



**ENTERGY**

Entergy Operations, Inc.  
PO Box 756  
Port Gibson, MS 39150  
Tel 601 437 6406

**W. T. Cottle**  
Vice President  
Operations  
Grand Gulf Nuclear Station

March 26, 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. 50-416/92-02,  
dated February 25, 1992  
(GNRI-92/00038)

GNRO-92/00033

Gentlemen:

Attached is the Entergy Operations, Inc. response to the Notices of Violation identified in NRC Inspection Report 50-416/92-02.

The violations identified in the subject Inspection Report are areas which warrant improvement. Entergy Operations is equally concerned about these areas and is placing special emphasis on: proper communications, attention to detail, teamwork, adherence to procedures, pride in your work and continuous improvement.

Since Entergy Operations is preparing for its fifth refueling outage, high performance in these areas is a necessity to have a successful outage.

These areas will continue to be monitored and management will continue to explore methods to preclude further occurrences.

Yours truly,

WTC/RR/cg  
attachments

cc: (See next page)

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cc: Mr. D. C. Hintz (w/a)  
Mr. R. B. McGehee (w/a)  
Mr. N. S. Reynolds (w/a)  
Mr. H. L. Thomas (w/o)  
Mr. J. L. Mathis (w/a)

Mr. Stewart D. Ebnetter (w/a)  
Regional Administrator  
U.S. Nuclear Regulatory Commission  
Region II  
101 Marietta St., N.W., Suite 2900  
Atlanta, Georgia 30323

Mr. P. W. O'Connor, Project Manager (w/a)  
Office of Nuclear Reactor Regulation  
U.S. Nuclear Regulatory Commission  
Mail Stop 13H3  
Washington, D.C. 20555

Notice of Violation 92-02-01

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 states that instructions for startup and shutdown should be prepared for the Standby Service Water System. System Operating Instruction (SOI), 04-1-01-P41-1, Standby Service Water System provides directions for startup and shutdown of the Standby Service Water (SSW) system.

Contrary to the above, on January 8, 1992, while shutting down the 'A' SSW system, the pump was not secured per the SOI and continued to pump water through the relief valve.

I. Admission or Denial of the Alleged Violation

Entergy Operations, Inc. admits to this violation.

II. The Reason for the Violation, If Admitted

On January 8, 1992, while returning the SSW 'A' system to standby, operations personnel failed to stop the SSW 'A' pump, as required by procedure. The pump operated approximately 30 minutes with the discharge and recirculation valve closed. The only flow path available was through the discharge relief valve upstream of the discharge isolation valve.

The failure of the operator to secure the pump was due to inattention to detail.

III. The Corrective Steps Which Have been Taken and the Results Achieved

- A. A nonconformance report was initiated as a result of the incident. The Inservice Testing procedure was performed to verify operability of the pump. Based on the results of the test, the pump was declared operable. The relief valve showed no sign of leakage during the test.
- B. A review of the SOI was performed to evaluate the need for changes. It was determined that no procedural changes were necessary.



C. The operator involved was disciplined by Operations Management.

D. Other operations personnel were made aware of the incident with emphasis on attention to detail.

IV. The Corrective Steps Which Will Be Taken To Preclude Further Violation

A. Entergy Operations feels that no further corrective actions are warranted at this time.

V. Date When Full Compliance Will Be Achieved

All corrective actions have been completed.

Notice of Violation 92-02-02

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 requires that Administrative procedures be in place for authorities and responsibilities for safe operation.

Operations Section Procedure 02-S-01-17, Control of Limiting Conditions for Operation, Section 2.1 states that the shift supervisor is responsible for documenting situations which exceed the Limiting Conditions for Operations described in Technical Specifications.

Contrary to the above, on January 14, 1992, the shift supervisor fail to recognize, or document entering a Limiting Condition for Operation when work was authorized on a containment isolation valve (RHR A Suppression Pool Suction Valve) which rendered the valve inoperable.

I. Admission or Denial of the Alleged Violation

Entergy Operations, Inc. admits to this violation.

II. The Reason for the Violation, If Admitted

On January 14, 1992, work was authorized by the operations shift supervisor on the 'A' Residual Heat Removal suction valve from the suppression pool. The scope of the work order (WO) was to investigate the failure of the valve to open after being giving an open signal. In the WO, maintenance personnel were instructed to calibrate the thermal overloads in accordance with plant procedure 07-S-12-82 if calibration was necessary. The plant procedure requires that the breaker for the overload device be de-energized.

During the conversation between the shift supervisor and Electrical Maintenance personnel, the supervisor did not realize the full scope of the work to be performed, in that the breaker for the valve would be opened during the evolution, thus rendering the valve inoperable during the maintenance.

The cause of the incident was poor verbal communication and work practices by the shift supervisor.

The shift supervisor involved was not normally assigned to shift and was standing a quarterly proficiency watch (QPW), which is required to maintain an active Senior Reactor Operator (SRO) License. The QPW is the mechanism used to enhance the work skills and verbal communications of the licensed personnel not normally assigned to shift.

Operation management expectations are that extra controls be exercised by the remainder of the shift management crew, and a heightened awareness in the control room when QPWs are being performed. The controls were successful in identifying the improper evaluation, after the work was started. Controls also ensured the proper LCO was documented and appropriate actions were taken by the shift to place the valve in a position that met the LCO action statement within the required time limits. However, the controls were not effective in ensuring the work was properly evaluated before the work started.

III. The Corrective Steps Which Have been Taken and the Results Achieved

- A. The shift supervisor and the two other SROs involved were removed from shift and retrained. Proper verbal communications and work practices were emphasized to the shift supervisor. Operations management's expectations of controls and heightened awareness during QPWs were emphasized to all SROs. Following training, the personnel involved were placed back on shift.
- B. Other operations personnel were made aware of this incident. Management expectations during QPWs were communicated to the shift management on other crews and the SROs who are currently standing QPWs.
- C. The shift supervisor was counselled on the occurrence.

IV. The Corrective Steps Which Will Be Taken To Preclude Further Violation

- A. Entergy Operations feels that the above corrective actions are appropriate to preclude recurrence.



V. Date When Full Compliance Will Be Achieved

All corrective actions have been completed at this time.

**Notice of Violation 92-02-03**

10 CFR 20.201(b) requires each licensee to make or cause to be made such surveys as (1) may necessary for the licensee to comply with the regulations in 10 CFR Part 20 and (2) are reasonable under the circumstances to evaluate the extent of radiation hazards that may be present.

Technical Specification 6.12.2 requires, in part, that areas accessible to personnel with radiation levels such that a major portion of the body could receive in one hour a dose rate greater than 1000 mrem shall be provided with locked doors to prevent unauthorized entry and that these doors shall remain locked except during periods of access by personnel under an approved Radiation Work Permit (RWP) which shall specify the dose rate levels in the immediate work area and the maximum allowable stay time for individuals in that area.

Contrary to the above, on November 13, 1991, an entry was made into a posted Transient Very High Radiation Area greater than 1000 mrem/hr on an RWP that did not authorize Very High Radiation Areas. Although radiological conditions may not have been greater than 1000 mrem/hr at the time of the entry, a survey for gamma dose was not performed to evaluate the extent of the radiation hazard that was present.

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

Entergy Operations, Inc. admits to this violation.

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

The following occurrence was identified by a recent Quality Programs audit of the HP department.

On October 24, 1991, a Health Physics (HP) technician provided coverage for a weekly operations surveillance of the drywell airlock door seals. The surveillance requires entry into an area that is posted Transient Very High Radiation (TVHR) Area. The HP technician entered the area on a RWP that did not address the entrance of personnel into TVHR areas and performed an inadequate survey (e.g., no gamma survey was performed).



Following the HP survey, Operations personnel entered the area to perform the surveillance on an inappropriate RWP due to the HP technician not re-posting the area.

A normal work practice of the HP section is to survey the area with a portable monitor; then re-post the area if the results of the survey permit. In this case, the HP technician failed to perform this duty.

The HP supervisor considered the assignment to be a routine evolution and did not consider the new employee's lack of experience. Therefore, the pre-job briefing did not include details to reinforce the requirements to ensure the task was adequately performed.

There are three causes associated with the occurrence.

The failure of the HP supervisor to conduct an adequate pre-job briefing.

The technician was not familiar with potential radiological hazards which existed in the traversing in-core probes (TIPS) area. This particular task was not a part of the qualification card. Therefore, the technician was not familiar with TIPS nor the task.

The technician had the mindset that there was no potential for a gamma hazard due to having verified that the TIPS were red tagged in their stored position.

### III. The Corrective Steps Which Have been Taken and the Results Achieved

- A. HP lab personnel were trained with an emphasis on the need for adequate pre-job briefings and surveys.
- B. A standing order was issued and training was conducted with the HP supervisors stressing the importance of considering the qualifications and experience of personnel prior to the assignment of tasks.
- C. The HP supervisor was counseled on the importance of documenting deficiencies when they are identified.

IV. The Corrective Steps Which Will Be Taken To Preclude Further Violation

- A. The proper HP practices concerning access to (transient) VHR areas (e.g. TIPS area) will become a part of the qualification training of HP technicians.

V. Date When Full Compliance Will Be Achieved

The action will be implemented by April 30, 1992.