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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 Notices of Violation 50-416/96-17-02, Failure to Follow Procedure
Report No. 50-416/96-17, dated 11/29/96
(GNRI-96/00234)

GNRO-96/00140

Gentlemen:

Entergy Operations, Inc. submits the response to Notices of Violation 50-416/96-17-02.

Notice of Violation (NOV) 50-416/96-17-02 cited Grand Gulf Nuclear Station (GGNS) for inadequate work practices in that steps contained in GGNS procedure to formally revise work orders subsequent to a change in work scope were not followed. GGNS shares NRC concern regarding the personnel safety aspects of this event.

The attachment to this letter contains the GGNS response to NOV 50-416/96-17-02.

Yours truly,

JJH/JEO/jeo
attachment: Response to Violation 50-416/96-17-02
cc: Mr. J. E. Tedrow (w/a)
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Notice of Violation 96-17-02

Technical Specifications 5.4.1.a. states, in part, that written procedures shall be implemented covering the applicable activities recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Paragraph 9.e of Appendix A to Regulatory Guide 1.33 recommends written procedures for the control of maintenance.

Procedure 01-S-07-1, "Control of Work on Plant Equipment and Facilities," Revision 31, Step 6.7.6 states, in part, "Changes to the work package will be handled by one of the following three methods: (1) Revision, (2) Correction, or (3) Minor correction. A revision to the work order is classified as an increase/decrease in the scope of the work."

Contrary to the above, on October 28, 1996, Work Order 00159564 (clean and inspect 480 volt Motor Control Center 21B31) was not revised to reflect a decrease in work scope to only inspect the motor control center.

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

On 10/27/96 a work order (WO) was released to begin inspection and cleaning of the 11HD bus. Bus 11HD was de-energized prior to commencing the scheduled work. However, Motor Control Center (MCC) 21B31 which is normally powered from the 11HD bus, was temporarily being powered from an alternate source. A short time after the WO was initiated, the work scope of the WO was changed to only inspect MCC 21B31 partically due to its energized state. By procedure, the WO should have been revised, this was not done.

In addition, the process for distinguishing an energized MCC was the word 'energized' written on a slip of paper stapled to the front of the WO. Completion of work on the 11HD bus took several shifts. By the beginning of night shift on the 28th, the paper stapled to the front of the WO to distinguish MCC 21B31 as energized had unknowingly been lost.

The electricians began work on MCC 21B31 by first verifying that its feeder breaker was racked out. However, the fact that the MCC was energized from an alternate source was not passed along to the electricians during their turnover. Also, due to the fact that the slip of paper that distinguished energized MCCs from de-energized MCCs had been lost, the electricians were unaware that MCC 21B31 was energized. Additionally, the electricians only checked the feeder breaker for the MCC, they did not use a voltage meter to verify that the MCC was not energized.

On October 28, 1996, electricians were performing task under Work Order (WO), which specified to clean and inspect 480-volt Motor Control Center (MCC) 21B31. Due tc factors previously stated, the electricians were unaware of the change in work scope and that MCC 21B31 remained energized. While cleaning in the MCC panels, an electrician received a 270 volt electrical shock to his hand. The electrician received no injuries and no additional treatment was required. Immediately following the event work was stopped, the area was placed in a safe condition, and an investigation initiated.

The root cause of this event was inadequate work practices, in that processes in place were not followed and some processes were inadequate.

II. Corrective Steps Which Have Been Taken and Results Achieved

Immediate Actions:

1. Work was stopped and the equipment placed in a safe condition.

2. The supervisor was summoned to investigate the accident

3. The worker was sent to first aid for treatment.

4. All bus work was placed under one supervisor.

5. Safety meetings were held to warn technicians of the potential for injury and their responsibility to verify the bus is de-energized prior to work.

These immediate corrective actions were followed up by programmatic changes to ensure this concern is addressed for the long term.

III. Corrective Steps to be Taken to Preclude Further Violations

Long Term:

1. Work Package Needs Improvement:
Change 01-S-07-1 to clarify management's expectation that WO impact statements must reflect work scope changes and actual plant conditions or be returned to planning for revision.

2. Pre-Job Briefing Needs Improvement:
Ensure that supervision is performing adequate pre-job briefs and turn-overs. Pre-job briefs and turn-overs will be monitored periodically as determined by the I&E Superintendent with the concurrence of the Manager of Maintenance.

3. Procedure not followed:
Conduct continuing training on safety practices regarding work on electrical equipment.

4. Procedural Improvement:
A procedure will be written to perform the cleaning and inspection preventative maintenance for MCCs only during a de-energized condition.

IV. Date When Full Compliance Will be Achieved

All actions are scheduled to be completed by June 30, 1997.