U. S. NUCLEAR REGULATORY COMMISSION NRC FORM 366 (7.77) LICENSEE EVENT REPORT Attachment to AECM-82/468 Page 1 of 2 CONTROL BLOCK: J(1)(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) 0 0 0 0 0 0 0 3 4 S 0 0 G G CON'T REPORT 6 0 0 9 0 9 8 0 0 8 8 2 (9) 0 0 0 0 4 1 8 L (6) SOURCE 68 REPORT DATE EVENT DATE DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) Reactor pressure vessel flange and head flange temperature were not monitored with 0 2 periodicity required by T.S.4.4.6.1.4.a. This is a reportable event under T.S.6.9.1.13.b. There was no effect on the health and safety of the public or a 0 4 threat to plant safety. 0 6 80 SYSTEM CAUSE COMP CAUSE VALVE SUBCODE COMPONENT CODE CODE SUBCODE | Z | (16 A 13 CI V ES IS 1E A (15 (12 IL A (11) A REPORT SEQUENTIAL OCCURRENCE REVISION EVENT YEAR REPORT NO CODE TYP Ŏ REPORT 0 16 8 10 13 8 2 L NUMBER COMPONENT EFFECT ON PLANT METHOD ATTACHMENT SUBMITTED NPRD-4 PRIME COMP. ACTION FUTURE TAKEN ACTION (22) HOURS FORM SUB. SUPPLIER MANUFACTURER 010 N (24) N (25 Z 0 Х ZI Ζ (20 |Y 1 (23 18) (26) CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The corrective action was to read and record The cause was operator error. required parameters verifying acceptable values. The temperatures were monitored thereafter in the required periodicity. 80 METHOD OF DISCOVERY FACILITY (30)OTHER STATUS DISCOVERY DESCRIPTION (32) % POWER 0 (31) Operator Observance 0 NA A B (28 0 44 80 ACTIVITY CONTENT LOCATION OF RELEASE (36) AMOUNT OF ACTIVITY (35) RELEASED_OF RELEASE Z (33) Z (34) NA NA 80 44 PERSONNEL EXPOSURES DESCRIPTION (39) TYPE NUMBER (3.7) Z (38) 0 0 0 NA 80 PERSONNEL INJURIES DESCRIPTION (41) NUMBER 0 0 0 (40) NA 80 LOSS OF OR DAMAGE TO FACILITY (43)TYPE DESCRIPTION Z (42) NA 80 8210220191 821008 PUBLICITY NRC USE ONLY DESCRIPTION (45 PDR ADOCK 05000416 ISSUED, PDR N (44) S NA 68 69 80 Original signed by G. S. Spark NAME OF PREPARER PHONE:-

Attachment to AECM-82/468 Page 2 of 2

SUPPLEMENTARY INFORMATION TO LER 82-068/03 L-0

Licensee: Mississippi Power & Light Company Facility: Grand Gulf Nuclear Station - Unit 1 Docket No: 50-416

On September 8, 1982, the plant was in condition mode 4 with no irradiated fuel in the Reactor Vessel and vessel temperature 100° F. The installed instrumentation for vessel flange and head flange temperatures were not operable. The temperatures for the vessel flange and head flange were monitored by a hand-held pyrometer.

T.S.4.4.6.1.4.a requires verifying the vessel and head flange temperatures greater than $70^{\circ}F$ at least once per 12 hours when reactor coolant temperature is less that $100^{\circ}F$.

On September 8, 1982, as part of the shift turnover, reactor coolant temperature was determined and recorded at 0730 and 2330. The values were 103° F and 98.7° F, respectively. On September 9, 1982 at 1013, ten hours and 45 minutes after it was determined that reactor coolant system temperature was less than 100° F, the vessel and head flange temperatures were verified to be greater than 70° F.

Existing procedures require recording coolant system temperature at every shift turnover. This was not done at the 1530 September 8, 1982 turnover. Had the coolant system temperature been recorded, it is anticipated that the observed trend would have resulted in subsequent monitoring and performance of the surveillance in the required interval.

Analysis of reactor coolant system temperature indicates that vessel temperature had dropped below 100°F at approximately 1900 on September 8, 1982. This indicates vessel and head flange temperatures were not verified to be greater than 70°F until 15 hours 13 minutes after coolant temperature dropped below 100°F. This did not meet strict compliance with the surveillance requirement to monitor temperature every 12 hours below Vessel Temperature of 100°F.

This event is only significant in that the surveillance requirement was not met. The potential for damage to the Reactor Vessel was insignificant because the measured values of the flange temperatures never approached 70°F. The threat to the public was insignificant since the plant had no irradiated fuel at the time of the event.

The problem is that the parameter of importance was not monitored adequately to ensure conformance with Technical Specification surveillance requirements.

Corrective action was to ensure temperatures monitored every 12 hours and temperatures recorded at the time of shift turnover as requested by procedure.