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MIDDLE SOUTH UTILITIES SYSTEM

September 24, 1986

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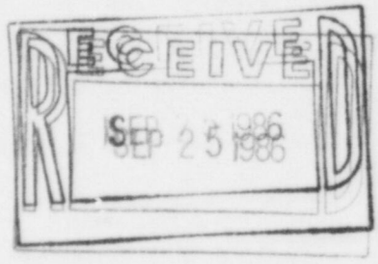

Mr. Robert D. Martin
Regional Administrator, Region IV
U.S. Nuclear Regulatory Commission
611 Ryan Plaza Drive, Suite 1000
Arlington, TX 76011

Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-38
NRC Inspection Report 86-15

Dear Mr. Martin:

Attachment A is the Louisiana Power & Light Company (LP&L) response to Violation Nos. 8615-01, 8615-02.

Per the verbal request for additional information regarding the recent Loss of Shutdown Cooling Event (PRE-86-049), Attachment B provides the LP&L bases for determining that the event did not require notification under 10CFR50.72.

If you have any questions on the responses, please contact G.E. Wuller, Onsite Licensing, at (504) 464-3499.

Very truly yours,

K.W. Cook
Nuclear Support & Licensing Manager

KWC:KLB:ssf

cc: NRC, Director, Office of I&E
G.W. Knighton, NRC-NRR
J.H. Wilson, NRC-NRR
NRC Resident Inspectors Office
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LP&L RESPONSE TO VIOLATION NOS. 8615-01 & 8615-02

VIOLATION NO. 8615-01

Technical Specification (TS) 6.8.1 requires, in part, that written procedures be established and implemented covering activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Appendix A of Regulatory Guide 1.33, Revision 2, requires written procedures be established for control of measuring and test equipment (M&TE). Administrative Procedure MD-1-015, Revision 1, was established to control M&TE. Paragraph 5.11 of MD-1-015 requires, in part, that all M&TE be delivered to the metrology lab on or before its expiration date for calibration.

Contrary to the above, Procedure MD-1-015 was not followed in that the following M&TE was found to be in the plant and available for use but was overdue for calibration:

1. MIPT 091.016, with a calibration due date of June 19, 1986, was still in the plant on July 2, 1986.

2. MEET 025.037, with a calibration due date of June 19, 1986, was still in the plant on July 3, 1986.

3. MIES 020.007, with a calibration due date of June 5, 1986, was still in the plant on July 3, 1986.

This is a Severity Level IV violation.

RESPONSE TO VIOLATION

(1) Reason for the Violation

The violation occurred as a result of inadequacies in the "Tool Control" and "Measuring and Test Equipment Control" procedures.

(2) Corrective Action That Has Been Taken

The Assistant Plant Manager, Operations and Maintenance, has issued a letter to all maintenance personnel to provide "consultation" on the matter of compliance with M&TE usage procedures. The letter also included a provision for potential disciplinary action for any employee who failed to follow the M&TE procedures.

(3) Corrective Action That Will Be Taken

A new procedure, "M&TE Accountability" is being developed. Requirements are being incorporated to enforce the return of M&TE to the issue facility when it is not in use or when its calibration has expired.

(4) Date When Full Compliance Will Be Achieved

The new procedure is expected to be approved by October 10, 1986.

VIOLATION NO. 8615-02

10 CFR Parts 50.72 and 50.73 require that, for specified occurrences, each nuclear power reactor licensee notify the NRC either via the Emergency Notification System or in writing with a Licensee Event Report (LER), as appropriate. 10 CFR 50.72(b)(2)(ii) requires, in part, that each nuclear reactor licensee notify the NRC Operations Center via the Emergency Notification System within 4 hours of any event or condition that results in a manual or automatic actuation of any engineered safety feature (ESF) which was not part of a preplanned sequence during testing or maintenance. 10 CFR Part 50.73(a)(2)(i)(B) requires the licensee to report in an LER any operation or condition prohibited by the plant's TS.

Contrary to the above, the licensee failed to make the required 4-hour notification to the NRC Operations Center and the licensee also failed to issue an LER within 30 days after discovery of the following reportable events:

1. On July 10, 1986, two of the safety injection tanks (SITs) were inadvertently injected into the reactor coolant system during maintenance and notification to the NRC Operations Center was not made within 4 hours as required by 10 CFR 50.72(b)(2)(ii).

2. On June 17, 1986, the licensee identified that radioactive effluent had been discharged via a pathway with a radioactive effluent monitor which has been inoperable for greater than 14 days. Notwithstanding the fact that this operation was specifically prohibited by ACTION 28 of TS 3.3.3.10, the licensee failed to submit an LER within 30 days of discovery of the event per 10 CFR 50.73(a)(2)(i)(B).

This is a Severity Level IV violation.

RESPONSE TO VIOLATION

(1) Reason for the Violation

1st Event: The initial evaluation by the Shift Supervisor determined that a phone notification, per 10CFR50.72(b)(2)(ii), was not needed. This determination was based on the source of the actuation signal. Each SIT isolation valve has a RCS pressure interlock. As RCS pressure is increased (i.e., following a shutdown) to 350 psia, Operations personnel are required by procedure to open the SIT isolation valve. Should plant operators neglect to perform this step, an interlock will automatically open the isolation valves when RCS pressure increases to approximately 500 psig. While performing work in cabinet CP-26, Maintenance personnel inadvertently actuated this interlock. Since the signal originates in the Process Analog Control System and not the Engineering Safety Features portion of the Plant Protection System (i.e., the signal is not an Engineered Safety Feature), plant personnel did not consider this event to be a "manual or automatic actuation of any Engineered Safety

1st Event: Feature (ESF)..." Therefore, a phone notification was not applicable. By strict interpretation of the reporting requirements, this event did not appear to be reportable.

2nd Event: The event described in the violation report was identified by Waterford plant personnel on June 16, 1986, and documented in Potential Reportable Event PRE-86-043. Based on past verbal communications between LP&L and representatives of the NRC, plant personnel did not consider this event to be a violation of Technical Specification 3.3.3.10 and, therefore, determined it to be not reportable. This event, along with the applicable Technical Specification, was discussed in detail by the Plant Operability Review Committee (PORC). Again, based on the communications above, it was determined that a violation of Technical Specifications did not occur.

(2) Corrective Action That Has Been Taken

1st Event: In subsequent conversations with the NRC, LP&L agreed to make a phone notification (this was done on July 17, 1986) per 10CFR50.72(b)(2)(i) and submit a LER pursuant to 10CFR50.73(a)(2)(iv) (see LER-86-014-00).

2nd Event: None

(3) Corrective Action That Will Be Taken

1st Event: Louisiana Power & Light realizes that inadvertent actuation of equipment that perform safety functions is an event of interest and presents the opportunity for an industry lessons learned. Therefore, future similar events will be reported.

2nd Event: In the future, LP&L will report, as an LER, similar events in accordance with 10CFR50.73(a)(2)(i).

(4) Date When Full Compliance Will Be Achieved

This will remain a continuing process for LP&L.

Bases For No Notification of PRE 86-049
Under the Requirements of 10CFR50.72

On July 14, 1986 a Potential Reportable Event (PRE-86-049) was written to describe a temporary Loss of Shutdown Cooling to the Waterford 3 reactor while the plant was in Mode 5, Cold Shutdown. At that time it was determined by the Shift Supervisor that the event did not require a notification per 10CFR50.72 but a report would be required per 10CFR50.73(a)(2)(vii) (LER-86-015).

Since that time the need for a 10CFR50.72 notification on the event has been reviewed. The Administration Procedure UNT-6-010 "Event Evaluation and Reporting" was consulted to determine the notification and reporting requirements of the Loss of Shutdown Cooling Event. The one hour notification requirements were reviewed and determined to be inappropriate. The four hour notification requirements were also reviewed, and the 10CFR50.72(b)(2)(iii) section was considered (Could this event alone have prevented the fulfillment of the safety function of structures or systems that are needed to remove residual heat?). In addition, the Waterford 3 Technical Specifications were consulted and it was determined that during Mode 4, Hot Shutdown (Waterford 3 was in Mode 5, Cold Shutdown), as a minimum, one Emergency Core Cooling System subsystem comprised of one operable high pressure safety injection pump, and an operable flow path capable of taking suction from the refueling water storage pool on a safety injection actuation signal and automatically transferring suction to the safety injection system sump on a recirculation actuation signal shall be operable and also during Mode 5, at least one charging pump or one high pressure safety injection pump, in the boron injection flow path, shall be operable. Since all of the above stated conditions were met it was determined that no safety function was in jeopardy. Based on the fact that the Emergency Core Cooling System was capable of performing its safety function to remove residual heat it was still determined that the event did not require notification under 10CFR50.72(b)(2)(iii).