



**ENTERGY**

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June 5, 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  
Report No. 50-416/92-09  
dated 5/6/92 (GNRI-92/00095)

GNRO-92/00068

Gentlemen:

Entergy Operations, Inc. hereby submits the response to Notices of Violation identified during Inspection 50-416/92-09.

As we have discussed with you, we recognize the trend of personnel related incidents and share the concerns conveyed in your inspection report. We have devoted considerable time and effort to heighten the awareness of personnel in the work place, with positive effect. We intend to continue to monitor this condition to confirm its resolution.

Yours truly,

WTC/RR:cg  
attachment:

cc: (See following page)

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**Notice of Violation 92-09-01**

Technical Specification 6.8.1.a requires that written procedures be established, implemented and maintained covering the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2. Regulatory Guide 1.33 recommends procedures to be in place for the control of maintenance, repair, replacement and modification work. Administrative Procedure 01-S-07-1, Control of Work on Plant Equipment and Facilities, provides instructions for authorizing work on plant equipment.

Contrary to the above, Procedure 01-S-07-1 was inadequate in that it allowed the scope of a work order to be changed without an operability review by the control room prior to resuming work. On April 1 1992, this inadequacy resulted in the loss of air flow monitoring from the fuel handling area (FHA) and the failure to manually estimate air flow from the FHA as required by Technical Specification 3.3.7.12.

**I. Admission or Denial of the Alleged Violation**

Entergy Operations, Inc. admits to this violation.

**II. The Reason for the Violation, if Admitted**

On March 31, 1992 work was authorized by the control room on the Fuel Handling Area (FHA) Flow Monitoring and Isokinetic Sampling (FM&IS) panel sample pump. The work order (WO) was initially issued as a mechanical WO to replace the sample pump. Following the completion of the pump replacement, problems still existed with the system. The original WO was returned to Planning to add instructions for an additional investigation under engineering directions. Instrument and Control personnel were requested to assist in the investigation. The WO was reviewed by the planner to verify that the increased work scope would not affect the WO impact statement. Based on the review, it was determined that the impact statement would not be affected and the WO was released to the field without control room review.

To support the investigation, the panel was deenergized resulting in the flow monitoring indication being inoperable. The flow indication was inoperable approximately 12 hours without control room knowledge. This configuration requires effluent flow to be estimated once per 8 hours. The Technical Specification requirement was met by use of the redundant flow monitoring channel.

The original WO impact statement stated that the FHA FM&IS panel would be isolated and out of service. This statement was incorrect since the only portion of the panel to be affected was the sample pump, which would not result in inoperable flow monitoring indication. Upon initial control room authorization, the conservative impact statement was noted but was not modified to convey actual system impact. Once the WO went back to Planning, the planner performed a review of the system impact and deemed control room re-authorization unnecessary. The procedure which was in place at the time of occurrence allowed the maintenance planner to change disciplines and work to continue without control room re-authorization.

A contributing factor in the incident was the failure of Operations personnel to modify the original impact statement.

### III. Corrective Steps Which Have Been Taken and Results Achieved

The FHA FM&IS panels were labeled emphasizing notification of the control room prior to deenergizing the panel.

Meetings were held with Instrument and Control Technicians to inform them of the incident.

The Planning Supervisor informed planning personnel that adding or changing disciplines is a scope change and requires control room re-authorization prior to the beginning of work.

### IV. Corrective Steps to be Taken to Preclude Further Violations

The procedure governing work on plant equipment will be revised to include discipline changes in the definition of work scope.

### V. Date When Full Compliance Will Be Achieved

These actions will be completed by June 26, 1992.



## Notice of Violation 92-09-02

Technical Specification (TS) 6.8.1.a requires that written procedures be established, implemented and maintained covering the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2. Regulatory Guide 1.33 recommends procedures covering equipment control and BWR offgas treatment.

1. Administrative Procedure 01-S-06-1, Protective Tagging System, paragraph 6.3.2.a requires that the operator have the equipment clearance form and tags with him, when positioning switches, valves, fuses, blank flange, etc., to the protective position as indicated on the equipment clearance form.

Administrative Procedure 01-S-06-2, Conduct of Operation, paragraph 6.2.10.f states that one of the specific responsibilities of the non-licensed operators is to ensure that the placing and removal of red tags authorized by the Plant Supervisor or Shift Supervisor are completed correctly.

Contrary to the above, on March 27, 1992, an operator accidentally opened a breaker that was not indicated on the equipment clearance form, causing an inadvertent Engineering Safety Feature actuation.

2. Surveillance Procedure 06-OP-1000-D-0001, Daily Operating Logs, Data Sheet III, requires operations to plot percent of rated thermal power versus offgas pretreatment radiation monitor reading every four hours to ensure that the adjusted radiation monitor reading has not increased by greater than 50 percent.

Contrary to the above, on March 28, at 1600 hours, an operator incorrectly plotted an acceptable reading for percent of rated thermal power versus offgas pretreatment radiation monitor reading. This resulted in an isotopic analysis of the offgas recombiner effluent not being performed as required by TS 4.11.2.7.2.b.

3. Chemistry Procedure 08-S-03-22, Installed Radiation Monitoring System Alarm Setpoint Determination and Control, paragraph 6.1.4.c requires, in part, that after calculations, if an installed effluent radiation monitor setpoint decreases by more than 25 percent, the chemist performing the calculation must recommend to the Shift Superintendent, that the monitor be declared inoperable until the new setpoint is incorporated.

Contrary to the above, on March 25, 1992, a chemist failed to recommend to the Shift Supervisor that the monitor be declared inoperable after determining that a setpoint change was required. This resulted in operations not declaring the monitor inoperable per TS 3.3.7.12.a in a timely manner.

#### I. Admission or Denial of the Alleged Violation

Entergy Operations, Inc. admits to this violation.

#### II. The Reason for the Violation, if Admitted

1. On March 27, 1992, a non-licensed operator was to hang a red tag on the breaker for the Division II Hydrogen Recombiner. The specified position on the clearance was racked-out open. The operator entered the area, located the breaker and verified the number of the breaker. The operator expected to find the breaker in the open position; however, the breaker was closed. The operator immediately called the control room to verify the position of the breaker. The control room conveyed that the breaker should normally be closed, but it would have to be opened locally before it could be racked-out. Following the conversation, the operator returned to the breaker panel and opened the breaker located above the correct breaker. The breaker, which was opened accidentally, supplied power to a motor control center (MCC). As a result, the MCC was deenergized and caused a partial secondary containment isolation. The breaker was immediately reclosed and the affected systems were restored to their normal configurations.

Even though the operator performed self-verification on the correct breaker initially, re-verification was not performed immediately prior to operating the open push-button for the breaker. The cause is attributed to inattention to detail and the lack of self-verification prior to operating plant equipment.

2. On March 28, 1992 at approximately 1600 during the performance of the Daily Operating Logs, a licensed operator incorrectly plotted the pretreatment radiation monitor reading on the log's data sheet. The graph which is located on Data Sheet III of the Daily Operating Log requires that the pretreatment radiation monitor reading be plotted on the graph with respect to the reactor thermal power level. The procedure also requires that the current reading be compared to the previous reading to ensure that a 50 percent increase has not occurred. Upon comparison of the readings, it was determined that no increase had occurred.

The plant was operating at approximately 70 percent power at the time of the reading. The operator plotted the point on the 100 percent power line instead of the 70 percent line. The error was not identified until the 2000 hour readings were taken. At that time, chemistry personnel were notified and a gross radioactivity rate measurement of the offgas recombiner effluent was taken to ensure the activity had not exceeded 380 millicuries per second. The results of the analysis confirmed that the limit had not been exceeded.

The graph used to determine the sampling requirement was more conservative than the Technical Specification, in that it required a sample to be taken even though there had been no increase in offgas pretreatment activity. Even though the procedure was more conservative than the Technical Specification sampling requirement, the sample would have been taken as required by the procedure.

The cause of the misplotted data point is attributed to inattention to detail due to the operator not verifying the proper power level on the graph prior to plotting the point.

3. On March 25, 1992 following a change in the reactor power level, Chemistry personnel initiated an analysis of the Radwaste Building Ventilation (RWBV) effluent to determine the alarm setpoint for the associated effluent radiation monitor. Following the analysis, the setpoint calculations were performed. The results indicated that an alarm setpoint change was necessary to maintain the monitor operable.

As required by the procedure governing setpoint calculations, the chemist initiated a Condition Identification (CI) at 1417 to install a new setpoint for the monitor. The procedure also requires the chemist to enter a comment on the CI recommending that the monitor be declared inoperable. Failure to make this recommendation led Operations personnel to overlook the effect on equipment operability and fail to declare the monitor inoperable in a timely manner.

The monitor was declared inoperable at 2050 and a sample was taken from the RWBV within the time specified by the Technical Specification Action Statement.

Even though the chemist was using the procedure to perform the calculations, failure to refer to the procedure step which required the comment to be placed on the CI resulted in the monitor not being declared inoperable in a timely manner. The cause as identified by a review of the incident is attributed to inattention to detail.

### III. Corrective Steps Which Have Been Taken and Results Achieved

As a result of several incidents involving inattention to detail, Operations personnel revised Administrative Procedures, Conduct of Operations and the Use and Control of Operations Section Procedures + incorporate the Management Standard of Self-Verification + provide self-verification guidelines for use during performance of operating and surveillance procedures, valve line-up manipulations, and red tag clearances.

Additional corrective actions for the specific examples are discussed below.

1. Corrective actions taken as a result of the operator operating the wrong breaker are as follows:
  - o Operations is placing greater emphasis on the self-check and verification process through Shift Seminars conducted by the Shift Superintendents.
  - o All other operators were made aware of the event.
  - o The operator involved was counseled on the proper technique in self-check and verification.
  
2. Corrective actions taken as a result of the misplotting of the pretreatment radiation reading are as follows:
  - o The operator involved was counseled.
  - o All other operators were briefed on the incident to heighten their awareness of the importance of following procedure and self-verification.

Other actions were taken to enhance the pretreatment radiation monitor section in the Daily Operating Logs.



3. Corrective actions taken as a result of the RWBV monitor not being declared inoperable in a timely manner are as follows:
- o Chemistry personnel were informed of the incident with special emphasis placed on the notification requirements of the Chemistry Procedure.
  - o The Chemistry Alarm Setpoint data sheet was revised to reflect the recommendation that the associated radiation monitor be declared inoperable.
  - o Attention to detail, procedural compliance, and prompt notification of the Operation Shift Superintendent of conditions adversely affecting Technical Specification compliance were the topic of training sessions performed by the Chemistry Superintendent.
  - o The procedure governing radiation monitor alarm setpoint determination and control has been revised to clarify monitor inoperability and emphasize control room notification.

IV. Corrective Steps to be Taken to Preclude Further Violations

The Chemistry department has performed a programmatic review and has determined that enhancements to surveillance procedures associated with setpoints of gaseous effluent monitors are warranted to preclude recurrence.

V. Date When Full Compliance Will Be Achieved

These enhancements to the Chemistry surveillances will be completed by July 30, 1992.