Entergy Operations, Inc.

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May 21, 1992

U.S. Nuclear Regulatory Commission Mail Station P1-137 Washington, D.C. 20555

Attention: Document Control Desk

SUBJECT: Grand Gulf Nuclear Station

Unit 1

Docket No. 50-416 License No. NPF-29

RWCU Isolation Due to Personnel Error

LER 92-005-00

GNRO-92/00057

Gentlemen:

Attached is Licensee event Report (LER) 92-005 which is a final report.
Yours truly,

COF CREEK

WTC/RSJ/cg attachment

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NRC Form 366 (9-63)		LICENSEE EVE	NT REPORT	(LER)		CLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104 EXPIRES 8-31-86	
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On April 21, 1992 at 2352 hours, an inadvertent reactor water cleanup (RWCU) system isolation occurred during performance of a scheduled reactor water sample valve surveillance. This unplanned isolation was due to personnel error resulting from inattention to detail.

The assisting Nuclear Operator A (NOA) was briefed on assigned surveillance step sequences and proceeded to the designated switch panels to place the reactor water sample valve logic test switches to the 'TEST' position. The NOA inadvertently manipulated the RWCU system logic test switches instead.

The Conduct of Operations and Control and Use of Operations Section procedures have been changed to provide self-verification guidelines for use during performance of operating and surveillance procedures, valve line-up manipulations, and red tag clearances.

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NRC Form 384

MRC Form 366A

#### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104 EXPIRES 8/31/88

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### A. Reportable Occurrence

On April 21, 1992, during performance of a surveillance which includes testing of reactor water sample valve isolation logic, an inadvertent RWCU system [CE] isolation occurred. This event is classified as an Engineered Safety Feature (ESF) actuation and is being reported pursuant to 10CFR50.73(a)(2)(iv).

#### B. Initial conditions

The plant was in Mode 5, Refueling during the occurrence.

### C. Description of Occurrence

On April 21, 1992, during performance of the reactor water isolation logic surveillance, an inadvertent RWCU isolation occurred at 2352 hours as a result of personnel error.

While performing the surveillance, the utility licensed Nuclear Operator A (NOA) proceeded to activate each reactor water sample isolation logic test switches on two separate control room panels as instructed by procedure. The NOA inadvertently activated the RWCU isolatic logic test switches instead, which immediately resulted in closure of inboard RWCU containment isolation valves. The RWCU system was restored seven minutes later at 2359 hours.

# D. Apparent Cause

The primary cause of the inadvertent RWCU isolation was personnel error resulting from inattention to detail. Just prior to assisting with the reactor water sample valve surveillance, the NOA was involved with RWCU maintenance activities which included removing a RWCU system filter from service.

The test switches associated with both activities are arranged on each end of both panel sectors as shown below. The RWCU System Logic Test switch is located at the left end and the Reactor Water Sample Logic Test switch is located at the right end.

RWCU SYSTEM

MSIV LOGIC

ISOLATION LOGIC TEST

RHR LOGIC

REACTOR WATER

NKC.		

#### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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The NOA, upon completion of the previous RWCU maintenance activity, was assigned to assist with the reactor water sample valve isolation logic testing. The previous activity obscured the NOA's train of thought in that he proceeded to manipulate RWCU switches instead of the reactor water sample switches as specified by the surveillance procedure.

Similar events also due to personnel error occurred on September 28, 1988 (LER 88-017) and September 29, 1989 (LER 89-014). The 1988 event occurred during a monthly surveillance when an operator was to place the RWCU bypass switch to 'BYPASS' but manipulated the Residual Heat Removal (RHR) [BO] bypass switch instead. The operator had been assisting with RHR isolation logic testing earlier.

The 1989 event occurred during an annual surveillance when an operator was to place the 'A' Reactor Core Isolation Cooling (RCIC) [BN] bypass switch to 'BYPASS' but placed the RWCU bypass switch to 'NORMAL'. As a result of the 1989 event, a Management Standard was issued January 1989 which established a programmatic method of performing self-verifications during work tasks. The Management Standard was not proceduralized at this time, therefore this deficiency was a contributing factor to the April 1992 event.

# E. Supplemental Corrective Actions

As a result of this event, the <u>Conduct of Operations</u> procedure, 01-S-06-2 and the <u>Control</u> and <u>Use of Operations Section procedure</u>, 02-S-01-2 were modified to implement the Management Standard of se fever fication to provide self-verification guidelines for use during performance of operating and surveillance procedures, valve line of manipolations, and red tag clearances.

The Training Department is initiating program changes to instill better work habits on self-verification for initial licensed and non-licensed operator training.

Other recent personnel error occurrences were given management attention through site meetings and distribution of newsletters to reiterate the importance of self-verification during performance of work tasks. The NOA was counselled on his inadequate practice of self-verification.

# F. Safety Assessment

The actuation of the RWCU isolation system did not compromise the sale operation of GGNS. All safety relited equipment operated as designed. Safety and health of the general public were not affected by this evenu

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Attachment to GNRO-92/00057

NRC Form 306A . LICENSEE EVENT REP	ORT (LER) TEXT CONTINU			GULATORY COMMISSION DMS NO. 3150-0104 1788
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G. Additional Information

Energy Industry Identification System (EIIS) codes are identified in the text within brackets  $[\ ].$ 

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