to cleanliness control during maintenance on instrument and control tubing and air lines, Instrument and Control Planners have been trained and instructed to include Cleanliness Control Forms (Attachment 6.1 of UNT-07-005) into the work authorization packages whenever breaking a system boundary.

(3) Corrective Actions To Be Taken

UNT-07-005 will be revised to include responsibilities for establishing and maintaining adequate cleanliness controls when performing maintenance activities on instrument and control tubing.

Although not specifically part of the corrective actions for this violation, it is worthwhile to note that beginning in September,

1988, a pilot program entitled "Operation ZERO Deviations" will be implemented at Waterford 3 in the areas of Operations, Maintenance, Security, Health Physics and Chemistry. The intent of this program is to emphasize procedure and work instruction compliance and to instill in employees the importance of stopping work when necessary as opposed to deviating from a procedure or instruction. This program emphasizes management concern and efforts toward reducing unauthorized procedure and work instruction deficiencies.

(4) Date When Full Compliance Will Be Achieved

UNT-07-005 will be revised by September 30, 1988.

B. VIOLATION 8813-02

Failure To Implement Quality Assurance Procedures

Criterion II of Appendix B to 10 CFR Part 50 states, in part, that a quality assurance program shall be documented in procedures and carried out in accordance with those procedures.

Quality Assurance Program Procedure QAP-012, Revision 6, "Corrective Action," requires initiation of a Quality Notice when conditions adverse to quality are identified.

Contrary to the above, Quality Assurance Inspection Report 88-012, dated April 21, 1988, noted that several wires of hydrogen analyzer "A" had been landed at the wrong terminal points and accepted by quality assurance inspectors during the replacement of the hydrogen analyzer. No Quality Notice had been initiated on this condition which is adverse to quality as of June 15, 1988, when the NRC inspector reviewed the work documentation.

This is a Severity Level IV violation.

RESPONSE

LP&L acknowledges that this incident was a violation of criterion II of Appendix B to 10CFR50 in that a Quality Notice (QN) should have been issued in accordance with Quality Assurance Procedure QAP-012, "Corrective Action" since a condition adverse to quality (incorrect wire terminations that damaged equipment) existed.

(1) Reason For The Violation

Prior to April 20, 1988, terminations were made and verified by QA Inspection to the Hydrogen Analyzer Sequencer Module. On April 20, 1988, during the performance of functional testing, damage to a

transistor on a different module occurred. Upon troubleshooting, an I&C technician found wires on the Hydrogen Analyzer Sequencer Module to be incorrectly terminated. Subsequently, on April 21, 1988, the following sequence of events took place: the work instructions were revised to correctly terminate the Sequencer Module, the work was completed per the revised work instructions and Quality Assurance verified the rework and reterminations.

On April 22, 1988, the QA inspector learned from a cognizant member of the Nuclear Operations Engineering Department that a design construction package change (DCPC) was going to be issued to address the wiring error. Based on the premise that the work instruction was revised, the errors were corrected, a DCPC was to be issued and the overall concerns were documented in Inspection/Observation Report 88-012, which was dated April 21, 1988 but signed off by the inspector on April 22, 1988, the inspector believed that no further actions were warranted. Consequently, a QN was not issued by Quality Assurance.

(2) Corrective Actions That Have Been Taken

Two QNs were issued on June 17, 1988 to document the errors made during the implementation of SM 983. QN QA-88-075 was issued to Operations QA for the inspection error and QN QA-88-080 was issued to Nuclear Operations Engineering and Construction for the incorrect wiring of the hydrogen analyzers. Corrective action taken by QA has resulted in an emphasis by the Quality Inspection organization on attention to detail involving inspections.

A training session on attention to details was presented to inspectors on August 8, 1988. Inspectors were cautioned as to the importance of recognizing, reviewing and understanding the inspection requirements imposed on the work document. Inspectors were also reminded to complete all the necessary steps when performing an inspection. In addition, the use of inspection observation reports has been discontinued as a means of problem identification.

(3) Corrective Actions To Be Taken

Quality Assurance personnel will undergo Lessons Learned Training. Emphasis will be placed on the importance of paying attention to detail and utilizing the corrective action systems that are currently in place.

(4) Date When Full Compliance Will Be Achieved

Lessons Learned Training will be completed by September 30, 1988.

C. VIOLATION 8813-03

Failure To Identify And Correct Deficiencies

Criterion XVI of Appendix B to 10 CFR Part 50 states, in part, that measures shall be established to assure that conditions adverse to quality, such as deficiencies, are promptly identified and corrected, and that the causes be determined and corrective action taken to preclude repetition.

Contrary to the above, NRC inspectors identified deficiencies in safety system operating procedures and/or component identification labeling during ten inspections performed from February 1, 1986, through May 31, 1988. Again, on June 7, 1988, the NRC inspector identified procedural and component identification labeling deficiencies with the hydrogen analyzer system. Licensee management has failed to establish adequate measures to independently identify, correct, and preclude repeated deficiencies with safety system procedures and component identification labeling.

This is a Severity Level IV violation.

RESPONSE

LP&L acknowledges that this incident was a violation of Criterion XVI of 10CFR Part 50, Appendix B in that adequate corrective actions have not been taken to preclude repeated deficiencies with safety system procedures and component identification labeling.

(1) Reason For The Violation

Plant Administrative Procedure OP-100-004, "UNID/EQ Tagging of Plant Components", delineates the method for replacement of Unique Identification (UNID)/Environmentally Qualified (EQ) equipment tags and also provides the administrative requirements for installation of new UNID/EQ tags. UNID tags which are hung as part of a design change are the responsibility of the department or group that implements the change. Since there are no requirements to verify that tags are hung correctly or to use controlled drawings for ensuring proper placement of tags, inconsistencies in the hanging of UNID tags have resulted. (NOTE: The failure to implement the above requirements has resulted in the incorrect hanging of various tags on the Hydrogen Analyzer as was stipulated in this inspection report.)

Additionally, for components which are identified as not having UNID numbers, the method in place for assigning a UNID to a component, ensuring the UNID tag is hung properly and notifying the cognizant work groups of this type of situation is not sufficiently integrated to ensure the elimination of the type of problem described in the violation. The current approach for addressing these items, which involves the use of several procedures by several different groups, has proven to be unreliable. This condition coupled with the lack of a formal program to identify, correct and preclude deficiencies with safety system procedures and component identification labeling is the basis for the violation.

(2) Corrective Actions That Have Been Taken

In early 1988, the responsibility for trending was transferred from the QA department to the Event Analysis, Reporting and Response (EAR&R) organization, which reports directly to the Plant Manager. In May, 1988, using the QA Trending Program as a baseline, the EAR&R organization established the Nuclear Operations Trending Program. This program, which broadens the scope of that which was previously trended, provides a method for collecting, correlating and analyzing corrective action reports in efforts to identify potentially significant trends. The Program is utilized for the review and analysis of Licensee Event Reports (LERs), NRC Reports, Quality Notices, Nonconforming Condition Identifications, Discrepancy Notices and other reports which identify incidents or occurrences to determine apparent and/or root cause.

Plant Administrative Procedure UNT-6-014, "Root Cause Determination and Trending", was approved in August, 1988. The specific purposes of this procedure are to establish the requirements for the evaluation and investigation of an event or condition for root cause determination and to provide a method for the categorization of root causes and their trending criteria. An adverse trend will be identified for recurring deficiencies. By the use of an Adverse Trend Report, an adverse trend, which will include a summary of the deficiency, root causes and any recommendations, will be submitted to the appropriate Department Head, Group Head and Assistant Plant Manager. The Department Head, with approval by the Assistant Plant Manager, will be responsible for determining the necessary corrective actions. After completion of the corrective actions, the item will be transmitted to EAR&R for closure. Implementation of this procedure will provide a significant enhancement to the existing trending program.

(3) Corrective Actions To Be Taken

OP-100-004 is being revised to specifically address the repeated tagging concerns regarding improper installation of UNID tags. To alleviate inconsistencies that currently exist on two forms, the forms will be consolidated into one. This form, the UNID Tag Replacement Form, will be used to request, hang and verify proper placement of UNID tags. This procedure will also be revised to require an individual, when hanging or verifying a UNID tag, to refer to the primary source document for ensuring that the tag is correctly placed. A procedural requirement will be implemented to ensure that labeling and/or tagging deficiencies found during lineups will be appropriately documented so that the necessary corrective actions will be performed. To ensure that separate procedures are not utilized by various departments, a Plant procedure will be developed to cover all aspects of UNID tagging.

Additionally, to ensure completeness of lineups in safety systems, the existing Procedure Review Checklist in Administrative Procedure OP-100-013, "Writer's Guide For Operating Procedures", will be revised to require that valve/breaker lineups be verified with appropriate documentation.

Implementation of these actions coupled with the performance of ongoing detailed system walkdowns in accordance with Administrative Procedure OP-10-001, "Duties and Responsibilities of Operators on Duty", will provide assurance that the procedures for safety related systems reflect the actual plant configuration to the maximum extent possible.

The above actions will address the present violation. However, to provide additional assurance that repeated deficiencies with safety system procedures and component identification labeling are minimized, Management has set an objective, which is scheduled for completion by December 31, 1989, to have applicable system engineers perform walkdowns of the accessible portions of safety systems using design documentation.

(4) Date When Full Compliance Will Be Achieved

Procedures OP-100-004 and OP-100-013 will be revised by September 30, 1988.

Development of the new procedure for UNID tagging is scheduled for completion by December 31, 1988.