



ENTERGY

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July 10, 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. 50-416/92-12
dated June 11, 1992 GNRI-92/00130)

GNRO-92/00085

Gentlemen:

Entergy Operations, Inc. hereby submits the response to Notice of Violation 50-416/92-12.

We share your concern that the cited violations reflect an adverse trend of inattention to procedural details which must be aggressively pursued. In that respect, we found that a particularly effective action for the drywell purge violation was to have a non-licensed operator conduct the shift briefings describing the circumstances surrounding the violation. Peer interaction on this matter appears to have greatly enhanced communication and understanding of the deficiency. We will continue to explore fresh and innovative approaches to resolving problems such as presented by this violation.

Yours truly,

WTC/RSJ/cg

attachments: 1. Notice of Violation 92-12-01
2. Notice of Violation 92-12-02

cc: See Next Page

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Notice of Violation 92-12-01

Technical Specification 3.6.7.3 requires that two independent drywell purge system subsystems shall be operable in operational modes 1 and 2.

Contrary to above, both divisions of drywell purge system were inoperable from 6:00p.m. April 9 to 7:00a.m. April 10, 1992 (approximately 13 hours), due to incorrect valve operation without initiating the power reduction requirements of TS 3.0.3.

I. Admission or Denial of the Alleged Violation

Entergy Operations, Inc. admits to this violation.

II. The Reason for the Violation, if Admitted

On April 9, 1992 cooling water to Division 2 drywell purge compressor was isolated to perform type C LLRT of its containment isolation valves. During the test, difficulty was experienced with the test equipment and the valve lineup was changed to expand the test boundary. A non-licensed operator was dispatched with the required lineup procedure. The operator was expected to verify that valve P41F244B was closed, initial the valve lineup procedure data sheet, and then proceed to containment to open a vent valve. A component locator aid was posted outside the room. This is distributed as information by the Health Physics (HP) group and used by station personnel in locating the correct area of the room to find a component, thereby saving time and reducing exposure. The HP component locator aid listed and designated valve P41F244 (not P41F244A or P41F244B). The valve was located in an upper region of the room and accessed via ladder. The valve had P41F244 stenciled on the valve body which was visible from the floor. The operator closed valve P41F244A, not realizing that he had selected the wrong valve. LLRT of containment isolation valves for Division 2 drywell purge compressor cooling water was completed on April 10, 1992. P41F244B was reopened as part of the division 2 restoration.

The error was discovered on April 14, 1992 while performing valve lineup for LLRT of containment isolation valves for Division 1 drywell purge compressor cooling water. P41F244A was found in the closed position contrary to the system operating instruction. With valve P41F244A closed, Division 1 drywell purge system was inoperable. This was concurrent with Division 2 drywell purge system being inoperable to facilitate LLRT. P41F244A had been closed for approximately 13 hours while Division 2 drywell purge system was inoperable. Both division were inoperable. This was nonconforming with Technical Specification 3.6.7.3. Therefore, the plant was in Technical Specification 3.0.3 for approximately 13 hours.

The cause of this event was the incomplete component designation stencilled on the valve. Components were stencilled in an informal process as part of the painting program at the plant. The process did not assure accuracy of identification and designations.

A contributing factor was inattention to detail by the operator. The operator failed to verify the unique label on the valve (which indicated the component correctly). Personnel are expected to check the unique component label when identifying or manipulating components or equipment. Although the individual had discussed the task and valve location in the control room with the control room supervisor before embarking on the duty, inadequate job briefing also contributed to the event. The operator found the valve open and proceeded to close it when he was to verify that the valve position was closed. The operator thought that P41F244 was P41F244B and proceeded to close the valve, thereby isolating SSW cooling water to the Division 1 drywell purge compressor. The operator observed from the floor the stencil painted on the valve body indicating it as P41F244. This detail agreed with the component locator aid and reinforced the error. In addition, P41F244B was not shown on the HP component locator aid even though it is in the same room.

III. Corrective Steps Which Have Been Taken and Results Achieved

Corrective actions resulting from this event include a 100% walkdown verification of painted stencils on components in the power block and correction of all incorrect or incomplete stencils. Stenciling has been removed from the uncontrolled GGNS painting program and is being incorporated into administrative procedure 01-S-06-43, Component Identification and Labeling. The incomplete stencil on valve P41F244B has been corrected. The HP locator aid has been revised to correctly designate the valves.

Immediate training was given to operators which emphasized the importance of the expected actions and results of self-verification while manipulating plant components and expected actions by operators when incomplete or incorrect labeling is discovered in the plant. Operations supervisors were trained on the elements of complete pre-job briefings and informed of the event.

IV. Corrective Steps to be Taken to Preclude Further Violations

Initial operator training will be revised to emphasize the component labeling program, concepts of human error, and proper self-verification techniques. This will be completed prior to commencing the next non-licensed operator class.

V. Date When Full Compliance Will Be Achieved

The next non-licensed operator class is expected to commence by November 30, 1993.

Notice of Violation 92-12-02

Technical Specification 6.8.1c requires that written procedures shall be established, implemented and maintained covering surveillance and test activities of safety related equipment.

Surveillance procedure 06-OP-1B21-R-0006, "Containment, Drywell and Auxiliary Building Isolation Valves Functional Test", steps 5.3.5b and 5.3.5c required that the operator place the reactor water sample valve logic B and C test switches to the test position.

Contrary to the above, during performance of surveillance procedure C5-OP-1B21-R-0006 on April 21, 1992, the operator mistakenly actuated the test switches for reactor water cleanup system (RWCU) logic instead of the specified reactor water sample valve test switches. This resulted in closure of the RWCU inboard containment isolation valves.

I. Admission or Denial of the Alleged Violation

Entergy Operations, Inc. admits to this violation.

I'. The Reason for the Violation, if Admitted

On April 21, 1992, a licensed operator was assigned to assist with performance of surveillance procedure 06-OP-1B21-R-0006, Containment, Drywell and Auxiliary Isolation Valves Functional Test. During performance of Attachment II in which the reactor water sample valve isolation logic is tested, the operator proceeded to activate each reactor water sample isolation logic test switch on two separate control room panels as instructed by procedure. The operator inadvertently activated the RWCU isolation logic test switches instead.

Just prior to assisting with the reactor water sample valve surveillance, the operator was involved with RWCU maintenance activities which included removing an RWCU system filter from service. The previous activity obscured the operator's train of thought in that he proceeded to activate RWCU switches instead of the reactor water sample switches as specified by the surveillance procedure. The RWCU system logic test switches are adjacent to the reactor water sample logic test switches on both panel sectors.

The cause is attributed to inattention to detail and inadequate practice of self-verification.

III. Corrective Steps Which Have Been Taken and Results Achieved

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

The Training Department has initiated program changes to instill better work habits on self-verification during licensed and non-licensed operator continuing 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 responsible operator was counselled on his inadequate practice of self-verification.

IV. Corrective Steps to be Taken to Preclude Further Violations

The Training Department will initiate changes to the initial licensed and non-licensed operator training program to instill better work habits on self-verification.

V. Date When Full Compliance Will Be Achieved

This will be completed prior to November 30, 1993.