LOUISIANA POWER & LIGHT / 317 BARONNE STREET • P. O. BOX 60340
NEW ORLEANS, LOUISIANA 70160 • (504) 595-3100
MIDDLE SOUTH UTILITIES SYSTEM

W3P89-1558
A4.05
QA

September 11, 1989

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 89-22

Gentlemen:

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

If you have any questions concerning this response, please contact T.J. Gaudet at (504) 464-3325.

Very truly yours,

R.F. Burski

R.F. Burski
Manager
Nuclear Safety & Regulatory Affairs

RFB/TJG/pi
Attachment
cc: Messrs: R.D. Martin, NRC Region IV
F.J. Hebdon, NRC-NRR
D.L. Wigginton, NRC-NRR
NRC Resident Inspectors Office
E.L. Blake
W.M. Stevenson

IE01
1/1

ATTACHMENT 1

LP&L RESPONSE TO THE VIOLATION IDENTIFIED IN APPENDIX A OF INSPECTION REPORT 89-22

VIOLATION NO. 8922-03

Failure to Perform Adequate Corrective Actions

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 and nonconformances, are promptly identified and corrected, and that the causes be determined and corrective action taken to preclude repetition.

Contrary to the above, actions taken to preclude repetition of a September 1988 incident where component seismic supports were found not installed in the core protection calculator (CPC) cabinets, were inadequate in that again on July 27, 1989, seismic supports for the CPC cooling fans in the CPC cabinets were found not completely installed.

This is a Severity Level IV violation.

RESPONSE

(1) Reason For The Violation

LP&L admits that implemented corrective actions for the September, 1988 incident of missing seismic restraints on the fixed incore amplifier (FICA) drawers located in the CPC cabinets were unsuccessful in preventing a recurrence. A preliminary root cause investigation has attributed this incident to a lack of a root cause evaluation following the September, 1988 incident. This led to inadequate planning when defining the scope of work for the September, 1988 incident.

Corrective actions for the September, 1988 incident included the performance of an engineering evaluation to support operability of the cabinets and inspections to verify that seismic supports and fasteners were installed in Control Room cabinets. The evaluation concluded that without the seismic restraints installed, the FICA drawers would not have become a missile hazard in the CPC cabinets during a seismic event; therefore, the CPC Channels were never rendered inoperable. As part of the inspections, however, maintenance personnel were instructed to inspect to drawings (the drawings for the CPCs do not show the brackets) and to only look for missing hold down brackets and screws specific to the area where they had first been identified as

being missing (equipment chassis i.e., drawers). The scope of the inspection lacked sufficient detail to require a generic check for any type of missing support brackets in the cabinets even though such support brackets may have been located by visual inspection.

Subsequently, during a plant walkdown on July 27, 1989, while inspecting the CPC cabinets (CP-22) in preparation for a Refuel 3 design change, it was discovered that the cabinet blower brackets were missing for the cooling fans in the CPC cabinets. The brackets did not show up on any drawings. It was confirmed that the brackets were installed during the seismic qualification of the CPC cabinets but it is unknown when the brackets were actually removed.

(2) Corrective Steps Which Have Been Taken And The Results Achieved

The lack of a root cause determination following the September, 1988 incident occurred because of weakness in the Waterford 3 corrective action program. This weakness has been discussed in several memorandums between LP&L and the NRC. As outlined previously by LP&L, a complete re-evaluation of the Corrective Action Program was performed. This re-evaluation culminated in the revision of procedure NOP-5, "Corrective Action".

A non-conformance Condition Identification (CI-264149) was generated on July 27, 1989 to address the issue and initiate necessary actions to install the brackets. On July 28, 1989, a potential reportable event (PRE-89-083) was generated to address the reportability of the event from a Technical Specification operability standpoint. An analysis dated August 18, 1989 demonstrated that the cooling fan blower installation with the missing restraints on the fan blower does not create a missile hazard and the seismic qualification of the CPC cabinets is still valid. Consequently, the CPCs were not rendered inoperable and therefore the event was determined to be not reportable.

On August 7 - 9, 1989, plant personnel inspected safety-related cabinets in the Control Room (WA-01042828). The purpose of the inspection was to document potential deficiencies within the cabinets. (NOTE: A complete inspection of the cabinets was impossible since the movement of some components, wires, etc., could cause an inadvertent reactor trip.) The inspectors documented each potential deficiency for further evaluation. These deficiencies were evaluated and determined to be of no safety significance. CI-264925 was written to conduct the appropriate repairs.

To heighten the awareness of this event and bring it to the attention of Waterford 3 plant personnel, a discussion of the missing brackets as a recurring incident was provided during the August Safety Meetings that were held on August 18 and 22, 1989.

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

The inspection results will be evaluated to ensure that existing deficiencies will be reworked, if necessary. Administrative controls are in place to identify future deficiencies. Procedure UNT-5-002, "Condition Identification," presently requires a NCI be written to document a deficiency that represents a potential indeterminate condition. This direction encompasses missing supports, bolts, nuts, etc. that an employee may discover while performing work or routine inspections. This guidance will be reinforced by discussing this incident at maintenance tool-box meetings and will be included as a topic in recurring training for maintenance personnel. To prevent recurrence these meetings and training sessions will also be used to review the necessity for reinstallation of supports, restraints, bolts, nuts, etc. at the completion of maintenance activities.

In addition, a complete root cause investigation will be performed to ensure the corrective actions identified above and in Section 2 are sufficient to prevent recurrence.

(4) Date When Full Compliance Will Be Achieved

Full compliance will be achieved by December 31, 1989. At that time LP&L will also determine if investigations of safety-related cabinets outside of the Control Room is warranted.