ENTERGY

Entergy Operations, Inc.
P.O. Box 756
Port Gibson, MS 39150
Tel 601 437 2800

C. R. Hutchinson
Vice President
Operations
Grand Gulf Nuclear Station

March 24, 1995

U.S. Nuclear Regulatory Commission
Mail Station P1-37
Washington, D.C. 20555

Attention: Document Control Desk

Subject: Grand Gulf Nuclear Station
Docket No. 50-416
License No. NPF-29
Response to Violation for Failure to Take
Adequate Corrective Actions
Report No. 50-416/94-21, dated 02/24/95
(GNRI-95/00050)

GNRO-95/00042

Gentlemen:

Entergy Operations, Inc. submits the response to Notice of Violation 50-416/94-21-01.

Notice of Violation (NOV) 50-416/94-21-01 stated that Grand Gulf Nuclear Station (GGNS) had failed to implement adequate corrective action to preclude recurrence of protective tagging procedural deficiencies. GGNS agrees with the findings of this inspection report (50-416/94-21).

The events referenced in the NOV were both examples of human error. These errors occurred because of failure to follow procedure. Though the detail of these events are different the fundamental cause of both events was inadequate management oversight.

GGNS has reviewed the oversight process for protective tagging and in addition to an ongoing long range program to address human performance deficiencies, specific short term corrective actions will be implemented to address tagging deficiencies. Key to this will be soliciting input from front-line personnel on effective measures to re-enforce adherence to procedure and attention to detail. GGNS has resolved to make every effort to reverse the current negative trend with protective tagging.

Yours truly,

CRH/JEO/
attachment: Response to Violation 50-416/94-21-01
cc: (See following page)

IE01
1/1

CC:

Mr. J. E. Tedrow (w/a)
Mr. H. W. Keiser (w/a)
Mr. R. B. McGehee (w/a)
Mr. N. S. Reynolds (w/a)
Mr. H. L. Thomas (w/o)

Mr. Stewart D. Ebneter (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/2)
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Mail Stop 13H3
Washington, D.C. 20555

Notice of Violation 94-21-01

10CFR 50 Appendix B, Criteria XVI, requires that measures shall be established to assure that conditions adverse to quality, such as malfunctions and deficiencies are promptly identified and corrected. 10CFR 50 Appendix B is implemented by the Quality Assurance Topical Report, GGNS-TOP-1A. Section 16.5.2 of the Topical Report requires that procedures shall provide for the evaluation of conditions such as malfunctions and deficiencies. Section 16.5.3 of the Topical Report requires follow-up reviews by the appropriate organizations to verify proper implementation of the corrective action.

Contrary to the above, on January 16, 1995, a control room operator failed to follow the Grand Gulf Nuclear Station (GGNS) protective tagging procedure by removing protective tags without having the tag clearance sheet in hand. This violation was subsequent to a non-cited violation (50-416/94-18-02) issued October 12, 1994, for failure to follow protective tagging clearance special instructions.

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

Entergy Operations, Inc. admits to this violation.

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

On October 12, 1994, operations removed the "B" circulating water pump lube water suction strainer (N71D030B) from service due to high differential pressure. The alternate strainer was placed in service and a clearance request was to be generated to clean the "B" suction strainer. However, the Mechanical Supervisor pulled the task card for the discharge stainer (N71D031B). Therefore, the protective tagging request was made for the "B" discharge strainer instead of the suction strainer. Additionally, the clearance request sent to the field contained special instruction to insure the alternate lube water pump was running before opening the breaker for the "B" lube water pump. These special instructions were not followed. The above actions were in violation of the protective tagging procedure and resulted in a non-cited violation from your staff.

This incident was the result of three causal factors:

- Maintenance and Operations personnel did not adequately discuss the component which was being tagged. Verbal communication and written communication were ineffective. Operation had requested the suction strainer be cleaned. This had been conveyed to maintenance and operations personnel. However, the tag request only used a component number with no written description which would cause personnel to question the accuracy of the request.

- Operation's personnel were well aware of the component that needed to be cleaned; however, the wrong component number was not questioned by personnel preparing and reviewing the clearance. There was no method of verification used to ensure that the proper component was being removed from service.

- The clearance had special instructions clearly specified even though, the operator did read these instructions he did not carry them out. Due to the mind set that these instructions had already been carried out during the previous shift. Therefore, no effort was made to verify the alternate pump was running.

The actions taken to address these causes consisted of counseling as well as a memo to operation personnel.

On January 16, 1995, tags on protective tagging clearance no. 950052 were being removed from various equipment following completion of switchyard maintenance. A reactor operator (RO) dispatched a building operator to remove the tag from the breaker 152-1905. Upon completing this task the building operator returned to the control room with the clearance. However, the RO had stepped out of the control room. The control room operator (CRO) dispatched a second building operator to independently verify the clearance. Upon returning, the RO noticed that the first building operator had returned from clearing the tags. The RO was unaware that the CRO had dispatched a second building operator to verify the tag. Therefore, the RO noting that the building operator had returned, looked on the CRO's desk, and seeing a tag clearance sheet, assumed that it was clearance 950052. He then removed the breaker handswitch tag and closed the breaker. This occurred while the clearance was being verified in the field. This was in violation of the protective tagging procedure which requires an operator to have the clearance in hand before manipulating plant equipment per clearance instructions

- The procedure requires the Operations controller to have tags hung or removed from the field then returned to the controller. The controller is responsible for coordinating the tagging evolution. In this case the RO took personal responsibility for completing the tag instead of allowing the controller to designate personnel for the specific tasks. This in itself was not a negative factor, but, the failure of control room personnel to communicate their action to one another was a critical factor.

- Even though these incidents can be attributed to specific causes i.e., failure to follow procedure, inattention to detail, it appears that the underlying cause is a lack of strict compliance with management expectations. A key method of communicating Operations Management's expectations concerning protective tagging is the protective tagging procedure. However, the procedure is cumbersome for personnel to use and understand. Therefore, personnel may not fully understand the expectation and concerns of management. Additionally, work practices play a major role in these incidents which also indicate inconsistent or ineffective enforcement of upper management expectations. Personnel assumed that the clearance actions (proper reviews, request) were correctly completed. This led them to not question the accuracy of the clearance.

III. Corrective Steps Which Have Been Taken and Results Achieved

Operation management held meetings with all on-shift management personnel to ensure that management's expectations were consistently enforced on all operating shifts.

IV. Corrective Steps to be Taken to Preclude Further Violations

The identified deficiencies are part of the broader human performance area. Operations has undertaken an ongoing long term effort to address human performance deficiencies. However to specifically address protective tagging deficiencies, Operations has stepped back in order to view the big picture concerning protective tagging. In taking this broader prospective, management oversight was determined to be less than adequate. The following corrective actions will be implemented to address the identified deficiencies.

- GGNS procedures contain management's philosophy and expectations. The current revision of the protective tagging procedure has become cumbersome and difficult to use. Therefore, expectations may not in all cases be adequately understood. In order to correct this situation, the procedure will be revised to make it easier for the front-line operations personnel to use. Procedural enhancements will include flow charts to provide quick and easy reference for protective tagging requirements.

- Upper management will continue to reenforce their philosophy and expectations, however, increased emphasis will be placed on consistant compliance with expectations from shift to shift. To aid in this , team building sessions will be held consisting of entire operations shifts. These sessions will provide opportunities for on-shift management to reinforce expectations through discussion of identified deficiencies. These sessions will provide an environment for soliciting valuable input from non-management personnel. This input should aid in identifying possible pitfalls during work activities that may not have been previously addressed.

V. Date When Full Compliance Will be Achieved

All actions are scheduled to be completed by November 30, 1995.