



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BOULEVARD
ARLINGTON, TEXAS 76011-4511

December 15, 2021

EA-20-125
EA-21-096
EA-21-110

Mr. Robert Franssen, Site Vice President
Entergy Operations, Inc.
Grand Gulf Nuclear Station
P.O. Box 756
Port Gibson, MS 39150

SUBJECT: GRAND GULF NUCLEAR STATION - NOTICE OF VIOLATION; NRC
INSPECTION REPORTS 05000416/2021091 AND 05000416/2021092; AND
INVESTIGATION REPORTS 4-2019-021, 4-2020-025, AND 4-2020-029

Dear Mr. Franssen:

This letter refers to three investigations conducted at the Grand Gulf Nuclear Station by the U.S. Nuclear Regulatory Commission (NRC) Office of Investigations. The purpose of these investigations was to determine whether willful violations of NRC requirements occurred at the Grand Gulf Nuclear Station involving the administration of engineering support qualification examinations (4-2019-021), maintenance on a main steam isolation valve (4-2020-025), and the adjustment of a hand geometry unit (4-2020-029). The investigations were initiated on September 19, 2019, July 9, 2020, and September 1, 2020, and completed on September 14, 2020, June 25, 2021, and July 21, 2021, respectively. A final exit briefing was conducted telephonically with you and other members of your staff on November 5, 2021.

In the letter transmitting NRC Inspection Report 05000416/2020016, dated February 24, 2021 (Agencywide Documents Access and Management System (ADAMS) Accession No. ML21055A001) we documented the results of Investigation Report 4-2019-021 and provided you with the opportunity to address the apparent violation identified in the letter by attending a predecisional enforcement conference, participating in an alternative dispute resolution mediation session, or providing a written response before we made our final enforcement decision. In a letter dated March 25, 2021 (ADAMS Accession No. ML21085A565) you provided a written response to address the apparent violation. The NRC delayed the final decision on this enforcement action while evaluating the other two cases involving deliberate misconduct.

Based on the information developed during the investigation and the information you provided in your response to the inspection report dated February 24, 2021, the NRC has determined that a violation of NRC requirements occurred. This violation (Violation A) is cited in Enclosure 1, "Notice of Violation" (Notice), and the circumstances surrounding it are described in detail in NRC Inspection Report 05000416/2020016. Violation A involved an exam proctor willfully providing inappropriate assistance to engineering students during engineering support qualification examinations.

The NRC considers Violation A to be significant. In determining the significance of a violation involving willfulness, the NRC considers such factors as: the position, training, experience level, responsibilities of the person involved in the violation; the significance of any underlying violation; and the intent of the responsible individual (careless disregard or deliberateness). Therefore, Violation A has been categorized in accordance with the NRC Enforcement Policy as Severity Level III violation. The NRC Enforcement Policy can be found on the NRC's website at <http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html>.

In accordance with the NRC Enforcement Policy, a base civil penalty in the amount of \$150,000 is considered for a Severity Level III violation.

Because your facility is the subject of a willful escalated enforcement action, the NRC considered whether credit was warranted for *Identification* and *Corrective Action* in accordance with the civil penalty assessment process in Section 2.3.4 of the NRC Enforcement Policy. The NRC has determined that *Identification* credit is warranted for Violation A because your staff identified the condition and entered it into the corrective action program. The NRC further determined that *Corrective Action* credit is warranted for the violation based on the corrective actions documented in your March 25, 2021, written response.

Therefore, to encourage identification and prompt and comprehensive correction of violations, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty for the Severity Level III violation. However, significant violations in the future could result in a civil penalty.

The NRC has concluded that information regarding: (1) the reason for Violation A; (2) the corrective actions that have been taken and the results achieved; and (3) the date when full compliance was achieved is already adequately addressed on the docket in your March 25, 2021, written response. Therefore, you are not required to respond to Violation A unless the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed Notice.

In addition to the Severity Level III Violation A described above, the NRC has determined that two Severity Level IV violations of NRC requirements occurred. These violations were identified based on the information developed during Investigations 4-2020-025 and 4-2020-029. The basis for determining that willfulness was associated with these violations (Violations B and C) is provided in factual summaries located in Enclosure 2. Violations B and C are cited in enclosed Notice and the circumstances surrounding them are described in detail in Enclosure 3, "Inspection Report 05000416/2021092." These violations involve the failure to maintain information required by the Commission's regulations that was complete and accurate in all material respects associated with main steam isolation valve maintenance (Violation B), and the failure to fully implement all provisions of the physical security plan associated with hand geometry unit adjustment (Violation C). The NRC considers Violations B and C to be of low safety significance and thus has characterized them in accordance with the NRC Enforcement Policy as Severity Level IV violations.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response for Violations B and C. If you have additional information that you believe the NRC should consider, you should provide it in your response to the Notice. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

I have authorized follow-up inspection to be performed using Inspection Procedure 92702, "Follow-Up on Traditional Enforcement Actions Including Violations, Deviations, Confirmatory Action Letters, and Orders," to review your actions to address all three violations. This inspection will be scheduled when you notify the NRC of your readiness.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice and Procedure and Procedure," a copy of this letter and its enclosures will be made available electronically for public inspection in the NRC Public Document Room or in the NRC's ADAMS, accessible from the NRC website at <http://www.nrc.gov/reading-rm/adams.html>. To the extent possible, your response should not include any personal privacy, proprietary, or Security-Related Information so that it can be made available to the public without redaction. The NRC also includes significant enforcement actions on its website at <http://www.nrc.gov/reading-rm/doc-collections/enforcement/actions>.

If you have any questions concerning this matter, please contact Mr. Jason Kozal of my staff at 817-200-1144.

Sincerely,



Signed by Morris, Scott
on 12/15/21

Scott A. Morris
Regional Administrator

Docket No. 05000416
License No. NPF-29

Enclosures:

1. Notice of Violation
2. Factual Summaries
3. Inspection Report 05000416/2021092

GRAND GULF NUCLEAR STATION - NOTICE OF VIOLATION; NRC INSPECTION REPORTS 05000416/2021091 AND 05000416/2021092; AND INVESTIGATION REPORTS 4-2019-021, 4-2020-025, AND 4-2020-029 DATED - DECEMBER 15, 2021

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ADAMS ACCESSION NUMBER: ML21349B337

SUNSI Review: ADAMS: Non-Publicly Available Non-Sensitive Keyword:
 By: JGK Yes No Publicly Available Sensitive

OFFICE	ES:ACES	TL:ACES	C:DRS/EB2	C:DRP/PBC	RC	NSIR	OE
NAME	ARoberts	JGroom	NTaylor	JKozal	DCylkowski	TKeene	DJones
SIGNATURE	/RA/ E	/RA/ E	/RA/ E	/RA/ E	/RA/ E	/RA/ E	/RA/ E
DATE	12/02/21	12/02/21	12/02/21	12/02/21	12/02/21	12/06/21	12/10/21
OFFICE	NRR	OGC	OGC	D:DRS	D:DRP	RA	
NAME	RFelts	MSimon	RCarpenter	RLantz	AVegel	SMorris	
SIGNATURE	/RA/ E	NLO	NLO	/RA/ E	/RA/ E	/RA/	
DATE	12/09/21	12/10/21	12/10/21	12/14/21	12/13/21	12/15/21	

OFFICIAL RECORD COPY

NOTICE OF VIOLATION

Entergy Operations, Inc.
Grand Gulf Nuclear Station

Docket No. 05000416
License No. NPF-29
EA-20-125
EA-21-096
EA-21-110

During NRC investigations that were initiated on September 19, 2019, July 9, 2020, and September 1, 2020, and completed on September 14, 2020, June 25, 2021, and July 21, 2021, respectively, three violations of NRC requirements were identified. In accordance with the NRC Enforcement Policy, the violations are listed below:

- A. 10 CFR 50.120 requires, in part, that the licensee shall implement and maintain a training program derived from a systems approach to training that provides for the training and qualification of engineering support personnel.

Entergy Procedure EN-TQ-104, "Engineering Support Personnel Training Program," Revisions 21-27, a quality-related procedure intended to establish appropriate training and qualification requirements for the engineering support personnel training program, Attachment 3, "NANTeL [National Academy for Nuclear Training e-Learning] Course Exam Pre-Job Briefing," requires, in part, that for students completing engineering support personnel NANTeL exams, an exam proctor must be available to clarify questions. The assistance must only be to clarify questions and not to reword any exam questions, not to explain any terms, and not to provide any additional information.

Contrary to the above, from November 2016 to July 2019, for students completing engineering support personnel NANTeL exams, the proctor failed to limit assistance to clarifying questions, but rather explained terms and provided additional information to the students. Specifically, for six students, an exam proctor deliberately provided inappropriate assistance to the students in the form of a drawing on a white board during the exam and verbal cues regarding their selection of answers during the exam.

This is a Severity Level III violation (NRC Enforcement Policy Section 2.2.1.d). (EA-20-125)

- B. 10 CFR 50.9 requires, in part, that information required by the Commission's regulations, to be maintained by the licensee, shall be complete and accurate in all material respects.

10 CFR Part 50, Appendix B, Criterion XVII, requires, in part, that sufficient records shall be maintained to furnish evidence of activities affecting quality.

Contrary to the above, from April 26 to April 28, 2020, the licensee failed to maintain information required by the Commission's regulations that was complete and accurate in all material respects. Specifically, inaccurate information was deliberately entered in Condition Report CR-GGN-2020-05570, which documented an adverse condition regarding a safety-related component. The condition report documented that pieces of foreign material were blocking air flow through the hole in the gasket of a flanged pipe connection in an operating air supply line to a main steam isolation valve, when in fact there was no foreign material found in this location, nor was there a hole in the gasket to allow for air flow. The information in the condition report was material to the NRC because it is subject to NRC inspection and informs the NRC's assessment of the

licensee's implementation of the corrective action program to address conditions adverse to quality.

This is a Severity Level IV violation (NRC Enforcement Policy Section 2.2.4). (EA-21-096)

- C. License Condition 2.E requires, in part, that the licensee shall fully implement and maintain in effect all provisions of the Commission-approved physical security plan.

The physical security plan, Section 20, requires, in part, that all testing and maintenance activities are conducted by trained and qualified personnel and in accordance with Entergy procedures.

Entergy Procedure EN-WM-100, "Work Request Generation, Screening and Classification," Revision 16, prescribes the process used for generation, screening, and classification of work requests. Step 5.1.1 requires, in part, that when a deficiency is identified that is not toolpouch maintenance and there is not a duplicate open work request, initiate a condition report.

Contrary to the above, on July 21, 2020, when a deficiency was identified that was not toolpouch maintenance and there was not a duplicate open work request, the licensee failed to initiate a condition report. Specifically, a senior security supervisor deliberately performed maintenance on a personal security access control device without initiating a condition report to document needed repairs, as specified in work management procedures. The supervisor adjusted the reject threshold operational setting without a work order authorizing the adjustment.

This is a Severity Level IV violation (NRC Enforcement Policy Section 2.2.4). (EA-21-110)

The NRC has concluded that information regarding: (1) the reason for Violation A; (2) the corrective actions that have been taken and the results achieved; and (3) the date when full compliance was achieved is already adequately addressed on the docket in your March 25, 2021, written response. However, if the description therein does not accurately reflect your position or your corrective actions for Violation A, you are required to submit a written statement or explanation pursuant to 10 CFR 2.201 within 30 days of the date of the letter transmitting this Notice of Violation (Notice). In that case, or if you choose to respond, clearly mark your response as a "Reply to a Notice of Violation, EA-20-102, 21-096, 21-110," and send it to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001 with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 1600 East Lamar Blvd., Arlington, Texas 76011-4511, and the NRC Resident Inspector at the Grand Gulf Nuclear Station and email it to R4Enforcement@nrc.gov.

Pursuant to 10 CFR 2.201, Entergy Operations, Inc. is hereby required to submit a written statement or explanation for Violations B and C to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 1600 East Lamar Blvd., Arlington, Texas 76011-4511, and the NRC Resident Inspector at the Grand Gulf Nuclear Station, and email it to R4Enforcement@nrc.gov within 30 days of the date of the letter transmitting this Notice. This reply should be clearly marked as a "Reply to a Notice of Violation, EA-20-102, 21-096, 21-110," and should include for Violations B and C: (1) the reason for the violation, or, if contested, the basis for disputing the violation or severity level; (2) the

corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken; and (4) the date when full compliance will be achieved.

Your response for Violations B and C may reference or include previous docketed correspondence if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, the NRC may issue an order or a demand for information requiring you to explain why your license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

If you contest this enforcement action, you should also provide a copy of your response, with the basis for your denial, to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001.

If your response does not contain Security-Related Information, it will be made available electronically for public inspection in the NRC Public Document Room or in the NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC website at <http://www.nrc.gov/reading-rm/adams.html>. Therefore, to the extent possible, the response should not include any personal privacy or proprietary information so that it can be made available to the public without redaction.

If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request that such material is withheld from public disclosure, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.390(b) to support a request for withholding confidential commercial or financial information).

If Security-Related Information is necessary to provide a response, please mark your entire response "Security-Related Information - Withhold from Public Disclosure Under 10 CFR 2.390" in accordance with 10 CFR 2.390(d)(1) and follow the instructions for withholding in 10 CFR 2.390(b)(1). If your response contains Security-Related Information, it will not be made available electronically for public inspection in the NRC Public Document Room or in the NRC's ADAMS.

Dated this 15th day of December 2021

FACTUAL SUMMARIES (VIOLATIONS B AND C)

OFFICE OF INVESTIGATIONS REPORT 4-2020-025 (VIOLATION B)

On July 9, 2020, the U.S. Nuclear Regulatory Commission (NRC) Office of Investigations Region IV initiated an investigation to determine if two former mechanical maintenance technicians, employed by Entergy Operations Inc. (licensee) at the Grand Gulf Nuclear Station (GGNS), deliberately submitted to the licensee information they knew to be incomplete or inaccurate in some respect material to the NRC. The investigation was completed on June 25, 2021.

On or about April 22, 2020, two mechanical maintenance technicians at GGNS installed an incorrectly manufactured gasket into a flange on the actuator air line of the "B" main steam isolation valve (MSIV). Specifically, they did not cut out the center portion of the gasket to allow air to flow through; this resulted in the failure of the MSIV to open during post-maintenance testing.

When operators noticed that the valve did not respond as expected during testing, they began troubleshooting actions. On or about April 25, 2020, the mechanical technicians replaced the incorrectly manufactured gasket, which they had installed, with another gasket, this time making sure to cut a hole for air flow. In an effort to conceal the original error, one of the technicians documented incorrect information in a Condition Report (CR) that the airflow problem was caused by foreign material "blocking the flange hole where the gasket sits...." The same technician also retrieved the old gasket from the trash and cut a center hole in it to claim that was the "as found" condition, and provided photos of "foreign material" that he had fabricated from other sources. Both technicians also completed written causal analysis forms in which they stated that foreign material had caused the airflow problem.

The two mechanical maintenance technicians continued to provide inaccurate information to GGNS management during the licensee's investigation into the issues with the MSIV actuator air line. On April 28, 2020, after learning that licensee management had found the plug that was cut from the original gasket, the two mechanical maintenance technicians met with and admitted to senior licensee officials that they had falsely reported that the original gasket had a center hole and that foreign material had caused the airflow blockage.

OFFICE OF INVESTIGATIONS REPORT 4-2020-029 (VIOLATION C)

On September 1, 2020, the NRC Office of Investigations Region IV initiated an investigation to determine if a former senior security supervisor (SS), employed by the licensee at the GGNS, willfully failed to follow a procedure associated with an adjustment to a hand geometry unit. The investigation was completed on July 21, 2021.

On July 21, 2020, GGNS management became aware that the "reject operational threshold" setting on the MAC8 turnstile hand geometry unit was set to 110, which is higher and less conservative than the expected setting of 80. The GGNS security manager directed the SS to verify the reject threshold operational setting for the hand geometry unit. During testimony with the Office of Investigations Special Agent, the SS admitted that he discovered the setting was "different than what they had been set when the system was installed." Rather than report this information, because he feared he would be blamed for the error, the SS changed the setting to 80 without initiating a CR and work order as required by site procedure. When asked what the proper method would be to perform changes, the SS responded that "[i]f you identified a

problem, either a condition report or a work order would be generated. It would be reviewed to determine the actions needed and then a change would be made to resolve the issue.”

**U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report**

Docket Number: 05000416

License Number: NPF-29

Report Number: 05000416/2021092

Enterprise Identifier: I-2021-092-0000

Licensee: Entergy Operations, Inc.

Facility: Grand Gulf Nuclear Station

Location: Port Gibson, MS

Inspection Dates: March 26, 2021 to November 5, 2021

Inspectors: C. Young, Senior Project Engineer
G. Pick, Senior Reactor Inspector

Approved By: Jason W. Kozal, Chief
Reactor Project Branch C
Division of Reactor Projects

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee’s performance by conducting an NRC inspection at the Grand Gulf Nuclear Station, in accordance with the Reactor Oversight Process (ROP). The ROP is the NRC’s program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

List of Findings and Violations

Failure to Use the Work Control Process to Adjust Hand Geometry Unit			
Cornerstone	Severity	Cross-Cutting Aspect	Report Section
Not Applicable	Severity Level IV NOV 05000416/2021092-01 Open EA-21-110	Not Applicable	Not Applicable
The NRC identified a Severity Level IV violation of License Condition 2.E and Section 20 of the Physical Security Plan for the licensee’s failure to accomplish activities affecting security in accordance with Procedure EN-WM-100, “Work Request Generation, Screening and Classification,” Revision 16. Specifically, an individual deliberately made an unauthorized adjustment to the hand geometry unit’s reject threshold operational setting without initiating a condition report and obtaining work authorization.			

Falsified Information Regarding a Condition Adverse to Quality			
Cornerstone	Severity	Cross-Cutting Aspect	Report Section
Not Applicable	Severity Level IV NOV 05000416/2021092-02 Open EA-21-096	Not Applicable	Not Applicable
The inspectors identified a violation of 10 CFR 50.9 for the licensee’s failure to maintain information required by the Commission’s regulations that was complete and accurate in all material respects. Specifically, inaccurate information was entered in Condition Report CR-GGN-2020-05570, which documented an adverse condition regarding a safety-related component.			

Additional Tracking Items

None.

INSPECTION RESULTS

Failure to Use the Work Control Process to Adjust Hand Geometry Unit			
Cornerstone	Severity	Cross-Cutting Aspect	Report Section
Not Applicable	Severity Level IV NOV 05000416/2021092-01 Open EA-21-110	Not Applicable	Not Applicable
<p>The NRC identified a Severity Level IV violation of License Condition 2.E and Section 20 of the Physical Security Plan for the licensee's failure to accomplish activities affecting security in accordance with Procedure EN-WM-100, "Work Request Generation, Screening and Classification," Revision 16. Specifically, an individual deliberately made an unauthorized adjustment to the hand geometry unit's reject threshold operational setting without initiating a condition report and obtaining work authorization.</p>			
<p><u>Description:</u> On July 13, 2020, the Security Operations Supervisor initiated Condition Report CR-HQN-2020-01372 because he had received a higher-than-normal value on a hand geometry unit when entering the secure owner-controlled area through the MAC 8 turnstile. The Security Operations Supervisor asked information technology personnel to determine the reject threshold operational setting for the hand geometry units and provide him the value of the setting. Concurrently, the Security Manager requested that the Senior Security Supervisor independently confirm that the reject threshold operational setting value because the reported value exceeded what he understood to be normal.</p> <p>Upon discovering the reject threshold value elevated when he logged into the system, the Senior Security Supervisor adjusted the reject threshold operational setting to the expected, nominal value. Concurrently, information technology personnel double checked the reject threshold operational setting after learning that the security manager had concerns about the reported value. When information technology personnel checked the reject threshold operational setting, they determined that the value had been changed without anyone asking them for an access password and without a work order to authorize the adjustment. Consequently, they informed the security manager that an unauthorized change had occurred to a critical digital asset.</p> <p>After being informed of the issue by information technology personnel, the Security Manager questioned the Senior Security Supervisor, who initially denied that he changed the setting, but then 30 minutes later admitted to adjusting the reject threshold setting.</p> <p>The Senior Security Supervisor had the skills and the administrative rights to make the adjustment of the reject threshold operational setting; hence, he did not need to talk to information technology to obtain a password. Lowering the reject threshold operational setting to the nominal value increased the sensitivity required to gain access through the MAC-8 turnstiles (i.e., it became more difficult). Procedure EN-WM-100, "Work Request Generation, Screening and Classification," Revision 16, prescribes the process used for generation, screening, and classification of work requests. Step 5.1.1 requires, in part, that when a deficiency is identified that is not tool pouch maintenance and there is not a duplicate open work request, initiate a condition report.</p> <p><u>Corrective Actions:</u> The licensee confirmed that the individual had adjusted the settings to the correct, nominal value and placed the individual on administrative leave while conducting</p>			

an internal investigation. The investigation confirmed the individual had extensive experience with the system and was considered a subject matter expert.

Corrective Action Reference: CR-HQN-2020-01372

Performance Assessment: The inspectors determined this violation was associated with a minor performance deficiency. The licensee’s failure to implement the station's work control procedure was determined to be a minor performance deficiency.

Enforcement: The ROP’s significance determination process does not specifically consider willfulness in its assessment of licensee performance. Therefore, it is necessary to address this violation which involves willfulness using traditional enforcement to adequately deter non-compliance.

Severity: This violation was determined to be Severity Level IV in accordance with Section 2.2.4 of the NRC Enforcement Policy.

Violation: License Condition 2.E requires, in part, that the licensee shall fully implement and maintain in effect all provisions of the Commission-approved physical security plan.

The physical security plan, Section 20, requires, in part, that all testing and maintenance activities are conducted by trained and qualified personnel and in accordance with Entergy procedures.

Entergy Procedure EN-WM-100, “Work Request Generation, Screening and Classification,” Revision 16, prescribes the process used for generation, screening, and classification of work requests. Step 5.1.1 requires, in part, that when a deficiency is identified that is not toolpouch maintenance and there is not a duplicate open work request, initiate a condition report.

Contrary to the above, on July 21, 2020, when a deficiency was identified that was not toolpouch maintenance and there was not a duplicate open work request, the licensee failed to initiate a condition report. Specifically, a senior security supervisor deliberately performed maintenance on a personal security access control device without initiating a condition report to document needed repairs, as specified in work management procedures. The supervisor adjusted the reject threshold operational setting without a work order authorizing the adjustment.

Enforcement Action: This violation is being cited because the violation was willful.

Falsified Information Regarding a Condition Adverse to Quality			
Cornerstone	Severity	Cross-Cutting Aspect	Report Section
Not Applicable	Severity Level IV NOV 05000416/2021092-02 Open EA-21-096	Not Applicable	Not Applicable
The inspectors identified a violation of 10 CFR 50.9 for the licensee's failure to maintain information required by the Commission’s regulations that was complete and accurate in			

all material respects. Specifically, inaccurate information was entered in Condition Report CR-GGN-2020-05570, which documented an adverse condition regarding a safety-related component.

Description: On the night shift on April 21-22, 2020, during a refueling outage, a maintenance technician (mechanic) and mechanic trainee were assigned to conduct maintenance to replace a gasket on a flanged pipe connection in a main steam isolation valve (MSIV) actuator air line. During post-maintenance testing, the associated MSIV failed to stroke due to no air supply to the actuator. The mechanics were assigned to troubleshoot the airflow problem. As part of the troubleshooting process, they discovered that in the gasket they had originally installed, they had failed to cut a hole in the gasket to allow airflow in the line. They replaced the flange gasket and discarded the gasket without the hole. On returning from performing the work, the mechanics informed a supervisor that the gasket installed during the April 21-22 maintenance did have a hole in it to allow air to flow in the line (which it did not), and that the problem they found was foreign material in the line blocking air flow. One of the mechanics initiated a Condition Report (CR-GGN-2020-05570) to enter this condition into the licensee's corrective action program, in which he documented that the airflow problem was caused by foreign material "blocking the flange hole where the gasket sits..." which was false information.

After performing the troubleshooting task, the mechanics threw away the old gasket. The supervisor subsequently asked one of the mechanics to go back and retrieve the old gasket and to take some photos of the foreign material in order to document evidence of the conditions that were reported/found during the troubleshooting. The mechanic retrieved the old gasket from the trash, which did not have the required center hole in it to allow for air flow, and proceeded to cut a hole in the center to claim that was the as-found condition. The mechanic returned with the old gasket and photos of the foreign material, which he had also manufactured from other sources and claimed to have found in the air line. Near the end of the shift, the mechanics completed written statements as part of the causal analysis that was being performed, in which both workers stated that the airflow problem was caused by foreign material in the flange near the gasket.

A maintenance manager subsequently performed a walkthrough of the job site and the tool room and found the plug that had been cut from the center of the gasket after removal from the system. This led to the maintenance manager to conclude that the gasket did not have a center hole in it when installed; that the mechanics removed the gasket and then cut a hole in it; and that the mechanics had provided false information (i.e., foreign material) regarding the condition of the plant system to avoid admitting a mistake (i.e., that they had installed an improperly manufactured gasket in the system, which was blocking air flow).

On April 28, 2020, the two mechanics admitted that they had falsely reported that the gasket had a center hole and that foreign material had caused the airflow blockage. This information was material to the NRC because it relates to the cause of condition adverse to quality affecting a safety-related plant component.

Corrective Actions: The issue was promptly identified and corrected, and the employment of the individuals was terminated. The licensee also took actions to address inadequate supervisory oversight of the activities. The licensee generated and distributed communications to all maintenance shops to reinforce usage of human performance tools, and issued requirements for increased focused observations by mechanical maintenance supervisors.

Corrective Action References: CR-GGN-2020-05564

Performance Assessment: The inspectors determined this violation was associated with a minor performance deficiency. The documentation of false information in Condition Report CR-GGN-2020-05570, which documented an adverse condition regarding a safety-related component, was a performance deficiency. This performance deficiency was determined to be minor because it was promptly identified and corrected by the licensee such that it did not have a significant impact on the availability of the associated system to perform its required safety function.

Enforcement: The ROP's significance determination process does not specifically consider willfulness in its assessment of licensee performance. Therefore, it is necessary to address this violation which involves willfulness using traditional enforcement to adequately deter non-compliance.

Severity: The violation was determined to be Severity Level IV since the individuals involved were non-supervisory employees and the occurrence was isolated to one instance that was identified and corrected within a short time period with limited consequences.

Violation: Title 10 CFR 50.9 requires, in part, that information required by the Commission's regulations, to be maintained by the licensee, shall be complete and accurate in all material respects.

Title 10 CFR Part 50, Appendix B, Criterion XVII, requires, in part, that sufficient records shall be maintained to furnish evidence of activities affecting quality.

Contrary to the above, from April 26 to 28, 2020, the licensee failed to maintain information required by the Commission's regulations that was complete and accurate in all material respects. Specifically, inaccurate information was entered in Condition Report CR-GGN-2020-05570, which documented an adverse condition regarding a safety-related component. The condition report documented that pieces of foreign material were blocking air flow through the hole in the gasket of a flanged pipe connection in an operating air supply line to a main steam isolation valve, when in fact there was no foreign material found in this location, nor was there a hole in the gasket to allow for air flow. The information in the condition report was material to the NRC because it is subject to NRC inspection and informs the NRC's assessment of the licensee's implementation of the corrective action program to address conditions adverse to quality.

Enforcement Action: This violation is being cited because the violation was willful.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

On November 5, 2021, Mr. Jason Kozal presented the NRC inspection results to Mr. R. Franssen, Site Vice President, and other members of the licensee staff in a telephonic exit meeting.