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February 10, 1993

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

Attention: Document Control Desk

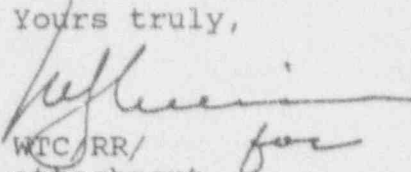
SUBJECT: Grand Gulf Nuclear Station
Unit 1
Docket No. 50-416
License No. NPF-29
No Licensed Senior Reactor Operator in Control Room
during Operational Condition 1
LER 93-001-00

GNRO-93/00018

Gentlemen:

Attached is Licensee Event Report (LER) 93-001 which is a Final report.

Yours truly,

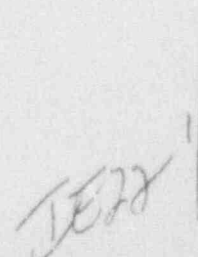

WTC/RR/
attachment
cc:

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 6/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Grand Gulf Nuclear Station	DOCKET NUMBER (2) 0 5 0 0 0 4 1 6	PAGE (3) 1 OF 0 5
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TITLE (4)

No Licensed SRO in Control Room during Operational Condition 1

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		
0 1	1 1	9 3	9 3	0 0 1		0 0	0 2	1 0			
									DOCKET NUMBER(S) 0 5 0 0 0		

OPERATING MODE (9) 1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)									
POWER LEVEL (10) 1 0 0		20.402(b)		20.406(c)		50.73(a)(2)(iv)		73.71(b)			
		20.406(a)(1)(ii)		50.36(a)(1)		50.73(a)(2)(v)		73.71(c)			
		20.406(a)(1)(iii)		50.36(a)(2)		50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
		20.406(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(vii)(A)					
		20.406(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(vii)(B)					
		20.406(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)					

LICENSEE CONTACT FOR THIS LER (12)

NAME Riley Ruffin, Licensing Specialist	TELEPHONE NUMBER 6 0 1 1 4 3 1 7 1 - 1 2 1 1 6 1 7
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE:)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On January 11, 1993 at approximately 0050 CST, a disturbance was heard outside of the control room. The sounds of distress were thought to be a woman calling for help.

Two of the three licensed reactor operators (RO), along with the licensed senior reactor operator (SRO) went to the control room door to investigate the matter. The remaining RO stayed at the reactor controls. The SRO stepped into the stairwell to intervene in the disturbance. After the SRO was in the stairwell, the control room operator at the door stepped back into the control room and allowed the door to close. The control room was without an SRO for approximately 5 minutes. Plant conditions did not change during the time the control room was without an SRO. Therefore, this occurrence did not compromise the health and safety of the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

A. Reportable Occurrence

On January 11, 1993 at approximately 0050 hours, the only licensed SRO in the control room, at that time, left the control room area. This resulted in no SRO being in the control room area while in Operational Condition 1. This was a violation of 10 CFR 50.54(m)(2)(iii). Additionally, this was a condition prohibited by Technical Specifications (TS) 6.2.2.b. The occurrence is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B).

B. Initial Conditions

The plant was operating in Operational Condition 1 at approximately 100 percent thermal power. Reactor pressure was 1027 psig and indicated temperature was 531 degrees F.

The Shift Superintendent and Shift Supervisor (both SROs) had turned-over the Control Room Command Function to the Plant Supervisor (also an SRO) and left the control room area. The Plant supervisor was aware of plant status and understood the responsibilities of the command function.

C. Description of Occurrence

On January 11, 1993 at approximately 0050 CST, a disturbance was heard outside of the control room. The sounds of distress seemed to be coming from the east side of the control room. The sounds were thought to be a woman calling for help.

Two of the three licensed ROs, along with the Plant Supervisor, went to the east door of the control room to investigate the matter. The remaining RO stayed at the reactor controls. Control room personnel at the east door called twice, however no verbal response was heard.

Outside of the east control room door is a stairwell which is considered a part of the radiological controlled area.

Of the three control room personnel investigating the disturbance, only the plant supervisor had self-indicating dosimetry. Therefore, the plant supervisor stepped into the stairwell with intentions to intervene in the disturbance. Once the plant supervisor was in the stairwell, the control room operator at the door stepped back into the control room and allowed the door to close. The plant supervisor made verbal contact with the individuals and confirmed that the situation was under control.

NRC Form 305A
(9-83)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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EXPIRES 9/31/88

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TEXT (If more space is required, use additional NRC Form 305A's) (17)

Following confirmation of the situation, the plant supervisor realized that he was outside the control room, inside the radiologically controlled area and the control room operators had returned inside the control room and allowed the door to close. The plant supervisor did not attempt to enter the control room without being processed through the Health Physics Lab (HP). Therefore, the plant supervisor immediately went to HP, processed through the personnel contamination monitor and returned to the control room.

Upon investigating the incident, it was determined that a female security officer was trapped in the room above the control room due to Door OC619 not opening when the palm switch was depressed. This room is directly above the control room and within the control room envelope. The only separation between the room and the control room is a false ceiling. Once the officer realized she was trapped, she began to call for help, while pounding on the door.

The security officer outside the room did not immediately hear the person from within. However, control room personnel were able to hear the calls of distress through the false ceiling. This immediately alarmed control room personnel.

The trapped officer did not attempt to transmit via portable radio due to being within the control room envelope area and transmitting via the radio possibly could have caused erratic instrument behavior in the control room and a possible plant transient.

The control room was without an SRO for approximately 5 minutes. This is a violation of Administrative Procedure 01-S-06-02, "Conduct of Operations"; Section 6.2.2.b of GGNS TS, "Unit Staff"; the "Table Notations" for TS Table 6.2.2-1, in addition to 10 CFR 50.54(m)(2)(iii). Plant deficiency reports were initiated as a result of these violations.

Plant conditions did not change during the time the control room was without an SRO.

D. Apparent Cause

A subsequent investigation determined that the event was caused by the decision of the plant supervisor to enter the stairwell.

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TEXT (if more space is required, use additional NRC Form 308A's) (17)

The reaction of the plant supervisor resulted from the perceived urgency of the situation. The decision was made by the plant supervisor to personally aid plant personnel whose safety he judged to be in danger. The decision to help another person under the fear of bodily harm was a personal value judgment on the part of the plant supervisor.

Two causal factors were also identified during the investigation. The plant supervisor felt he was still in the control room as long as he was not isolated by a closed door. Additionally, the plant supervisor was the only individual in the control room at the time of occurrence who had self-indicating dosimetry.

Other factors which aided in the decision making process were determined to be: 1) the trapped security officer's behavior gave a false impression of imminent urgency, 2) scenarios of this type have not been addressed by Operations Management.

E. Corrective Action

Meetings were held with SROs by Operations Management to convey their expectations of SROs and the role of the control room command function including a review of Management Standards and Administrative procedure "Conduct of Operations" regarding the "Control Room Command Function."

Appropriate operations personnel were made aware of the event and the resulting radiological and administrative deficiencies exhibited.

Security personnel reviewed the event emphasizing professionalism and expectations for future actions that would preclude a similar circumstance.

The "Control Room Command Function" will be presented as a part of the continuing training program for SROs.

The plant supervisor involved was disciplined by Operations Management.

NRC Form 305A
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION

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Grand Gulf Nuclear Station	0 5 0 0 0 4 1 6 9 3	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	0 5	OF 0 5
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TEXT (If more space is required, use additional NRC Form 305A's) (17)

F. Safety Assessment

During the absence of an SRO in the control room, there was a full complement of licensed reactor operators present. There was no change in operating parameters during this time. The SRO was out of the control room approximately five minutes. The SRO designated as the Shift Superintendent had a portable radio and control room personnel were aware of this fact. There was an operator at the controls at all times during this event. The occurrence did not compromise the safety of the public at anytime.