



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION IV  
611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064**

March 31, 2000

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

**SUBJECT: PLANT PERFORMANCE REVIEW - GRAND GULF NUCLEAR STATION**

Dear Mr. Eaton:

The purpose of this letter is to communicate our assessment of your performance and to inform you of our planned inspections at your facility. On March 2, 2000, we completed a Plant Performance Review (PPR) of Grand Gulf Nuclear Station. We conduct these reviews to develop an integrated overview of the safety performance of each operating nuclear power plant. We use the results of the PPR in planning and allocating inspection resources and as inputs to our senior management meeting (SMM) process. This PPR evaluated inspection results and safety performance information for the period from January 25, 1999, through February 11, 2000, but emphasized the last 6 months to ensure that our assessment reflected your current performance. Our most recent summary of plant performance at Grand Gulf Nuclear Station was provided to you in a letter dated September 16, 1999.

The NRC has been developing a revised reactor oversight process that will replace our existing inspection and assessment processes, including the PPR, SMM, and Systematic Assessment of Licensee Performance (SALP). We recently completed a pilot program for the revised reactor oversight process at nine participating sites and are making necessary adjustments based on feedback and lessons learned. We are beginning initial implementation of the revised reactor oversight process industry-wide, including your facility, on April 2, 2000.

This PPR reflects continued process improvements as we make the transition into the revised reactor oversight process. You will notice that the following summary of plant performance is organized differently from our previous performance summaries. Instead of characterizing our assessment results by SALP functional area, we are organizing the results into the strategic arenas embodied in the revised reactor oversight process. Additionally, in assessing your performance we have considered the historical performance indicator data that you submitted in January 2000 in conjunction with the inspection results. The results of this PPR were used to establish the inspection plan in accordance with the new risk-informed inspection program (consisting of baseline and supplemental inspections). Although this letter incorporates some terms and concepts associated with the new oversight process, it does not reflect the much broader changes in inspection and assessment that will be evident after we have fully implemented our revised reactor oversight process.

During the last 6 months, Grand Gulf Nuclear Station encountered several operating challenges. Power was reduced on several occasions to repair steam leaks on the main turbine first stage pressure sensing line, perform impeller work on a reactor feedwater pump, and repair a bushing on a main transformer. Overall, it was determined that Grand Gulf Nuclear Station continues to operate in a safe manner.

In the reactor safety strategic arena, we noted that you were challenged by failure of the high pressure core spray diesel generator, by continued leakage problems of the main steam isolation valves, and by balance-of-plant challenges to continuous power operations. The baseline inspection program will be adequate to monitor performance in this strategic arena.

In the radiation safety and safeguards strategic arenas, no significant performance issues were identified. Based on our assessment, only baseline inspections are planned for these strategic arenas.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were used during this PPR process to arrive at our integrated view of your performance trends. The PIM for this assessment is grouped by the prior SALP functional areas of operations, maintenance, engineering, and plant support, although the future PIM will be organized along the cornerstones of safety as described in the revised reactor oversight process. The attached PIM includes items summarized from inspection reports or other docketed correspondence regarding Grand Gulf Nuclear Station. We did not document all aspects of licensee programs and performance that may be functioning appropriately. Rather, we only documented issues that we believe 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 enclosed PIM, including observations from events and inspections that had occurred since our last inspection report was issued but had not yet received full review and consideration. We will make this material publically available as part of the normal issuance of our inspection reports and other correspondence.

Enclosure 2 lists our planned inspections for the period April 2000 through March 2001 at Grand Gulf Nuclear Station to allow you to resolve scheduling conflicts and personnel availability in advance of our inspector arrival onsite. The inspection schedule for the latter half of the period is more tentative and may be adjusted in the future due to emerging performance issues at Grand Gulf Nuclear Station or other Region IV facilities. Routine resident inspections are not listed due to their ongoing and continuous nature.

Entergy Operations, Inc.

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We will inform you of any changes to the inspection plan. If you have any questions, please contact me at (817) 860-8243.

Sincerely,

***/RA/***

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 w/enclosures:

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# 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
12/22/1999	1999018-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Failure to ensure the can of oil was attended in the RCIC room</b> The inspectors identified numerous examples of poor housekeeping in the reactor core isolation cooling pump room that were not identified by operations personnel, indicating inattention to detail. The failure to ensure the can of oil was attended while located in the 119-foot level of the reactor core isolation pump room or to have a combustible control permit to allow use of the can in the area is a violation of the Grand Gulf Nuclear Station License Condition C(41) because the oil exceeded the licensee's fire hazards analysis limits for that room. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report CR-GGN-1999-2004.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
12/09/1999	1999019	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Operator rounds sheets not adequately controlled</b> The licensee's method of controlling the operator round sheets for monitoring equipment was ineffective in that the existing change process did not require updating the round sheets in response to changes in the plant.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
12/09/1999	1999019-01	<b>Pri:</b> OPS <b>Sec:</b>	Self	E EI	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<b>Failure of Division III Diesel</b> An apparent violation of Technical Specification 3.8.1.b was identified regarding Division III diesel generator inoperability. As a result of lowering the level of the oil in generator Bearing B to below the level required in Drawing 3636-009, "Electric Products Co. No. 150 AC Synchronous Generator," Revision 5, the Division III diesel generator was inoperable for approximately 74 days. This apparent violation is in the licensee's corrective action program as Condition Report CR-GGN-1999-1054
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
12/09/1999	1999019-02	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	E EI	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Inadequate annunciator response procedure</b> An apparent violation of Technical Specification 5.4.1 was identified regarding the failure to include the diesel generator bearings as a potential cause for the "Generator RTD TEMP HI" Alarm in the applicable alarm response instruction. This apparent violation is in the licensee's corrective action program as Condition Report CR-GGN-1999-1054
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
11/27/1999	1999017	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Poor documentation of operability determination</b> The operability determination performed to justify continued operability of the alternate decay heat removal subsystem after a transient in the plant service water system was not thoroughly documented. The operators on shift adequately explained why the alternate decay heat removal subsystem was not affected. Although the operability determination was satisfactory, the licensee acknowledged that it was not thoroughly documented.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
08/13/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Performance on biennial written examination less than expected</b> Licensed operator performance on the biennial written was less than expected. Three of the six individuals examined failed and were assigned remediation tasks and re-examination prior to resuming licensed duties.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						

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Region IV  
 GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
08/13/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>The licensee was operating with 15 licensed reactor operators assigned 3 each to 5 crews.</b>  During the inspection, it was necessary to cover absences caused by 4 reactor operators performing remedial training due to failing the biennial written examination. Staffing reduction to 2 reactor operators on low activity shifts and maximum overtime without special authorization had to be used for several reactor operators. No reactor operator license applicant training was in progress, which could alleviate this problem in the short term.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
08/13/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Licensee's evaluator performed well</b>  The licensee's evaluators demonstrated sustained high levels of competence in examination administration and operator performance assessment.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
08/13/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	STR	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>Operators performed at a high level on operating test</b>  The licensed operators performed at a high level during the operating test portion of the annual examinations, while exhibiting improved performance from the previous inspection in several behavioral skills, including communication, self-verification, concurrent or peer verification, and supervisory oversight. The crew was sensitive to increased core melt risk caused by degrading plant equipment availability during the dynamic scenarios and imposed appropriate administrative controls.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
07/22/1999	1999003-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Failure to provide prompt corrective actions for the emergency diesel generator governor controls.</b>  During the review of numerous condition reports and other associated corrective action documents, the inspectors observed an example of a failure to provide prompt corrective actions for conditions adverse to quality regarding the electrolytic capacitors for the emergency diesel generator governor controls. This was a Severity Level IV violation of 10 CFR Part 50, Appendix B, Criterion XVI and was being treated as a noncited violation consistent with Appendix C of the Enforcement Policy.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
05/18/1999	1999002-02	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> 4A <b>Ter:</b> 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 P81-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	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<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						

## 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
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						
02/10/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 2A Ter:	<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						
01/30/1999	1998017	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: 3A Ter:	<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						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

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Region IV  
**GRAND GULF**

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/30/1999	1998017	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<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						
01/27/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Operator inattention to detail during plant startup resulted in inadvertant 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						
12/09/1999	1999019	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Incorrect frequency on storage procedure for generator</b>  The replacement of the Division III diesel generator was well conducted. The licensee did not meet the preventive maintenance guidance provided by the manufacturer for the storage of the generator in that the rotating element had not been rotated monthly. The licensee verified that no corrosion was found on the bearing and modified the preventive maintenance task for future storage.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
12/09/1999	1999019-03	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	EEI	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to comply with procedural requirements in planning a work package to add oil to Division III EDG bea</b>  An apparent violation of Technical Specification 5.4.1 was identified regarding the failure of the maintenance planner to adequately plan a work package to add the required amount of oil to the Division III diesel generator bearing and to adequately describe the scope and the effects of the work on the design basis in the impact statement. This apparent violation is in the licensee's corrective action program as Condition Report CR-GGN-1999-1889.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
11/27/1999	1999017	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Technician misunderstanding troubleshooting procedure resulted in plant service water transient</b>  The 12 maintenance activities observed during this period were well conducted, with one exception. An electrical maintenance technician inadvertently caused an isolation of the plant service water system to the auxiliary building while troubleshooting a computer alarm point. The licensee determined that poor understanding of the scope of the troubleshooting work package led to the trip of the auxiliary building isolation valve power supply. Operators were able to restore plant service water to the auxiliary building and the standby decay heat removal system within 2 minutes.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
11/27/1999	1999017	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Senior reactor operator identified procedure problems which could result in unintended mode change</b>  Operators successfully demonstrated the alternate decay heat removal subsystem capability within 24 hours of reactor shutdown. However, the sequence of steps in the procedure used to perform the demonstration had the potential to cause an unintended mode change if the steps were not timed properly. The senior reactor operator in charge of the evolution recognized this deficiency and resequenced the procedure steps before the prejob brief. The licensee subsequently revised the procedure.
<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
10/16/1999	1999016	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> 2B <b>Ter:</b>	<b>Inadequate post maintenance test results in 24-hour delay</b> The 11 maintenance and testing activities observed were well conducted, with the exception of the postmaintenance test for the reactor core isolation cooling system outage. The procedure did not take system valve interlocks into account and, as a result, the test would not work as written. This resulted in a 24-hour delay in returning the system to service.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
10/07/1999	1999018-02	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3B <b>Sec:</b> 2B <b>Ter:</b>	<b>Failure to maintain SSW Valves 1P41F023A and -B in the required position</b> The failure to maintain standby service water Valves 1P41F023A and -B in the position required in Instruction 04-1-01-P41-1, "Standby Service Water System," Revision 107, which resulted in less than required flows to some components was a violation of Technical Specification 5.4.1.a. The licensee subsequently determined that the mispositioned valves would not have prevented the equipment from performing its safety function. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report CR-GGN-1999-1209.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
07/24/1999	1999009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Incomplete instructions for fill and vent of HPCS diesel generator auxiliary lube oil system.</b> Incomplete work instructions for the proper fill and vent of the auxiliary lube oil system for the high pressure core spray diesel generator led to a delay of approximately 20 hours in returning the diesel generator to service.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
06/12/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<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	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<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	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<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						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/06/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Corrective actions were limited for SLC 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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
05/19/1999	1999008-01	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
05/01/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
05/01/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<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 represented 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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
04/30/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						

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03/20/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
03/20/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<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 3.3.1.1.15. 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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
03/10/1999	1999004-01	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 4A <b>Ter:</b>	<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 adverse 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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
02/07/1999	1999005-03	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Engineered Safety Features Actuation Due to Inattention to Detail</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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
01/30/1999	1998017	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
01/30/1999	1998017	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						

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01/30/1999	1998017	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
01/30/1999	1998017-02	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<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.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
01/27/2000	2000001	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Instrument setpoint values adequately justified</b>  Selected safety-related instrument setpoints were reviewed and found to be adequately justified by calculations or other appropriate documentation (Section E8.1). This closes Unresolved Item 50-416/9902-03.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
12/09/1999	1999019	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>SERT team did not identify two failed barriers</b>  The SERT report addressed the identified root and contributing causes, but was not self-critical or thorough. The report did not adequately address inappropriate actions and failed barriers not related to the identified root and contributing causes.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
12/09/1999	1999019-04	<b>Pri:</b> ENG <b>Sec:</b>	NRC	EEI	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Failure to enter two identified concerns in the corrective action program</b>  Two examples of an apparent violation of 10 CFR Part 50, Appendix B, Criterion V, were identified regarding the failure to document nonconformances in condition reports. The nonconformances included a difference in oil requirements between the controlled drawing and the Division III generator bearing nameplate and the potential for bearing damage due to oil frothing. These examples of an apparent violation are in the licensee's corrective action program as Condition Report CR-GGN-1999-1054.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
10/16/1999	1999016	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4C <b>Sec:</b> 2B <b>Ter:</b>	<b>Leakage control program does not require assessment of total leakage from system</b>  The inspectors identified a potential limitation in the licensee's primary coolant sources outside containment leakage control program. The program did not require the quantification of the total leakage into a room to determine whether the prioritization of individual identified leaks was appropriate to minimize leakage to as-low-as-practicable levels.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						

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10/16/1999	1999016	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Water hammer concerns with drywell purge compressors</b> The inspectors found that the scope and corrective actions of the condition report documenting the failure to meet NRC commitments in regard to potential standby service water hammer concerns were limited. The condition report did not include potential water hammer concerns in the standby service water line to the drywell purge compressors, although references identified in the condition report indicated that the problem existed. The operating procedures for the standby service water system and the drywell purge system did not contain precautions or references to the potential for water hammer. Although the concern was addressed in procedures for chemical addition to standby service water, it was not included in the system operating procedures. As a result, operators did not take precautions to minimize the operation of the purge compressors during testing in order to limit the potential for water hammer in the system in the event of a loss of offsite power.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/04/1999	1999012	<b>Pri:</b> ENG <b>Sec:</b>	NRC	WK	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Three examples of untimely or limited corrective actions</b> The inspectors identified three examples where limited and untimely corrective actions indicated a weakness in the corrective action program. The examples include: 1) the licensee missed an opportunity to resolve a procedural problem with the operation of the diesel driven fire pumps when they closed one condition report to a similar condition report, then failed to address differences between the two (Section F3.1); 2) the licensee failed to identify degraded seals on three high energy break doors after identifying that they did not have an inspection program for the seals and had identified similar problems and inadequate preventive maintenance for flood door seals the year before (Section E2.1); and 3) the corrective actions for the inadequate acceptance criteria and inconsistent procedural guidance for the reactor core isolation cooling system turbine oil level were limited in that operators had not received training on the changes.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
08/02/1999	1999012-01	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Untimely corrective actions for failure of Valve P41F169B</b> The failure to address the cause for the failure of the standby service water stop check Valve P41F169B identified in Condition Report CR-GGN-1998-740 was identified as a violation of 10 CFR Part 50, Appendix B, Criterion XVI. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is captured in the licensee's corrective action program as Condition Report CR-GGN-1999-802. The licensee subsequently repaired the valve.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
07/22/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	WK	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Temporary or interim solutions identified as a concern.</b> A second area of concern was identified involving the use of temporary or interim solutions. In some instances, temporary or interim engineering dispositions to accept-as-is material deficiencies and interim repairs were not effectively tracked by the corrective action program. The corrective action quality review group was in the process of developing a formal tracking process for these temporary or interim solutions.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
05/19/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<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						

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05/18/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 5C <b>Ter:</b>	<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	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 4B <b>Ter:</b>	<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						
05/01/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<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						
03/20/1999	1999004-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> 4C <b>Ter:</b>	<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	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<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> 05000416 Grand Gulf 1						

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02/23/1999	1999004	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<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	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<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	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 5C <b>Ter:</b>	<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						
11/27/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Poor method of immobilizing vehicle in protected area</b>  The daily security activities during the outage were generally well conducted. The inspectors identified one example where an unattended truck was immobilized with a loosely chained steering wheel. The licensee promptly tightened the steering wheel. The licensee met procedure requirements in that security officers maintained control of the vehicle by chaining the steering wheel and maintaining control of the key. The licensee acknowledged that the method of locking the truck did not meet management expectations and completed a security deficiency report.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
11/27/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>High radiation area rope boundary down</b>  Observed activities involving radiological controls were generally well performed. The inspectors identified one example where a high radiation area boundary rope had fallen. The area had been conservatively posted as a high radiation area and the corrective actions for a similar problem identified in Condition Report CR-GGN-1999-1375 should prevent repeat of this problem. The licensee immediately replaced the rope and initiated CR-GGN-1999-1736 to document the incident.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
11/16/1999	1999013	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 3C <b>Ter:</b>	<b>Overall, a good ALARA program was implemented</b>  Overall, a good ALARA program was implemented. The 1999 refueling outage dose goal of 200 person-rem was established using past best performance and industry experience for similar work. Department ALARA coordinators and the ALARA committee were appropriately involved in establishing and monitoring outage exposure goals. A good temporary shielding program which reduced general dose rates by approximately 40 percent was in place.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						

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11/16/1999	1999013	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>External and internal exposure control programs were effectively implemented</b>  Overall, the external and internal exposure control programs were effectively implemented. In general, high radiation areas were properly controlled and posted in accordance with station procedures and regulatory requirements. Radiation workers were knowledgeable of the radiation levels in assigned work locations, knew the proper response to electronic dosimeter alarms, and wore dosimetry properly. In general, portable air samplers and high efficiency particulate air filter ventilation units were appropriately used to evaluate radiological conditions and limit airborne exposures during work evolutions. No problems were identified with the whole-body counting and internal dose assessment programs.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
11/03/1999	1999013-03	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 3C <b>Ter:</b>	<b>Failure to assess the part of the whole-body receiving the highest exposure</b>  On November 3, 1999, the inspectors identified a violation of 10 CFR 20.1201(c) for the failure to assess the part of the whole-body receiving the highest dose for work under the reactor vessel. General area head level dose rates were a factor of about 1.7 higher than the chest level dose rates in the work area. No over exposures occurred due to this event. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a. of the NRC Enforcement Policy. The licensee wrote Condition Report 99-1511 documenting this issue.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
11/01/1999	1999013-02	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform an airborne radiological survey</b>  On November 1, 1999, the licensee identified a violation of 10 CFR 20.1501(a) for the failure to perform an airborne radiological survey during the "Traversing Incore Probe" tubing removal work to evaluate the concentrations or quantities of radioactive material and the potential radiological hazards. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a. of the NRC Enforcement Policy. The licensee documented the above issue in Condition Report 99-1477.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
10/26/1999	1999013-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure to barricade a high radiation area</b>  On October 26, 1999, the licensee identified a violation of Technical Specification 5.7.1. for the failure to barricade the reactor cavity area to prevent inadvertent access. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a. of the NRC Enforcement Policy. The licensee documented this issue in Condition Report 99-1375
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/03/1999	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Problems with housekeeping and material condition</b>  Problems with the material condition of the inlet and decant piping of the spent resin pump were noted. There was surface rust in several locations of each of the pipes, and resin was on the floor of the spent resin tank room.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/03/1999	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Documentaion Errors</b>  Several minor shipping documentation errors and inconsistencies were noted with three shipments. For example forms were not properly completed, and one form did not contain the required signature. This issue was entered in the licensee's corrective action program as Condition Report CR-GGN-1999-1010.
<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
09/03/1999	1999011-01	Pri: PLTSUP Sec:	NRC	NCV	Pri: 3A Sec: Ter:	<b>The failure to follow Procedure 01-1-08-61, Revision 10, was identified as 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 issue was entered in the licensee's corrective action program as Condition Report CR-GGN-1999-0989.</b>
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/03/1999	1999011-02	Pri: PLTSUP Sec:	NRC	NCV	Pri: 3A Sec: Ter:	<b>The failure to properly describe the hazardous material on the shipping papers of Radioactive Material Shipment 99-0404 as special form was identified as a violation of 49 CFR 172.202. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This issue was entered in the licensee's corrective action program as Condition Report CR-GGN-1999-1011.</b>
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/03/1999	1999014	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	<b>Effective maintenance and testing program of engineered-safety-feature ventilation systems was implemented.</b> An effective maintenance and testing program was implemented for the in-place filter and laboratory charcoal testing of the engineered-safety-feature ventilation filter systems.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/03/1999	1999014	Pri: PLTSUP Sec:	NRC	POS	Pri: 3B Sec: Ter:	<b>Good chemistry and radwaste operator training programs were in place.</b> Training and qualification programs for the chemistry technical staff and radwaste operators were properly implemented. The chemistry and operations departments maintained well trained, qualified, and experienced staffs for conducting sampling, analyses, processing, and release operations for radioactive waste effluents.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/03/1999	1999014	Pri: PLTSUP Sec:	NRC	POS	Pri: 3B Sec: 3C Ter:	<b>A good radioactive waste effluent management program was implemented.</b> A good liquid and gaseous radioactive waste effluent management program was implemented. The processing, sampling, and analyses of radioactive liquid and gaseous waste effluents and the performance of waste discharges were conducted in accordance with Offsite Dose Calculation Manual requirements. Improved performance was noted in the reduction of liquid and gaseous effluent radionuclide curies released and offsite dose.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
09/03/1999	1999014	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 5C Ter:	<b>The quality assurance assessment program was properly implemented.</b> The licensee's quality assurance audit program of the radioactive waste effluent program was properly implemented. The auditors assigned to perform the audit of the radioactive waste effluent program were experienced and well qualified to perform the evaluations. The biennial quality assurance audit provided management with a good perspective to assess the radioactive waste effluent management program.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV  
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
08/20/1999	1999015	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>The access authorization program was effectively implemented.</b>  The access authorization program was effectively implemented. The compensatory measures program met physical security plan requirements. The security officers were well trained on program requirements. A good records and reporting system was in place for reporting safeguards events. Audits of the security, access authorization, and fitness-for-duty programs were effective, thorough, and intrusive.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
08/20/1999	1999015-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Inadequate Protected Area Detection Aids</b>  A noncited violation was identified involving a section of the vehicle barrier system that did not conform to the requirements of Paragraph 4.2.7 of the physical security plan and 10 CFR 73.55 (c)(7). This Severity Level IV violation is being treated as a noncited violation consistent with Appendix C of the NRC Enforcement Policy. The degraded barrier system was entered into the corrective action system as CR-GGN-1999-902.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
08/11/1999	1999018-03	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure of a radiation worker to log onto a radiation work permit</b>  On August 11, 1999, the licensee identified a willful violation of Technical Specification 5.4.1.a. for the failure of a radiation worker to log onto a radiation work permit or wear the required dosimetry when entering a controlled access area. The NRC Office of Investigations reviewed this matter and concluded that the violation was deliberate (O14-1999-044). The licensee estimated that the individual received an unmonitored dose of less than 1 millirem, therefore, no actual radiological safety consequences resulted from this event. This Severity Level IV violation (EA 99-320) is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report CR-GGN-1999-0849.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
07/24/1999	1999009	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 2B <b>Ter:</b>	<b>Untimely corrective actions for poor fire protection system integrity</b>  Although the ability of the fire protection system to perform its safety function was not affected, the overall integrity of the system and the material condition of the jockey pump were poor. The corrective actions taken in response to the deficiencies were untimely and ineffective in that system leakage was allowed to decay to the point that the jockey pump now ran continuously. This condition has existed since October 1998 and has not been repaired to date.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
06/25/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<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	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b>	<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						

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Region IV  
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
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 implementaion of mitigation strategies for plant equipment failures
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
06/25/1999	1999007-01	Pri: PLTSUP Sec:	NRC	IFI	Pri: 1C Sec: Ter:	<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 Sec: Ter:	<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 Sec: Ter:	<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 Sec: Ter:	<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 Sec: 3B Ter:	<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						

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## PLANT ISSUE MATRIX

By Primary Functional Area

Region IV  
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
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						
02/23/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C	<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	<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	<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						

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By Primary Functional Area

Region IV  
 GRAND GULF

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/05/1999	1999001-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	VIO IV	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<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						
02/05/1999	1999001-02	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<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.  This previously identified URI (50-416/9806-02) was reviewed and determined to be a non-cited violation of Technical Specification 5.4.1 for failure to follow radiation work permit program requirements. This non-repetitive, licensee-identified, and corrected violation is being treated as a non-cited violation consistent with Section VII.B.1 of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000416 Grand Gulf 1						
01/30/1999	1998017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4A <b>Sec:</b> 4B <b>Ter:</b>	<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						

# 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	NonCited 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
VIO	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.

**GRAND GULF**  
**Inspection / Activity Plan**  
**04/02/2000 - 03/31/2001**

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates Start	Planned Dates End	Inspection Type
	<b>RPBA17</b>	<b>- DRILL, EXERCISE, AND EVENT EVAL.</b>	<b>2</b>				
1	IP 7111406	Drill Evaluation		2	04/02/2000	07/01/2000	Baseline Inspections
	<b>RPBA13</b>	<b>- TEMPORARY PLANT MODIFICATIONS</b>	<b>2</b>				
1	IP 7111123	Temporary Plant Modifications		2	04/02/2000	03/31/2001	Baseline Inspections
	<b>PSB-RP1</b>	<b>- RAD MONITORING INSTRUMENTATION</b>	<b>1</b>				
1	IP 7112103	Radiation Monitoring Instrumentation		1	04/03/2000	04/07/2000	Baseline Inspections
	<b>PSB-RP2</b>	<b>- ACCESS CONTROL TO RAD SIGN AREAS AND PIV</b>	<b>1</b>				
1	IP 7112101	Access Control to Radiologically Significant Areas		1	04/17/2000	04/21/2000	Baseline Inspections
1	IP 71151	Performance Indicator Verification		1	04/17/2000	04/21/2000	Baseline Inspections
	<b>EMB</b>	<b>- SSD&amp;PC BAGMAN</b>	<b>1</b>				
1	IP 7111121	Safety System Design and Performance Capability		1	05/08/2000	05/10/2000	Baseline Inspections
	<b>PSB-RP3</b>	<b>- ALARA PLANNING/CONTROL 1</b>	<b>1</b>				
1	IP 7112102	ALARA Planning and Controls		1	05/08/2000	05/12/2000	Baseline Inspections
	<b>OB-EXAMS</b>	<b>- RO/SRO EXAMS</b>	<b>3</b>				
1	X02031	GG/INITAL EXAMS		1	05/08/2000	05/12/2000	Not Applicable
1	X02031	GG/INITAL EXAMS		3	05/22/2000	05/26/2000	Not Applicable
	<b>RPBA21</b>	<b>- EQUIPMENT ALIGNMENTS</b>	<b>2</b>				
1	IP 7111104	Equipment Alignment		2	05/14/2000	07/01/2000	Baseline Inspections
	<b>PBA-TI</b>	<b>- TI-144, PI DATA REVIEW</b>	<b>1</b>				
1	IP 2515/144	Performance Indicator Data Collecting and Reporting Process Review		1	05/14/2000	08/05/2000	Safety Issues
	<b>EMB</b>	<b>- SSD&amp;PC</b>	<b>6</b>				
1	IP 7111121	Safety System Design and Performance Capability		4	06/05/2000	06/23/2000	Baseline Inspections
	<b>PSB-EP1</b>	<b>- A&amp;N, ERO, PI&amp;R, EAL/EP, AND PIV</b>	<b>2</b>				
1	IP 7111402	Alert and Notification System Testing		2	06/26/2000	06/30/2000	Baseline Inspections
1	IP 7111403	Emergency Response Organization Augmentation Testing		2	06/26/2000	06/30/2000	Baseline Inspections
1	IP 7111405	Correction of Emergency Preparedness Weaknesses and Deficiencies		2	06/26/2000	06/30/2000	Baseline Inspections
1	IP 71151	Performance Indicator Verification		2	06/26/2000	06/30/2000	Baseline Inspections
	<b>OB-PIR</b>	<b>- PIR INSPECT</b>	<b>5</b>				
1	IP 71152	Identification and Resolution of Problems		3	08/28/2000	09/01/2000	Baseline Inspections
	<b>PSB-S1</b>	<b>- ACCESS AUTH/CONTROL</b>	<b>1</b>				
1	IP 7113001	Access Authorization Program (Behavior Observation Only)		1	09/11/2000	09/15/2000	Baseline Inspections
1	IP 7113002	Access Control (Search of Personnel, Packages, and Vehicles: Identification an		1	09/11/2000	09/15/2000	Baseline Inspections
	<b>RPBA18</b>	<b>- DRILL, EXERCISE, AND EVENT EVAL.</b>	<b>2</b>				
1	IP 7111406	Drill Evaluation		2	10/01/2000	01/06/2001	Baseline Inspections
	<b>RPBA25</b>	<b>- ADVERSE WEATHER</b>	<b>2</b>				
1	IP 7111101	Adverse Weather Protection		2	10/01/2000	01/06/2001	Baseline Inspections

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

**GRAND GULF**  
**Inspection / Activity Plan**  
**04/02/2000 - 03/31/2001**

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates		Inspection Type
					Start	End	
	<b>EMB - 50.59</b>		<b>1</b>				
1	IP 7111102	Evaluation of Changes, Tests, or Experiments		1	12/04/2000	12/08/2000	Baseline Inspections
	<b>RPBA22 - EQUIPMENT ALIGNMENTS</b>		<b>2</b>				
1	IP 7111104	Equipment Alignment		2	01/07/2001	02/17/2001	Baseline Inspections
	<b>PSB-S2 - RESP TO CONT EVENTS, SEC PLAN, AND PIV</b>		<b>2</b>				
1	IP 7113003	Response to Contingency Events (Protective Strategy and Implementation of P		2	01/08/2001	01/12/2001	Baseline Inspections
1	IP 7113004	Security Plan Changes		2	01/08/2001	01/12/2001	Baseline Inspections
1	IP 71151	Performance Indicator Verification		2	01/08/2001	01/12/2001	Baseline Inspections
	<b>OB-EXAMS - RO/SRO EXAMS</b>		<b>3</b>				
1	X02031	GG/INITAL EXAMS		1	02/12/2001	02/16/2001	Not Applicable
1	X02031	GG/INITAL EXAMS		3	03/12/2001	03/16/2001	Not Applicable
	<b>PSB-RP4 - ALARA PLANNING/CONTROL 2</b>		<b>1</b>				
1	IP 7112102	ALARA Planning and Controls		1	03/11/2001	03/15/2001	Baseline Inspections
	<b>EMB - MAINT RULE IMPLEMENTATION</b>		<b>1</b>				
1	IP 7111112B	Maintenance Rule Implementation		1	03/19/2001	03/23/2001	Baseline Inspections