



ENTERGY

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March 5, 1993

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Vice President
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Grand Gulf Nuclear Station

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
Response to Violations Identified during Inspection
50-416/92-28: No SRO in the Control Room during Operational Condition
1 and One Example of Failure to Follow Procedure.
Report No. 50-416/92-28, dated 02/04/93
(GNRI-93/00016)

GNRO-93/00028

Gentlemen:

Entergy Operation, Inc. hereby submits the response to the Notice of Violation 50-416/92-28-01 and 50-416/92-28-02.

In your transmittal letter for these violations you expressed concern, shared by us, over the potential consequences should such violations occur under other circumstances. In addition to our enclosed violation response, we feel it is worthwhile to further address your areas of concern.

In the first violation, the only Senior Reactor Operator (SRO) present in the control room left the control room for a period of five minutes. As you noted, the SRO appeared to be more concerned about administrative Health Physics practices than regulatory manning requirements. Without getting into the details of the event, which are fully discussed in the enclosed response, we feel that it is important to explain the mindset of the SRO at the time the event occurred. As you know, the SRO (and the entire control room staff) felt that an employee was in physical danger in the Radiological Controlled Area (RCA) location just outside of the rear control room door. In stepping across the door's threshold, the SRO intended merely to make himself visible believing that this action would be sufficient to quell the disturbance. He believed (incorrectly) that by taking several steps through the

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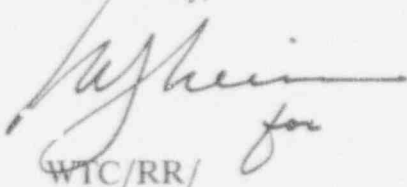
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door he would be remaining within the control room and be able to maintain command and control because he believed (also incorrectly) that the control room door would be held open. With this mindset (i.e., that he was not leaving the control room) the SRO focused on following the procedural requirements associated with entry into an RCA. Since he was the only person in the control room with self-indicating dosimetry and since he believed that he was in compliance with regulatory manning requirements, his judgement dictated that he be the person to enter the RCA. Had the SRO understood that stepping through the control room door constituted leaving the control room, he would have chosen instead to violate Health Physics directives by sending one of the ROs into the RCA.

This entire event, from first hearing the disturbance to exiting the control room, occurred during a period of not more than several minutes. We believe the thought process of the SRO was proper but his assumptions were faulty concerning what constitutes presence in the control room. Similar scenarios have not previously been considered in our SRO Training Program, nor have we conveyed management expectations during similar events. Consequently, we have taken corrective actions to address this lack of guidance and have held meetings between management and appropriate operations staff to convey our expectations of SRO response during these types of events, emphasizing the prime importance of maintaining control room command and control.

We agree that the second violation concerning failure to follow procedures represents the potential for personnel over-exposure and deserves additional attention beyond that normally given a procedural violation. Operations management has implemented methods to establish more adequate controls over the types of evolutions which resulted in the violation, and we are confident that such situations will not recur.

Yours truly,

A handwritten signature in dark ink, appearing to read "WTC/RR/ for", is written over the typed name "WTC/RR/".

WTC/RR/

cc:

(See next page)

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cc:

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Notice of Violation 92-28-01

10 CFR Part 50.54(m)(2)(iii), requires, in part, that when a nuclear power unit is in an operational mode other than cold shutdown or refueling, as defined by the unit's technical specifications, each licensee shall have a person holding a senior operator license for the nuclear power unit in the control room at all times.

Contrary to the above, on January 11, 1993, at about 0050 hours, the control room was not manned by a Senior Reactor Operator for approximately five (5) minutes, while the SRO in command responded to a disturbance outside of the control room.

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 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.

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.

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

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.

III. Corrective Steps Which Have Been Taken and Results Achieved

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 plant supervisor involved was disciplined by Operations Management.

IV. Corrective Steps to be Taken to Preclude Further Violations

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

V. Date When Full Compliance Will Be Achieved

These actions will be completed by June 30, 1993.

Notice of Violation 92-28-02

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, Appendix "A", recommends a procedure for administrative control of procedural adherence. Administrative Procedure 01-S-02-1, "Description and Use of the GGNS Operations Manual," paragraph 6.1., requires that verbatim compliance shall be strictly adhered to by all personnel, and that deviation from, omitting of, or deleting any part of approved procedures and instructions is not allowed.

Contrary to the above, on December 22, 1992, operations personnel failed to close valve 1N64-F201A, as required by step 5.1.2(11) of System Operating Instruction 04-1-01-N62-1, Condenser Air Removal, resulting in a locked but un-posted Very High Radiation Area in the "A" steam jet air ejector room.

I. Admission or Denial of the Alleged Violation

Entergy Operations, Inc. admits to this violation.

II. The Reason for the Violation, if Admitted

On December 22, 1992, Operations personnel were securing the "A" Steam Jet Air Ejector (SJAE) following rotation to the "B" train. After "A" SJAE was removed from service, a one hour air purge was established, as required by procedure, to remove any remaining gases in the "A" system.

After one hour, a licensed reactor operator (RO) directed a non-licensed operator (NOB) to secure the air purge. The RO read the appropriate procedural step to the NOB, however, the complete statement was not read, and the NOB did not refer to the procedure prior to securing the purge. This resulted in an outlet valve for the out-of-service SJAE train being left in the open position. Subsequently, offgas flow from the in-service train entered the out-of-service train via the open outlet valve resulting in a Very High Radiation Area (VHRA) in the SJAE room.

During the time the VHRA existed in the SJAE room, the door was locked and no personnel entered the area.

The procedural violation was the result of a failure to properly control the evolution.

The NOB was directed by an RO to perform the task. However, complete procedural directions were not given to the NOB prior to performance of the task, nor did the NOB obtain a controlled copy of the procedure for use.

A contributing factor to the event was the final step of the procedure governing the evolution. Following a one hour purge period, two valves are required to be closed. The two actions were combined into one step of the procedure. This contributed to the last actions being omitted.

III. Corrective Steps Which Have Been Taken and Results Achieved

Operations management has established methods to ensure planned evolutions are controlled. The Plant Supervisor has been tasked with conducting a briefing prior to a planned evolution taking place. This briefing would outline the evolution and assign responsibilities for procedural steps to specific plant personnel. Additionally, personnel will be assigned to track the evolution until completion, ensuring all procedural steps are performed.

The procedure was revised to separate the two actions into two steps. The new procedure revision also requires a sign to be placed on the control room panel which states that a purge is in progress and refers the responsible RO to the appropriate procedural step for securing the air purge. Additionally, the procedure now requires Health Physics personnel to survey radiations levels following the evolution.

IV. Corrective Steps to be Taken to Preclude Further Violations

Entergy Operations feels that the above corrective actions will preclude recurrence of the event.