

Ginna

Initiating Events

Mitigating Systems



Significance: Dec 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately establish a continuous fire watch.

The inspectors identified a non-cited violation involving the failure to properly implement fire protection program procedures. RG&E did not adequately station a continuous fire watch for an inoperable automatic fire suppression system. This finding was of very low safety significance because the inadequate compensatory fire watch existed for a short duration, the installed fire detection systems were operable, and the station's fire brigade effectiveness was not degraded.

Inspection Report# : [2000010\(pdf\)](#)



Significance: Nov 11, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

Both source range nuclear instruments inoperable.

On Sept 21, in Mode 5, operations management identified that the one presumed operable source range nuclear instrument (N-32), was also inoperable for approximately 14 hours, and unrecognized by the control room staff.

Inspection Report# : [2000008\(pdf\)](#)



Significance: Nov 11, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

Two of four containment recirculation fan coolers inoperable during plant mode change.

On October 14, during plant heat-up, control room operators discovered that two of four containment recirculation fan coolers were inoperable, due to their main control switched being in the pull-stop position.

Inspection Report# : [2000008\(pdf\)](#)



Significance: Aug 12, 2000

Identified By: NRC

Item Type: FIN Finding

Less than thorough evaluation of temporary modification.

GREEN. The inspectors identified that RG&E did not thoroughly consider the risk associated with the implementation of a temporary modification to the refueling water storage tank (RWST) purification system. Installation of the modification increased the probability of internal flooding and RWST loss of inventory events. RG&E subsequently determined that the overall increases in core damage frequency for these events were minimal. (Section 1R23)

Inspection Report# : [2000005\(pdf\)](#)

Significance: N/A Nov 10, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

10CFR50, Appendix B, Criterion V, RG&E failed to provide appropriate instructions for the re-lug of all four service water pump motor leads following motor replacement

10CFR50, Appendix B, Criterion V, Instructions, Procedures, and Drawings requires in part, activities affecting quality be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and be accomplished in accordance with these instructions, procedures, and drawings. The replacement of the service water pump motors in 1996 -1997 time frame was not accomplished using

procedures with appropriate instructions.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Green. RG&E did not include appropriate instructions and acceptance criteria for the acquisition, installation, and testing of EDG fuel oil booster pumps.

Green. RG&E did not include appropriate instructions and acceptance criteria in applicable station documents for the acquisition, installation, and vendor testing of the emergency diesel generator (EDG) fuel oil booster pumps. As a result, incorrectly assembled pumps experienced shaft seal failures when their associated EDGs were placed in service. This finding was determined to be a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings." This issue had an actual impact on safety because both EDGs experienced unplanned unavailability due to the common cause failure of the fuel oil booster pump shaft seals.

Inspection Report# : [2001008\(pdf\)](#)

G

Significance: Jun 08, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Lack of procedural guidance for a loss of service water event.

Green. The team determined there was no procedure to address a loss of service water (LOSW) event with offsite power available. The finding related to two LOSW transient scenarios concerning the turbine drive auxiliary feedwater (TDAFW) pump and the standby auxiliary feedwater (SAFW) pumps and the need to maintain the secondary heat removal function and prevent core damage. Neither the control room annunciator response procedures nor applicable emergency operating procedures, contained entry or transition criteria to direct the operators, following a LOSW transient, to conduct existing procedures to align temporary fire water cooling to the TDAFW pump or to align the alternate city water suction supply to the SFW pumps. This issue was of more than minor concern because the Ginna Phase 2 SDP worksheet assumed that following a LOSW transient the failure of operators to take the appropriate action for TDAFW and SAFW pumps would lead to core damage. A subsequent Phase 3 SDP analysis showed that the lack of specific entry or transition criteria in procedures were of very low safety significance (Green); because operators could reasonably have been expected to maintain the secondary heat removal function. Specifically, in the sequence which required the alignment of temporary cooling water to the TDAFW pump, the pump could reasonably be expected to operate, without cooling water, for longer than the licensing basis of two hours and longer than the approximately 3.5 hours required for the condensate storage tank to reach a water level of five feet, allowing a proceduralized transfer to the SAFW pumps with the alternate city water supply. In the sequence that included the failure of the TDAFW pump to start or to run; given the frequency of the pump failure and allowing for recovery actions to restore the service water system, the operators trained in the alignment of the SAFW pumps to city water would reasonably have been effective. (Section 1R21.b, Loss of Service Water)

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Feb 10, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to take appropriate corrective actions for an inoperable service water flow instrument.

The inspectors identified a non-cited violation involving the failure to take appropriate corrective actions for an inoperable service water flow instrument. Without appropriate operational guidance for this condition, operators would not have been able to verify the service water flows to the component cooling water heat exchangers specified in emergency operating procedures. This finding is of very low safety significance because the inoperable flow instrument did not result in a loss of safety function in the affected systems.

Inspection Report# : [2000011\(pdf\)](#)

Barrier Integrity

G

Significance: Jul 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to properly translate system design information into surveillance testing procedures.

GREEN. The inspectors identified that RG&E did not properly translate emergency core cooling system (ECCS) design information into a procedure used for determining ECCS leakage outside containment. The procedure did not contain instructions for increasing leakage rates

measured at low system pressure to those rates expected at the higher system pressures during the recirculation phase following a loss of coolant accident. Actual measured leakage rates were determined to be far below technical specification limits. This finding is a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control." (Section 1R22)
 Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Nov 02, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Green. A Non-Cited Violation of 10CFR50 Appendix B, Criterion XVI, Corrective Action, for failure to identify that the support for a containment isolation valve did not meet seismic qualification.

Green. A Non-Cited Violation of 10CFR50 Appendix B, Criterion XVI, Corrective Action, for failure to identify that the support for containment isolation valve AOV-966C did not meet the screening criteria for seismic qualification, and therefore was not properly evaluated. The license declared the penetration inoperable and closed the redundant containment isolation valve pending resolution of the problem. This finding was of very low safety significance because, (1) the probability of a design basis earthquake is very low, (2) the existing valve supports, though they did not meet the seismic qualification screening criteria, would provide some support to mitigate the consequences of a seismic event, (3) although not leak tested, there are other normally closed valves located in the line upstream of AOV-966C, and (4) a manual containment isolation valve is located upstream of AOV-966C. Also, there was no actual open pathway in reactor containment, therefore the SDP Phase 1 screens to Green. Because the finding is of very low safety significance and the finding was captured in the licensee's corrective action program, this finding is being treated as a Non-Cited Violation, consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001010\(pdf\)](#)

Significance: N/A Sep 29, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure to perform technical specification surveillance requirement 3.6.3.2 for the main steam isolation bypass valves.

Technical specifications surveillance requirement 3.6.3.2 requires, in part, that containment isolation boundaries that are located outside containment and not locked, sealed, or otherwise secured are verified to be in their required position every 92 days. On September 4, 2001, RG&E identified that this surveillance was not being performed as required for the main stream isolation bypass valves. This issue was entered into the corrective action program (ACTION report No. 2001-1588) and is being treated as a Non-Cited Violation.

Inspection Report# : [2001008\(pdf\)](#)

Emergency Preparedness

Significance: N/A Sep 29, 2000

Identified By: NRC

Item Type: FIN Finding

Supplemental inspection for WHITE performance indicator

The NRC performed a supplemental inspection, using inspection procedure 95001, to assess RG&E's evaluation associated with a white performance indicator for alert and notification system reliability. The inspector determined that RG&E performed a thorough evaluation for the performance indicator's change in color. This change was primarily due to a silent test failure that occurred on June 26, 2000. RG&E determined the cause of the silent test failure was the temporary interruption in the telephone communication line which serves to activate and transmit test signals to the Wayne County sirens. The inspector concluded that RG&E developed comprehensive corrective actions for this performance issue.

Inspection Report# : [2000007\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

G

Significance: Jul 01, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure to properly sample a gas decay tank prior to release.

GREEN. During a gas decay tank release evolution, operators mistakenly released the wrong tank. The resultant radioactive release was well below regulatory limits. Nevertheless, the inspectors determined this issue to be a non-cited violation of technical specification 5.4.1, "Procedures," because RG&E did not sample the noted tank within twelve hours of releasing it, as required by station radioactive effluent control program procedures. (Section 2PS1)
 Inspection Report# : [2000003\(pdf\)](#)

Significance: N/A Jun 30, 2001
 Identified By: Licensee
 Item Type: NCV NonCited Violation

Failure to perform the required radioactive gaseous effluent vent flow rate determination every 18 months in accordance with Section 5.5.4 of the ITS and Table 3.2-2 of the ODCM.

Section 5.5.4 of the Improved Technical Specifications and Table 3.2-2 of the Offsite Dose Calculation Manual require that the radioactive gaseous effluent vent flow rate determination be performed every 18 months. RG&E did not perform flow rate determinations for the plant and the containment vents as specified in the ODCM. RG&E documented the corrective actions in Action Report No. 2000-1630. This is being treated as a NCV.

Inspection Report# : [2001006\(pdf\)](#)

Physical Protection

Miscellaneous



Significance: Nov 17, 2000
 Identified By: Licensee
 Item Type: NCV NonCited Violation

Failure to ensure that the alternate shutdown capability for the screen house was electrically and physically independent of the area.

The failure to isolate all potentially affected cables within the screen house constitutes a violation of the requirements of 10 CFR 50, Appendix R, Section III.G.3. (reference LER 05000244/2000-002)

Inspection Report# : [2000009\(pdf\)](#)

Significance: N/A Nov 11, 2000
 Identified By: NRC
 Item Type: NCV NonCited Violation

Violation of 10 CFR 50.59

Inadequate safety evaluation for main steam non-return check valves. (Closes EEI 05000244/1999-005-01.)

Inspection Report# : [2000008\(pdf\)](#)

Significance: N/A Aug 11, 2000
 Identified By: NRC
 Item Type: FIN Finding

Annual Problem Identification and Resolution inspection

The Ginna Nuclear Power Plant had an acceptable problem identification and resolution process. The multi-tier problem identification system was adequately integrated and the threshold for reporting equipment and personnel performance issues was low. Assigned priorities for problem assessment and identification of required corrective actions were acceptable; operability and reportability evaluations were reasonable. Root cause analyses were also reasonable with occasional weaknesses in the evaluation of and reporting of human performance. Corrective actions were commensurate with the safety significance of the issue and timely. Work environment was safety conscious with plant personnel showing no reluctance in reporting plant issues.

Inspection Report# : [2000004\(pdf\)](#)

Significance: N/A Jul 01, 2000
 Identified By: NRC
 Item Type: NCV NonCited Violation

Failure to promptly identify and correct leaking containment tendons grease fill piping.

NO COLOR. RG&E did not promptly enter problems into their corrective action program for two equipment issues. First, station personnel had noted containment tendon grease leakage since at least September 1999; however, the impact on plant equipment and the development of long-term corrective actions were overlooked until an Action Report was written in June 2000. In the second example, RG&E personnel did not promptly initiate an Action Report for emergency siren test failures. As a result, RG&E failed to complete an NRC notification in a timely manner. These findings are a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions." (Section 4OA2)

Inspection Report# : [2000003\(pdf\)](#)

Significance: N/A Jul 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to perform 10 CFR 50.59 safety evaluation.

NO COLOR. RG&E did not perform safety evaluations as required by 10 CFR 50.59 and Ginna's associated implementing procedure (IP-SEV-1). Four examples were identified and determined not to be unreviewed safety questions. The examples indicated improper procedure implementation during the safety review process. This issue was determined to be a non-cited violation of 10 CFR 50.59. (Section 4OA4.2)

Inspection Report# : [2000003\(pdf\)](#)

Significance: N/A Nov 02, 2001

Identified By: NRC

Item Type: FIN Finding

71152 Identification and Resolution of Problems Summary

The team determined that the licensee's performance in the area of problem identification and resolution at the Ginna site was adequate. Based on a review of items from the licensee's operating, maintenance, engineering, and quality assurance processes, the team concluded the licensee was identifying problems and entering them into their corrective action program at the proper threshold. Notwithstanding, the team identified an example of a failure to promptly identify and subsequently correct problems associated with a primary containment isolation valve. The team also determined that the licensee was evaluating and categorizing problems at the correct significance level. Identified problems were properly prioritized. The evaluations were normally of adequate depth to identify the causes of problems and appropriately broad in considering the extent of the condition. The licensee developed and implemented corrective actions that appeared reasonable to address the identified problems. The team determined that, in general, the corrective actions were completed or scheduled to be completed in a timely manner.

Inspection Report# : [2001010\(pdf\)](#)

Last modified : March 28, 2002