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GNRO-2009/00029

April 23, 2009

U.S. Nuclear Regulatory Commission

Attn: Document Control Desk
Washington, DC 20555-0001

Subject: LER 2009-001-00 – Containment Isolation Valves Placed in Service after
Maintenance without Administrative Controls Due to Human Performance Error

Grand Gulf Nuclear Station, Unit 1
Docket No. 50-416
License No. NPF-29

Dear Sir or Madam:

Attached is Licensee Event Report (LER) 2009-001-00 which is a final report.

This letter does not contain any commitments.

Sincerely,

A handwritten signature in cursive script, appearing to read "Christina L. Perino".

CLP/dmc
attachment: LER 2009-001-00
cc: (See Next Page)



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cc: NRC Senior Resident Inspector
Grand Gulf Nuclear Station
Port Gibson, MS 39150

U.S. Nuclear Regulatory Commission
ATTN: Mr. Elmo E. Collins, Jr. (w/2)
612 East Lamar Blvd, Suite 400
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U. S. Nuclear Regulatory Commission
ATTN: Mr. Carl F. Lyon, NRR/ADRO/DORL (w/2)
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NRC FORM 366 (9-2007)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB: NO. 3150-0104	EXPIRES: 08/31/2010
<h2 style="margin: 0;">LICENSEE EVENT REPORT (LER)</h2> <p style="margin: 0;">(See reverse for required number of digits/characters for each block)</p>		Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.	

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4. TITLE Containment Isolation Valves Placed in Service after Maintenance without Administrative Controls Due to Human Performance Error

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
02	25	2009	2009	- 001 -	00	04	23	2009	N/A	N/A
									FACILITY NAME	DOCKET NUMBER
									N/A	N/A

9. OPERATING MODE 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: <i>(Check all that apply)</i>			
10. POWER LEVEL 100	<input type="checkbox"/> 20.2201(b) <input type="checkbox"/> 20.2201(d) <input type="checkbox"/> 20.2203(a)(1) <input type="checkbox"/> 20.2203(a)(2)(i) <input type="checkbox"/> 20.2203(a)(2)(ii) <input type="checkbox"/> 20.2203(a)(2)(iii) <input type="checkbox"/> 20.2203(a)(2)(iv) <input type="checkbox"/> 20.2203(a)(2)(v) <input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 20.2203(a)(3)(i) <input type="checkbox"/> 20.2203(a)(3)(ii) <input type="checkbox"/> 20.2203(a)(4) <input type="checkbox"/> 50.36(c)(1)(i)(A) <input type="checkbox"/> 50.36(c)(1)(ii)(A) <input type="checkbox"/> 50.36(c)(2) <input type="checkbox"/> 50.46(a)(3)(ii) <input type="checkbox"/> 50.73(a)(2)(i)(A) <input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(i)(C) <input type="checkbox"/> 50.73(a)(2)(ii)(A) <input type="checkbox"/> 50.73(a)(2)(ii)(B) <input type="checkbox"/> 50.73(a)(2)(iii) <input type="checkbox"/> 50.73(a)(2)(iv)(A) <input type="checkbox"/> 50.73(a)(2)(v)(A) <input type="checkbox"/> 50.73(a)(2)(v)(B) <input type="checkbox"/> 50.73(a)(2)(v)(C) <input type="checkbox"/> 50.73(a)(2)(v)(D)	<input type="checkbox"/> 50.73(a)(2)(vii) <input type="checkbox"/> 50.73(a)(2)(viii)(A) <input type="checkbox"/> 50.73(a)(2)(viii)(B) <input type="checkbox"/> 50.73(a)(2)(ix)(A) <input type="checkbox"/> 50.73(a)(2)(x) <input type="checkbox"/> 73.71(a)(4) <input type="checkbox"/> 73.71(a)(5) <input type="checkbox"/> OTHER Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME Christina Perino – Licensing Manager, GGNS	TELEPHONE NUMBER (Include Area Code) 601-437-6299
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
		N/A							

14. SUPPLEMENTAL REPORT EXPECTED <input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE	MONTH DAY YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On February 25, 2009 maintenance was completed on two Residual Heat Removal Primary Containment Isolation Valves (PCIVs). The PCIVs were returned to service before the required Technical Specification (TS) 5.5.6 Inservice Testing Program stroke time tests were performed to confirm operability. The PCIVs should have been placed under administrative controls or isolated per TS 3.6.1.3 Required Action (RA) A.1 within 4 hours. TS 3.6.1.3 RA E.1 requires entry into Mode 3 within 12 hours if A.1 is not met. Neither PCIV was tested within the combined 16 hour RA completion times of TS 3.6.1.3. A condition prohibited by TS existed for both valves.

The cause of this event was failure to correctly follow procedure and inadequate work order verification. Control Room personnel did not follow station procedure for entering separate Limiting Conditions for Operation when prepared for multiple components within the same TS. One LCO was entered for both PCIVs and the RHR A system. Both Control Room and Outage Control Center personnel misinterpreted the work order tasks as cancelled resulting in the retest being marked not applicable.

There is no safety consequence associated with this event.

Operations management initiated a standing order to ensure retest and TS / LCO requirements are reviewed by additional crew Senior Reactor Operators during LCO and tagging activities.

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A. REPORTABLE OCCURRENCE

Between February 23 and February 25, 2009 maintenance was performed on two Residual Heat Removal (RHR) valves [BO]: the RHR A System Shutoff isolation valve (E12F027A) and the RHR A minimum flow isolation valve (E12F064A). The two valves are primary containment isolation valves (PCIVs). After maintenance was performed both PCIVs required Technical Specification (TS) 5.5.6 Inservice Testing Program (IST) stroke time tests prior to returning the valves to an operable status. However, the valves were returned to service before the required IST stroke time tests were performed. Both valves were declared inoperable due to maintenance in accordance with TS 3.6.1.3 - Primary Containment Isolation Valves.

TS 3.6.1.3 Note 1 allows the valves to be operated intermittently under administrative controls or the penetration flow path under TS 3.6.1.3 Required Action A.1 is required to be isolated within four hours. The valves were not placed under administrative controls nor were the flow paths isolated. Additionally, TS 3.6.1.3 Required Action E.1 requires entry into Mode 3 within 12 hours if the required actions and completion times of A.1 are not met. Neither valve was tested within the combined 16 hour completion time of TS 3.6.1.3 Required Actions A.1 (4 hour completion time) and E.1 (12 hour completion time). Both valves exceeded TS LCO 3.6.1.3 Required Action Completion Times of 16 hours. Therefore, a condition prohibited by technical specifications existed for both valves.

This condition is reportable as required by 10 CFR 50.73(a)(2)(i)(B) "Any operation or condition which was prohibited by the plant's Technical Specifications..." as a LER within 60 days.

B. INITIAL CONDITIONS

At the time of the event, the reactor was in OPERATIONAL MODE 1 with reactor power at approximately 100 percent. There were no additional inoperable structures, systems, or components that contributed to this event.

C. DESCRIPTION OF OCCURRENCE

On February 23, 2009 GGNS entered a Limiting Condition for Operation (LCO) in preparation for maintenance on the Residual Heat Removal (RHR) A system. Included in the maintenance was work on two RHR A PCIVs – the RHR A minimum flow PCIV (E12F064A) and the RHR A system shutoff PCIV (E12F027A). Between February 23 and February 25, 2009 maintenance was performed on both RHR A PCIVs. Since maintenance was performed on both valves an In Service Testing stroke time retest per TS 5.5.6 was required prior to declaring both valves operable.

On February 25, 2009 preparations were made to perform the RHR A quarterly pump test by clearing tags on the system for the pump test. Control Room personnel failed to communicate that the two RHR A PCIVs would have to be placed under administrative controls as required by TS and station procedure

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02-S-01-17 "Control of Limiting Conditions for Operation" until the post maintenance IST stroke time test was performed. Operators proceeded with partial system restoration to perform the RHR A quarterly pump test. The partial restoration included opening both RHR A PCIVs (E12F027A and E12F064A). E12F027A was opened at 01:38 and E12F064A was opened at 01:53. The valves were not placed under administrative controls as required by TS 3.6.1.3 note 1 during the time the valves were open. The RHR A pump quarterly surveillance was completed at 13:15.

An IST stroke time test per TS 5.5.6 was successfully completed on the E12F027A on February 25, 2009 at 17:47. E12F027A was declared operable and the RHR A LCO was cleared at 18:00. This was more than 16 hours after the "inoperable" valves were returned to service. E12F064A had not been IST stroke time tested when the LCO was cleared due to the retest being deleted in the work order.

On February 26, 2009, the NRC Senior Resident Inspector questioned operations personnel about the retests performed on PCIVs during the RHR A system maintenance outage. Operations personnel reviewed the valve retests and work orders for the RHR A outage. They discovered that after maintenance E12F027A and E12F064A had been returned to service without being placed under administrative controls. Additionally, operations personnel discovered that an IST stroke time test had not been performed on E12F064A. Subsequently, E12F064A was stroke time tested and successfully passed its test.

The two valves should have been placed under administrative controls or closed per TS 3.6.1.3 Required Action A.1 within four hours. The valves were not placed under administrative controls nor were they isolated during the four hour period. Additionally, TS 3.6.1.3 Required Action E.1 required entry into Mode 3 within 12 hours if the conditions of A.1 were not met. Neither valve was IST tested within combined 16 hour required action completion times of TS 3.6.1.3 Required Actions A.1 and E.1.

D. CAUSE of OCCURRENCE

The cause of this event was failure to follow procedure correctly and inadequate work order verification.

First Apparent Cause - Procedure not followed correctly. Control Room personnel did not follow station procedure 02-S-01-17 "Control of Limiting Conditions for Operation" correctly. Procedure 02-S-01-17 states that a separate LCO should be prepared for multiple components within the same TS. This is to ensure that required action times for individual components are tracked separately. Procedure 02-S-01-17 was not followed in that the affected PCIVs were included on the same LCO as the RHR A system.

Second Apparent Cause – Verification of work order status and retest requirements inadequate. Control Room personnel were informed that some of the work scope had been deleted from the RHR A system outage. Both Control Room personnel and Outage Control Center personnel misinterpreted the work order tasks as cancelled in the work tracking software, resulting in the retest being marked not applicable. There was sufficient information available in the software to confirm that the work had been performed.

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E. CORRECTIVE ACTIONS

Immediate Corrective Actions - Operations management conducted an error debrief with shift Senior Reactor Operators (SROs). Operations management established a standing order to ensure retest and TS / LCO requirements are reviewed by additional crew SROs during LCO and tagging activities.

Long Term Corrective Actions - Condition Report CR-GGN-2009-01069 was written and will address any additional actions.

F. SAFETY ASSESSMENT

Both PCIVs passed their Inservice Testing TS 5.5.6 stroke time tests. The PCIVs isolation safety function would have been met for the period of time between the valves being returned to service following maintenance and the time the TS Surveillance IST stroke time testing was completed. There was no negative impact on safety due to this error since the PCIVs were capable of performing their safety function

G. ADDITIONAL INFORMATION

Previous Similar Events – Pursuant to 10 CFR 50.73 (b)(5) this issue is considered an infrequent event. There has not been an occurrence with the same underlying concern in the past two years at Grand Gulf Nuclear Station.