



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV  
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ARLINGTON, TEXAS 76011-8064

September 16, 1999

William A. Eaton, Vice President  
Operations - Grand Gulf Nuclear Station  
Entergy Operations, Inc.  
P.O. Box 756  
Port Gibson, Mississippi 39150

SUBJECT: MIDCYCLE PLANT PERFORMANCE REVIEW (PPR) - GRAND GULF  
NUCLEAR STATION

Dear Mr. Eaton:

On August 18, 1999, the NRC staff completed the midcycle Plant Performance Review (PPR) of the Grand Gulf Nuclear Station. The staff conducts these reviews for all operating nuclear power plants to integrate performance information and to plan for inspection activities. The focus of this performance review was to identify changes in performance over the past 6 months and to allocate inspection resources for the next 7 months.

We did not identify any areas in which your performance warranted inspection beyond the core inspection program during the next 7 months. However, as a result of the extended performance assessment cycle and a scheduled refueling outage, 64 hours were added as regional initiative to inspect your implementation of radiation protection measures during the outage.

During the course of our inspections, we will focus on the implementation of your corrective action program. The need for this emphasis is a result of our observations during recent inspections. We plan to discuss these observations with you during a meeting in our offices scheduled for the week of October 18, 1999.

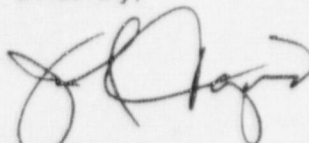
Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at our integrated review of licensee performance trends. The PIM includes items summarized from inspection reports or other docketed correspondence between the NRC and Entergy Operations, Inc., from October 1, 1998, to July 16, 1999. As noted above, greater emphasis was placed on those issues identified in the past 6 months during this performance review. The NRC does not attempt to document all aspects of licensee programs and performance that may be functioning appropriately. Rather, the NRC only documents issues that it believes warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. Once this predecisional material is finalized, it will be placed in the NRC Public Document Room as part of normal issuance of NRC inspection reports and other correspondence.

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PDR ADOCK 05000416  
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This letter advises you of our plans for future inspection activities at your facility so that you will have an opportunity to prepare for these inspections and to provide us with feedback on any planned inspections that may conflict with your plant activities. Enclosure 2 details our inspection plan through March 2000. This date was chosen to coincide with the scheduled implementation of the revised reactor oversight process in April 2000. The rationale or basis for each inspection outside the core inspection program is discussed above so that you are aware of the reason for emphasis in these program areas. Routine resident inspections are not listed due to their ongoing and continuous nature.

If circumstances arise which cause us to change this inspection plan, we will contact you to discuss the change as soon as possible. Please contact Joseph I. Tapia at (817) 860-8243 with any questions you may have.

Sincerely,



Joseph I. Tapia, Chief  
Project Branch A  
Division of Reactor Projects

Docket No.: 50-416  
License No.: NPF-29

Enclosures:

1. Plant Issues Matrix
2. Inspection Plan

cc:

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-5-

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# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 1 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/18/1999	1999002-02	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: 4A Ter: 4C	<b>Failure to maintain diesel generator air start valve fully open</b> A noncited violation of Technical Specification 5.4.1, consistent with Appendix C of the NRC Enforcement Policy, was identified for failure to ensure that Valve PB1-F032A, "Engine A Air Motors (2) Air Supply," which provides starting air to the high pressure core spray diesel generator, remained open, as required. The team found this valve to be partially closed. A concern was identified that the design of the system combined with licensee operating policies (these valves were not locked open) could result in failure to detect mispositioned diesel air supply valves. The team did not find any requirement for the licensee to lock these valves open, although this is the normal industry practice. This violation is in the licensee's corrective action program as condition report 1999-0235.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
05/01/1999	1999005	Pri: OPS Sec:	NRC	NEG	Pri: 3A Sec: 2A Ter:	<b>FPCC and RWCU precoat tank high level annunciator remained in alarm.</b> The inspectors identified a poor Operations practice. Operations personnel allowed fuel pool cleanup and reactor water cleanup precoat tank high level annunciators (nonsafety-related annunciators) to remain in alarm without taking any action to address the condition causing the alarm or to rectify an inconsistency in the procedures.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
04/19/1999	1999005	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	<b>Inappropriate restoration caused control rod drive pump suction piping overpressurization.</b> Inappropriate restoration directions for the control rod drive pump, part of a nonsafety-related system, resulted in momentary overpressurization of the suction piping and exercising the relief valve each time the system was restored from maintenance.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
04/04/1999	1999005-01	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: Ter:	<b>Failure to follow procedures resulting in overpressurization of standby liquid control discharge piping</b> The failure of operators to establish the standby liquid control system flow path prior to starting Pump A, as directed by the quarterly surveillance, resulting in overpressurization of the discharge piping, is a violation of Technical Specification 5.4.1 a. This Severity Level IV violation is being treated as a noncited violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CR-GGN-1999-0423.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
03/24/1999	1999005	Pri: OPS Sec:	NRC	NEG	Pri: 3B Sec: Ter:	<b>Operators not aware of degraded voltage relay flags.</b> The inspectors found that operators were not aware of the existence of indication flags on Bus 17AC degraded voltage relays or how to reset them following an automatic start and loading of the high pressure core spray diesel generator. No training on this aspect of the equipment had been provided to the operators.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
03/01/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	<b>Operator performance during startup improved.</b> A reactor startup and plant heatup performed on March 1, 1999 was conducted well. Operator performance and attention to detail showed considerable improvement over a January 27, 1999 plant startup.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						



# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 2 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title	Item Description
02/10/1999	1999004	Pri: OPS	NRC	POS	Pri: 1B	<b>Operator actions on the simulator during emergency preparedness drills were good.</b>	Licensed operator actions in the simulator during an emergency preparedness drill were good. Emergency operating procedures were effectively implemented, communications were good, and effective training was provided. Licensee response to an inspectors observation that post accident monitoring recorders for drywell radiation did not have the units of measurement displayed (rads per hour) in the simulator and the main control room was good because the licensee subsequently displayed these units in the main control room. The licensee also planned on assessing other post accident monitoring instrumentation for any similar concerns.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1	Sec:			Sec: 2 Ter:		
01/30/1999	1998017	Pri: OPS	NRC	NEG	Pri: 1A	<b>Operators failed to verify cooling water valve position with CRDM high temperature annunciation lit.</b>	Control room operators displayed good communications during a downpower to 80 percent for rod sequence exchange. Three way communications between the operator at the controls and the plant supervisor were always used. However, in one instance, the operators displayed poor attention to annunciator response. Control rod drive mechanism high temperature annunciation was illuminated, but the operators failed to verify local cooling water valve position.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1	Sec:			Sec: 3A Ter:		
01/30/1999	1998017	Pri: OPS	NRC	POS	Pri: 1A	<b>Conservative decision made to shutdown in response to degraded current transformers.</b>	Plant management demonstrated conservative decision making by directing a plant shutdown, in response to the possibility of degraded, safety related, current transformers, when no failure of these current transformers had occurred. Control room operators displayed good communications and command and control during this shutdown. Three way communications were consistently used, coordination with chemistry and health physics was good, and shift briefs were comprehensive. In one instance procedural guidance was weak as implemented by a reactor operator. This resulted in an automatic, unplanned, reactor feed pump trip.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1	Sec:			Sec: 1C Ter:		
01/27/1999	1999004	Pri: OPS	NRC	NEG	Pri: 1A	<b>Operator inattention to detail during plant startup resulted in inadvertent entry into TS 3.3.6.1.</b>	Generally, a reactor startup and plant heatup performed on January 27, 1999, was conducted properly and in accordance with existing procedures. No procedural or Technical Specification violations occurred, however two instances of operator inattention to detail did occur. This inattention resulted in an inadvertent entry into a Technical Specification 3.3.6.1 action statement for a period of time less than the allowed action time, because automatic main steam isolation on low condenser vacuum was bypassed with main turbine stop valves open, and an automatic shutdown of the reactor water cleanup system on high filter/demineralizer inlet temperature due to an inappropriate valve alignment for plant heatup.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1	Sec:			Sec: 3A Ter:		
12/12/1998	1998015	Pri: OPS	NRC	STR	Pri: 1A	<b>Operator response to a turbine building high radiation alarm was timely.</b>	The control room staff continued to exhibit effective communications, a high level of operator knowledge, and good oversight. Operator response to a turbine building ventilation high radiation alarm was timely and in accordance with procedures. The actions taken by operations personnel in response to predictions of cold weather were prompt and thorough.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1	Sec:			Sec: 1B Ter:		

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV  
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12/12/1998	1998015-02	Pri: OPS Sec:	Licensee	NCV	Pri: 3A Sec: 1C Ter:	<b>Containment penetration opened contrary to Technical Specification requirement</b>	On June 25, 1998, operations personnel failed to realize that a test connection valve in drywell purge compressor Train B was a containment isolation valve when tagging the system to perform repairs on a stop check valve. The resulting valve lineup created a potential leakage path through containment. This flow path was in existence for 10.6 hours and was a violation of Technical Specification 3.1.6.3. The licensee's identified root cause was the failure of personnel to perform self-checking and independent verification. Operations management stressed the event through issuance of a memorandum and night orders to ensure that the existing protective tagging procedures were followed. This non-repetitive, licensee-identified and corrected violation is being treated as a noncited violation consistent with Section VII B.1 of the NRC Enforcement Policy. This closed LER 98-004-00 and -01
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
10/31/1998	1998013	Pri: JPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	<b>Control room staff exhibited effective communications, high level of knowledge, and very good oversight.</b>	The control room staff continued to exhibit effective communications, a high level of operator knowledge, and very good oversight. Scheduled work in the switchyard was well planned and controlled, appropriately addressing the risk of the task.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
10/09/1998	1999005-02	Pri: OPS Sec:	Licensee	NCV	Pri: 3A Sec: Ter:	<b>Delinquent Limiting Conditions for Operation action due to inadequate work practices</b>	The failure to conduct a surveillance to verify the electrical lineup within 1 hour of declaring the diesel inoperable on October 9, 1998, was a violation of Technical Specification 3.8.1. This Severity Level IV violation is being treated as a noncited violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CR 1998-1075. This closed LER 98-005-00
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
06/12/1999	1999008	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: Ter:	<b>Missing fasteners on electrical penetration assembly access doors noted.</b>	With one exception, the areas of the plant toured were maintained in good condition. The inspectors identified missing or improperly secured fasteners on the access doors to three containment electrical penetration assemblies. The licensee identified similar problems on three additional assemblies. Operability of the assemblies was not affected because the equipment inside the assemblies remained environmentally qualified.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
06/12/1999	1999008	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	<b>Maintenance rule period assessment was thorough.</b>	The maintenance rule periodic assessment performed for 1998 was thorough and fulfilled the requirements of Section (a)(3) of the maintenance rule. The licensee was adequately balancing maintenance outages with minimizing system unavailability.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
06/07/1999	1999008-02	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: Ter:	<b>Failure to enter LCO action during surveillance of standby liquid control system</b>	Operators failed to enter Technical Specification 3.1.7.C, while the standby liquid control system was inoperable with both standby liquid control system pump suction valves closed for approximately 30 minutes as required by a surveillance procedure. This Severity Level IV violation of Technical Specification 5.4.1.a. is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy and is entered in the licensee's corrective action program as CR-GGN-1999-0606.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 4 of 15  
09/03/1999 14:38:35  
IR Report 3

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06/06/1999	1999008	Pri: MAINT Sec:	NRC	NEG	Pri: 5C Sec: Ter:	<b>Corrective actions were limited for SiC relief valve lifting caused by lack of fill and vent procedure.</b>  The licensee's corrective actions in response to a pressure relief valve on the standby liquid control system lifting 200 psi early in October 1998 were limited. The licensee determined that the event occurred because the procedure to fill and vent the system was not added to subsequent work instructions for performing preventive maintenance on the relief valve. As a result of the limited corrected actions, the relief valve again lifted 200 psi early during a recent pump run after replacement of the pump packing.
05/19/1999	1999008-01	Pri: MAINT Sec:	NRC	NCV	Pri: 5C Sec: Ter:	<b>Failure to promptly correct inadequate criteria and procedures for RCIC turbine oil levels for 6 months.</b>  The licensee failed to promptly address inadequate acceptance criteria for the oil level in the reactor core isolation cooling turbine and correct inconsistencies in procedures addressing the oil level. This Severity Level IV violation of 10 CFR 50, Appendix B, Criterion XVI, is being treated as a noncited violation consistent with Appendix C of the NRC Enforcement Policy and is entered in the licensee's corrective action program as CR-GGN-1999-0675.
05/01/1999	1999005	Pri: MAINT Sec:	NRC	NEG	Pri: 1C Sec: 3A Ter:	<b>Lack of guidance on when to use clearance or protective tagging.</b>  Eight maintenance and testing activities observed were performed properly with the exception of the following concerns. A maintenance activity involving troubleshooting leakage in the standby service water system demonstrated a potential inadequacy in the existing site program for equipment control in that there was no procedural guidance to determine when a clearance or protective tagging is required or to direct personnel to which method of equipment control should be used. Although the equipment was returned to the appropriate configuration following maintenance, informal configuration control and poor communications resulted in personnel in the field not being aware that a tank they were using for indication had been isolated so that work had to be repeated. During a different maintenance activity, poor communications between system engineering and work planning groups, during the planning process, resulted in replacement of the least suspect valve during troubleshooting and repair of CRD12-13 directional control valves.
05/01/1999	1999005	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: 3A Ter:	<b>Material condition inside containment was acceptable.</b>  The material condition inside containment, based on inspectors' tours, was acceptable, however, small debris was present, some housekeeping was not good, paint was deteriorating, and a containment foreign materials log was not current. None of these items presented an operability concern for emergency core cooling equipment. The inspectors also observed one example of inattention to detail in that operators had not identified loose latches on the standby gas treatment units during their rounds.
04/30/1999	1999008	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: 2B Ter:	<b>Addition to surveillance instructions without walk-through or test was a poor practice.</b>  The addition of test instructions to three different essential core cooling system surveillance procedures without verification by system walk-through or test was identified as a poor practice. In each case, operators stopped performance of the procedures in the field after determining they could not be performed as written. The inspectors questioned the repeat errors. The licensee acknowledged the poor practice and determined that future revisions were to be verified prior to approving the revision.
03/20/1999	1999004	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: 3A Ter:	<b>Two recent main condenser seal failures were influenced by installation with maximum allowed offset.</b>  Maintenance activities associated with two recent main condenser seal failures were acceptable. A 1999 main condenser to main turbine seal failure was influenced by installing the seal joint, in 1995, at a location with the maximum vendor recommended turbine to condenser vertical offset. Additionally oil introduced into this same seal joint area at some point prior to 1995 caused, an earlier, 1995, seal failure. Both these failures resulted in unplanned forced outages. Actions taken in accordance with the Maintenance Rule, for the 1995 failure, were appropriate because no industry information was available to anticipate the 1999 seal failure.

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

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Page: 5 of 15  
09/03/1999 14:38:35  
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03/20/1999	1999004	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: Ter:	<b>Response time test results were not compared to acceptance criteria until 15 months later.</b>  Time response testing of reactor protection system functions was performed in compliance with Technical Specification Surveillance Requirement 3.3.1.15. The licensee was responsive to an inspectors observation that, because the total response time was measured in parts, at different times, no acceptance criteria was being applied to some data until about 15 months after the data was obtained, which was a poor practice. The surveillance periodicity and acceptance criteria was being met because total response time was summed and verified to be less than the Technical Specification allowable response time within Technical Specification allowed intervals.
03/10/1999	1999004-01	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: 4A Ter:	<b>Design was invalidated by welding which repositioned ASME pipe in a support.</b>  Maintenance and Engineering personnel demonstrated a lack of attention to ensuring that design drawings and calculations remained valid. The position of an ASME class 3 pipe was changed in a support, as a result of a welding activity, but the effects of the support no longer acting to completely support the pipe deadweight, and the differences between the as left pipe support configuration and the applicable drawing, were not rigorously considered. Failing to identify this condition advise to quality, deviating from the support drawing and the associated pipe stress calculation, was a non cited violation of 10 CFR 50, Appendix B, Criterion XVI. This violation is in the licensee's corrective action program as condition report 1999-339. The weld itself was performed satisfactorily.
02/07/1999	1999005-03	Pri: MAINT Sec:	Licensee	NCV	Pri: 1A Sec: 3A Ter:	<b>RCIC containment isolation valve automatic closure due to failing to follow surveillance procedure</b>  The failure of instrument and controls technicians to follow a surveillance procedure, resulting in the inadvertent closure of reactor core isolation cooling containment inboard steam isolation Valve E51F063 on February 7, 1999, is a violation of Technical Specification 5.4.1 a. This Severity Level IV violation is being treated as a noncited violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CR-GGN-1999-0167. This closed LER 99-002.
01/30/1999	1998017	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: 3A Ter:	<b>Configuration control attention to detail was poor.</b>  Overall plant material condition and housekeeping were excellent. Color coding of trains and systems, and paint condition, were good. Attention to detail with reference to configuration control, in some instances, was poor. The inspectors found two fire rated doors open and unattended (for an indeterminate period of time not necessarily in excess of requirements), a valve locking device improperly installed, and sliding covers on safety related switchgear improperly left open.
01/30/1999	1998017	Pri: MAINT Sec:	Licensee	NEG	Pri: 3A Sec: 2A Ter:	<b>Maintenance did not reinstall seismic retainer clips properly on Agastat relays.</b>  Maintenance technicians demonstrated poor attention to detail by not reinstalling some seismic retainer clips properly. The licensee determined that 21 Agastat relays in seismically qualified safety related control cabinets had improperly installed or missing retainer clips. This incident had low risk and safety significance based on a licensee determination that the relays would have remained in place and functioned properly during a design basis seismic event, without the seismic retainer clips installed.
01/30/1999	1998017	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: Ter:	<b>The standby liquid control system was properly maintained and aligned.</b>  The standby liquid control system was, based on external material condition, properly maintained and aligned to satisfy Technical Specification requirements.
05/000416	GRAND GULF 1					
05/000416	GRAND GULF 1					
05/000416	GRAND GULF 1					
05/000416	GRAND GULF 1					

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/30/1999	1998017-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: Ter:	<b>Maintenance performed on wrong hydraulic control unit.</b> Mechanical maintenance personnel displayed poor attention to detail. During a scheduled rebuild of a hydraulic control unit, work was recommenced on the wrong hydraulic control unit. This nonrepetitive, licensee identified and corrected violation of Technical Specification 5.4.1.a is a noncited violation, consistent with Section VII B.1 of the NRC Enforcement Policy. Also, during the same maintenance activity, a torque less than that prescribed by the work order was recorded as having been applied, and this error was not noticed by supervisory review of the work order.
12/12/1998	1998015	Pri: MAINT Sec:	NRC	NEG	Pri: 4B Sec: 2A Ter:	<b>Actions taken to address correct level of lube oil in RCIC turbine were initially inadequate.</b> The eight maintenance and testing activities observed were properly performed. Actions taken by the licensee to address questions about the correct level of lube oil that should be maintained in the reactor core isolation cooling system turbine were initially inadequate and less than prompt.
12/03/1998	1999008-03	Pri: MAINT Sec:	Self	NCV	Pri: 3A Sec: 2B Ter:	<b>Inadequate procedure for fill and vent of RCIC turbine oil resulted in overspeeding the turbine.</b> The failure to provide adequate written procedures for the proper venting and filling of the reactor core isolation cooling turbine oil system was a violation of Technical Specification 5.4.1.a, which resulted in overspeeding the turbine during testing. This Seventy Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. Corrective actions to address each of these failures are part of CR-GGN-1998-1442. This NCV closed URI 416/9815-01 which documented an overspeed condition that occurred on 12/3/98 to the reactor core isolation cooling turbine.
10/31/1998	1998013	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: 2B Ter:	<b>Combustible gas control system was in good material condition and aligned to satisfy Technical Specification requirements.</b> The combustible gas control system was in good material condition and aligned to satisfy Technical Specification requirements.
10/31/1998	1998012	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 3B Ter:	<b>Seven maintenance and testing activities observed were properly performed.</b> The seven maintenance and testing activities observed were properly performed.
10/23/1998	1998013	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: Ter:	<b>Practice of staging plastic in a safety-related room was a poor housekeeping practice due to items being car</b> The practice of staging plastic sheeting and lighter materials in a safety-related room was identified as a poor housekeeping practice due to the concern for the items being carried to the drain during a flooding event.

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 7 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title	Item Description
10/14/1998	1998013-01	Pri: MAINT Sec:	NRC	VIO IV	Pri: 5C Sec: 3A Ter:	<b>Failure to install temporary restraining cables on floor grating</b>	The inspectors identified that fasteners and temporary restraining cables required as a corrective action for a previously identified deficiency with grating in containment had not been installed following the refueling outage. This was identified as a violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the failure to take corrective actions for a known deficiency. No response is required.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
05/19/1999	1999008	Pri: ENG Sec:	NRC	POS	Pri: 3A Sec: Ter:	<b>System engineer questioned lack of oil level in RCIC turbine oil gauge.</b>	Eleven maintenance and testing activities observed were well performed. A system engineer exhibited good attention to detail in questioning a lack of indicated level in the reactor core isolation cooling turbine oil gauge prior to the overspeed test of the turbine.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
05/18/1999	1999002	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: 5C Ter:	<b>Corrective action program was, in some cases, too limited in scope or did not resolve the problem.</b>	The corrective action program was effective in the identification of design and design basis issues related to the emergency diesel generators. With respect to problem resolution, one notable exception involved an issue related to the Division III emergency diesel generator lube oil inventory, where an excessive oil consumption problem created inconsistencies between the technical specification bases and the design bases. Additionally, the team identified three other instances in which the corrective actions were either limited in scope or did not fully resolve the problems.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
05/18/1999	1999002-01	Pri: ENG Sec:	NRC	NCV	Pri: 3A Sec: 4B Ter:	<b>Unusually high number of errors in the UFSAR</b>	A noncited violation of 10 CFR 50.71(e), consistent with Appendix C of the NRC Enforcement Policy, was identified concerning an unusually high number of errors that were identified in the Updated Final Safety Analysis Report. The licensee's prior contracted review had missed many of the discrepancies identified by the team. The licensee's onsite review of the subject sections had not yet taken place. None of the errors resulted in an operability concern. However, the number of errors identified suggested a potential overall fidelity problem with the Updated Final Safety Analysis Report. This violation is in the licensee's corrective action program as condition reports 1999-0256, -0325, -0331, -0319, -0317, -0279, and -0261.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
05/18/1999	1999002-03	Pri: ENG Sec:	NRC	URI	Pri: 4C Sec: Ter:	<b>Instrument Setpoint Program Weaknesses</b>	Setpoint and scaling calculations did not exist for many of the technical specification parameters associated with the diesel generators, and a setpoint calculation reviewed by the team was observed to be marginal, in that it did not address loop uncertainties or sensor types and installations. This matter was considered unresolved pending further NRC review.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
05/01/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	<b>Engineering evaluation of SLC overpressurization was thorough and technically sound.</b>	The engineering evaluation conducted in response to overpressurization of the standby liquid control system discharge piping was thorough and technically sound.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 8 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title	Item Description
03/20/1999	1999004-02	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: 4C Ter:	<b>Control of scaffolding</b>	Control of plant scaffolding was weak with respect to the length of time scaffolding was allowed to remain in place, and was also weak with respect to the use of nylon straps to secure the scaffold to structural members. A non-cited violation of 10 CFR 50, Appendix B, criterion V was identified when the licensee erected permanent scaffolding, in containment, without following procedures for plant changes, including performing a safety evaluation. The scaffolding had been in place for approximately two years. This violation is in the licensee's corrective action program as condition report 1999-0259. Also translation of calculational assumptions into procedure, concerning the use of nylon straps, was weak. Licensee response to these concerns was good.
	<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
03/20/1999	1999004-03	Pri: ENG Sec:	NRC	NCV	Pri: 4B Sec: Ter:	<b>Trains A and B SSW minor through-wall pipe leakage</b>	Engineering initially performed a poor operability assessment of a through wall pipe flaw in the standby service water system, resulting in a non cited violation of 10 CFR Part 50, Appendix B, Criterion V for failing to follow Technical Requirements Manual 6.4.2 and 6.0.1 required actions for flawed ASME class 3 components. This violation is in the licensee's corrective action program as condition report 1999-0250. Separately, engineering also was not proactive in responding to an issue of excessive cycling of standby service water relief valves resulting in valve seat leakage, originally raised by the NRC in a 1996 inspection.
	<b>Dockets Discussed:</b> 05000415 GRAND GULF 1						
02/23/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	<b>Engineering response to degraded standby service water flow indicator was good.</b>	Engineering response to indications of a degraded standby service water flow indicator was good. Engineering troubleshoot the issue successfully, found through wall leakage on the underwater sensing lines, and isolated the degraded piping from the main system recirculation line.
	<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
01/30/1999	1998017	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	<b>Engineering's response to and assessment of improperly installed seismic retainer clips was comprehensive</b>	The engineering department's response to and assessment of improperly installed safety related control relays in seismic class one cabinets was comprehensive and their operability recommendations had sound engineering basis. Engineering promptly identified the scope of the potential degradation and performed pull testing on the relays of concern to assess seismic capability.
	<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
01/30/1999	1998017	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 5C Ter:	<b>Engineering response to degraded current transformers was excellent.</b>	Engineering response to the discovery of possible degradation of safety related and non safety related current transformers was excellent. The scope for current transformer inspections encompassed all safety related current transformers and 282 non safety related transformers, which was comprehensive. Acceptance criteria were conservative. Licensee Engineering evaluation of a current transformer vendor 10 CFR 21 report, performed in the 1991 time frame, was weak because the scope of planned inspections did not encompass all current transformers susceptible to the degradation described in the 10 CFR 21 report. However, this evaluation was not necessarily indicative of present day engineering performance.
	<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
11/30/1998	1998015	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: Ter:	<b>Off-gas hydrogen analyzer sample cooler placed in service prior to a leak test resulted in minor release.</b>	The design engineering decision to perform postwork testing of a modification on the off-gas hydrogen analyzer Train A sample cooler by placing the system in service prior to a leak test was considered to be a poor work practice that resulted in a minor release of radioactive gasses to the environment.
	<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV  
 GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title
10/31/1998	1998013	Pri: ENG Sec:	NRC	NEG	Pri: 3A Sec: 4B Ter:	<b>Documentation of engineering evaluation failed to quantify leakage through the RCIC valve, although action:</b> The documentation of an engineering evaluation concerning leakage through a reactor core isolation cooling check valve failed to adequately quantify the leakage through the valve, although actions taken by engineering in response to the concern were found to be complete.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
10/31/1998	1998013	Pri: ENG Sec:	NRC	WK	Pri: 5B Sec: 5A Ter: 3A	<b>Root cause analysis report of loss of heavy load was less than adequate.</b> The inspectors concluded that the root cause analysis report conducted for the event involving the near loss of a heavy load over the reactor was less than adequate. The conclusions reached were narrowly focused and did not comply with the definition provided in the corrective action program. The report failed to identify the failure of personnel to follow procedures or the failure of engineering personnel to understand regulatory requirements that were in place. Both of these failures contributed to the event and would have to be corrected to prevent recurrence.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
10/31/1998	1998013-02	Pri: ENG Sec:	NRC	VIO IV	Pri: 4A Sec: 3A Ter: 3B	<b>Failure to follow procedures regarding engineering evaluation of heavy lifts resulting in near drop of tool rin:</b> The engineering evaluations prior to and after the event involving the near drop of a heavy load over the reactor were inadequate and engineering personnel did not have a full understanding of the requirements of NUREG-0612 or Grand Gulf's commitments to comply with NUREG-0612. The engineering screening for this evaluation was inadequate and was a missed opportunity to identify UFSAR requirements and the need to perform a safety evaluation. This was identified as an example of a violation of 10 CFR Part 50, Appendix B, Criterion V, for failing to follow procedures. Four additional examples of a violation for failure to follow procedures or inadequate procedures were identified. The examples included the failure to review the procedure to perform the heavy lift for safety evaluation applicability, failure to ensure that adequate special lift procedures were developed, failure to develop a complete work package that accurately described the scope, and failure to coordinate the heavy lift with the control room.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
06/25/1999	1999007	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: Ter:	<b>Confusing or conflicting information on emergency notification forms</b> Some of the emergency notification forms prepared in the control room had confusing or conflicting information. For example, the initial form stated that an alert had been declared based on exceeding Technical Specification allowable levels during a routine discharge but also indicated that there had been no release. In the exercise, a discharge had occurred but had been secured prior to the notification.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
06/25/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5A Ter:	<b>Licensee's post-exercise critiques were generally thorough</b> The licensee's post-exercise critiques were generally thorough, open, and self critical with input from participants, controllers, and evaluators. The licensee's continued use of peer evaluators from other facilities provided additional perspective to the critique process.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
06/25/1999	1999007	Pri: PLTSUP Sec:	NRC	STR	Pri: 1C Sec: 3A Ter:	<b>Implementation of mitigation strategies for plant equipment failures was a strength.</b> Overall, performance was good. The control room, technical support center, operations support center, and emergency operations facility successfully implemented key emergency plan functions including emergency classifications, protective action recommendations, and dose assessment. A strength was identified in the technical support center concerning implementation of mitigation strategies for plant equipment failures.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						



# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Page: 10 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title	Item Description
06/25/1999	1999007-01	Pri: PLTSUP Sec:	NRC	IFI	Pri: 1C	<b>Exercise Weakness - Failure to complete site accountability in a timely manner</b>	An exercise weakness was identified for failure to determine site accountability within 30 minutes (58 minutes from the site area emergency declaration) as required by procedure. Conflicting priorities (accountability versus addressing the accident) prevented the technical support center personnel from completing the accountability. Since this issue was also identified by the licensee during the self-critique and entered into the corrective action program as Condition Report 99-0652, no response is required.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1						
06/12/1999	1999008	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A	<b>RP and security activities were performed well.</b>	Observed activities involving radiological controls were well performed. The inspectors identified an unsecured drainage hose routed into a contamination area which had the potential to allow the spread of contamination. The licensee corrected the problem. Health physics technicians exhibited good attention to detail in maintaining personnel dose ALARA. Daily security activities were well conducted.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1						
05/01/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 3B	<b>Locked high radiation doors were properly controlled, high radiation and contamination areas were properly</b>	Locked high radiation doors were properly controlled, high radiation and contamination areas were properly posted, and radiological area survey maps accurately reflected radiological conditions in the respective areas.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1						
04/23/1999	1999006	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C	<b>Overall, fire protection program was properly controlled, implemented and maintained.</b>	Overall, the licensee's fire protection program was properly controlled, implemented, and maintained in accordance with their approved fire protection program.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1						
04/23/1999	1999006	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C	<b>Fire brigade training and qualifications and licensee's performance of fire drills met the requirements of the</b>	The training and qualification of fire brigade members and the licensee's performance of fire drills met the requirements of the fire protection program. The response of the fire brigade to the observed fire drill was timely, good command and control were exercised by the brigade leader, and fire fighting activities were appropriate to the circumstances.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1						
04/23/1999	1999006-01	Pri: PLTSUP Sec:	NRC	URI	Pri: 1C	<b>Consideration of the effects of fire-induced circuit failures on equipment required for safe shutdown</b>	An unresolved item was identified to further review the licensee's position that damage to safe shutdown equipment as a result of fire-induced circuit failures is not required to be considered. This position is contrary to the NRC's interpretation of Generic Letter 86-10.
<b>Dockets Discussed:</b>							
05000416	GRAND GULF 1						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/23/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	<b>HP actions in response to an unanticipated shutdown were good.</b> Health Physics actions in response to an unanticipated unit shutdown were good. Areas within the radiologically controlled area were surveyed for changing radiological conditions expeditiously, survey maps were updated and posted, and the general workforce was aware of the new radiological conditions.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
02/10/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	<b>TSC performance improved from previously observed drill.</b> Station emergency response organization performance in the technical support center showed considerable improvement from previously observed drills, during the first 1999 quarterly emergency preparedness training drill. Communications between the emergency response facilities and prioritization of response teams was significantly better than past drills. The addition of engineers to the Technical Support Center staff and the increased use of licensed and certified senior reactor operators were strengths.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
02/05/1999	1999001	Pri: PLTSUP Sec:	NRC	STR	Pri: 2A Sec: Ter:	<b>Very good housekeeping throughout controlled access areas.</b> Housekeeping throughout the controlled access area was very good. Areas were free of debris, loose tools, and equipment.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
02/05/1999	1999001	Pri: PLTSUP Sec:	NRC	STR	Pri: 3A Sec: 3C Ter:	<b>Overall good exposure control programs.</b> Overall, good exposure control programs were implemented. The following program areas were performed properly (1) high radiation area barricades and postings, (2) radiation worker dosimetry use, (3) continuous air monitor use to trend general radiological airborne conditions throughout the controlled access area, (4) calibration of the whole-body counter, and (5) workers use of the personnel contamination monitors. Contamination boundaries were clearly marked and posted. A strong portable radiation protection instrumentation calibration program was in place.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
02/05/1999	1999001	Pri: PLTSUP Sec:	NRC	WK	Pri: 3A Sec: 3C Ter:	<b>ALARA program was weak. Station exposure of 305 person rem significantly above BWR average.</b> In general, the ALARA program was weak. The station's actual 1998 exposure of 306 person-rem was significantly above the 1998 industry BWR national average of 205 person-rem, the station's 3-year average remained above the industry BWR national 3-year average. The majority of ALARA committee members did not attend ALARA committee meetings during 1998. ALARA committee meeting minutes were not reviewed and approved in a timely manner. The ALARA staff had not evaluated which hot spots located throughout the controlled access area contributed unnecessary dose to station radiation workers. None of the temporary shielding packages contained pre and post shielding survey information or a picture/drawing of the installation. No program was in place to evaluate whether an ALARA suggestion was cost effective to implement when it required the station to budget resources for implementation.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
02/05/1999	1999001-01	Pri: PLTSUP Sec:	NRC	VIO IV	Pri: 3C Sec: Ter:	<b>Failure to control a locked high radiation area</b> A violation of Technical Specification 5.7.2 was identified for the failure to control the locked high radiation area around the spent fuel pool cooling and cleanup heat exchanger.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 12 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/05/1999	1999001-02	Pri: PLTSUP	Licensee	NCV	Pri: 3A Sec: Ter:	<b>Failure to follow radiation work permit requirements</b> On March 29, 1998, an unplanned intake of radioactive material occurred because either radiation protection personnel failed to evaluate the level of contamination in a work area or a radiation worker failed to obey radiological posting. The matter is unresolved, pending the NRC's review of the licensee's investigation.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
01/30/1999	1998017	Pri: PLTSUP	NRC	NEG	Pri: 4A Sec: 4B Ter:	<b>Missed opportunity to discover plant construction deficiency, lack of fire alarm in the Div II EDG room.</b> Licensee personnel missed an opportunity to discover a plant construction issue. The inspectors identified that there was no local audible fire alarm in the Division II emergency diesel generator room. The licensee confirmed the omission and planned on installing an alarm.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
12/12/1998	1998015	Pri: PLTSUP	NRC	POS	Pri: 3A Sec: Ter:	<b>HP support of emergency repairs to the main condenser outlet water box was good.</b> Observed activities involving radiological controls were performed well. Health physics department response to and support of the emergency repairs to the main condenser outlet water box were good.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
12/11/1998	1998016	Pri: PLTSUP	Licensee	NEG	Pri: 1B Sec: 3A Ter: 3B	<b>Offsite agency notification process was not always effectively implemented during the walkthroughs.</b> The offsite agency notification process was not always effectively implemented during the walkthroughs. For example, timeliness requirements were challenged on several occasions and forms were not always completed properly.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
12/11/1998	1998016	Pri: PLTSUP	NRC	NEG	Pri: 1C Sec: 2B Ter:	<b>Time allowed for updating the emergency plan and procedures in the emergency facilities was too long.</b> A concern was identified involving the time allowed for updating the emergency plan and procedures in the emergency response facilities, including the control room.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						
12/11/1998	1998016	Pri: PLTSUP	NRC	NEG	Pri: 5C Sec: Ter:	<b>Corrective actions for a previously identified weakness were not well documented.</b> Corrective actions for a previously identified weakness were not well documented.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 13 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/11/1998	1998016	Pri: PLTSUP Sec:	NRC	POS	Pri: 1B Sec: 3B Ter: 5A	<b>Crew performance during walkthroughs was good. Emergency classifications were correct and timely.</b> Crew performance during the walkthroughs was good. Emergency classifications were correct and timely. The site evacuation process was implemented in a timely fashion but actions were not fully consistent with the site evacuation procedure. Dose assessment activities were satisfactorily performed, and protective action recommendations were correct and timely. The emergency preparedness staff performed a self-critical evaluation of crew performance during the walkthroughs.
12/11/1998	1998016	Pri: PLTSUP Sec:	Licensee	POS	Pri: 1C Sec: 5A Ter: 5B	<b>A comprehensive plan was developed to resolve chronic emergency response organization qualifications.</b> A comprehensive action plan was developed to resolve chronic emergency response organization qualification maintenance and tracking problems.
Dockets Discussed: 05000416 GRAND GULF 1						
12/11/1998	1998016	Pri: PLTSUP Sec:	NRC	STR	Pri: 1C Sec: 2B Ter: 5A	<b>Overall, emergency preparedness program was effectively implemented.</b> Overall, the emergency preparedness program was effectively implemented. Emergency response facilities were operationally maintained, and appropriate equipment and supplies were readily available. There was an increase in program visibility and management involvement, and processes for program maintenance were well defined. The emergency preparedness staff consisted of knowledgeable and conscientious individuals with the appropriate expertise. Comprehensive and in-depth program audits were conducted.
Dockets Discussed: 05000416 GRAND GULF 1						
12/11/1998	1998016-01	Pri: PLTSUP Sec:	NRC	VIO IV	Pri: 1C Sec: 2B Ter:	<b>Extending the response times for two health physics personnel in the EP plan was a violation.</b> Extending the response times for two health physics technicians from 30 to 60 minutes in the emergency plan was identified as a violation of 10 CFR 50.54(q). Since corrective actions were taken, no response is required.
Dockets Discussed: 05000416 GRAND GULF 1						
11/19/1998	1998015	Pri: PLTSUP Sec:	NRC	WK	Pri: 5C Sec: Ter:	<b>Weaknesses identified in previous EP drills were not corrected.</b> The end-of-drill critique was open and self-critical. However, not including all participants and allowing personnel running the drill to provide input prior to the participants were identified as poor practices. The continued existence of weaknesses identified by the licensee during previous quarterly drills indicated a need for continued attention to this program.
Dockets Discussed: 05000416 GRAND GULF 1						
11/18/1998	1998015	Pri: PLTSUP Sec:	NRC	WK	Pri: 5A Sec: 5C Ter:	<b>Communicating through a single three point link between emergency facilities limited management of event.</b> During the fourth quarter emergency preparedness training drill, the licensee staff demonstrated acceptable performance in the operations support center. Although the communications had improved between the different facilities, the practice of communicating solely through a single three-point communication link between three facilities was identified as limiting for management of the event. The method of assigning tasks in the operations support center was inefficient in that personnel were pulled from areas in which they were proficient to perform tasks they had not been trained to perform.
Dockets Discussed: 05000416 GRAND GULF 1						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Page: 14 of 15  
09/03/1999 14:38:35  
IR Report 3

Region IV  
GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title	Item Description
10/31/1998	1998013	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 3A Sec: Ter:	<b>Radiological controls were well performed with exception of a poor posting around a high contamination area</b>	With one exception, observed activities involving radiological controls were well performed. The inspectors identified one poor posting practice where the posting around a high contamination area did not meet the licensee's documented guidance.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
10/30/1998	1998014	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 3A Sec: Ter:	<b>Licensee's event investigation process was not thorough, knowledgeable individuals were not interviewed.</b>	The licensee's event investigation process was not thorough. All individuals having potentially significant information about problems occurring during a drywell entry on September 15, 1998, were not interviewed before conclusions were reached.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
10/30/1998	1998014	Pri: PLTSUP Sec: Ter:	NRC	STR	Pri: 3A Sec: 3B Ter:	<b>Overall, radiation protection program was implemented effectively.</b>	Overall, the radiation protection program was implemented effectively. Good exposure controls were implemented. Radiological areas were posted properly and high radiation areas were controlled effectively. Radiation protection personnel provided good support and oversight of work activities within the controlled access area. Effective dose reduction methods and contamination control measures were used. Quality assurance reviews of radiation protection activities provided licensee management with good insights into program performance. Audits and surveillances were critical and acceptably diverse and detailed. However, radiation protection personnel demonstrated a lack of a questioning attitude and missed early opportunities to identify a problem involving radiation survey results prior to a planned, drywell entry on September 15, 1998. Also, procedural definitions of radiation work permits were vague and inconsistent and the concept of a radiation work permit with multiple parts was communicated poorly through radiation worker training material and procedural guidance.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
10/30/1998	1998014-01	Pri: PLTSUP Sec: Ter:	Licensee	NCV	Pri: 3A Sec: Ter:	<b>Failure to survey associated with drywell entry</b>	The licensee identified a violation of 10 CFR 20.1501(a), a failure to perform proper radiation surveys. The violation was associated with a personnel entry into the drywell on September 15, 1998. Discretion was applied in accordance with Section VII.B.1 of the NRC Enforcement Policy. This issue was documented in IR 9811 as EEI 9911-01.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
10/30/1998	1998014-02	Pri: PLTSUP Sec: Ter:	Licensee	NCV	Pri: 3A Sec: Ter:	<b>Failure to instruct individuals about radiological conditions</b>	The licensee identified a violation of 10 CFR 19.12, a failure to instruct individuals with the correct radiological information. The violation was associated with a personnel entry into the drywell on September 15, 1998. Discretion was applied in accordance with Section VII.B.1 of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							
10/30/1998	1998014-03	Pri: PLTSUP Sec: Ter:	Licensee	NCV	Pri: 3A Sec: Ter:	<b>Failure to maintain contaminated material within the controlled access area</b>	The licensee identified a violation of Technical Specification 5.4.1, a procedural violation involving the unintended movement of contaminated material outside the controlled access area. The violation was associated with a release of contaminated liquid on November 21, 1997. Discretion was applied in accordance with Section VII.B.1 of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000416 GRAND GULF 1							

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

## Legend

### Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	Non-Cited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
V/O	Violation
WK	Weakness

### Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

### Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

ENCLOSURE 2  
GRAND GULF

Inspection / Activity Plan  
09/01/1999 - 03/31/2000

Units	Inspection Activity	Title	Number of NRC Inspectors / Individuals	Planned Dates Start	Planned Dates End	Inspection Type
1	IP 84750	Radioactive Waste Treatment, And Effluent And Environmental Monitoring	1	08/30/1999	09/03/1999	Core
1	IP 86750	Solid Radioactive Waste Management And Transportation Of Radioactive Mate	1	08/30/1999	09/03/1999	Core
1	IP 83750	Occupational Radiation Exposure	1	11/01/1999	11/05/1999	Regional Initiative
1	X02031	GG/INITIAL EXAMS	1	02/14/2000	02/18/2000	Not Applicable

This report does not include INPO and OUTAGE activities.  
This report shows only on-site and announced inspection procedures.