Ginna
3Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Instrument lines not adequately supported
The inspectors identified a non-cited violation (NCV) of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," on April 5, 2005 when they noted that Ginna did not implement effective corrective action(s) to ensure seismic supports on various instrumentation sensing lines in the pressurizer enclosure were properly installed. Degraded seismic supports had previously been identified by the NRC during plant walkdowns in February 2004 and November 2001.

This finding is more than minor, because it is associated with the "Design Control" attribute of the Initiating Events Cornerstone and affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety systems. In accordance with Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Findings for At-Power Situations," the inspectors conducted a Significance Determination Process (SDP) phase 1 screening and determined that the finding is of very low safety significance (Green). The SDP process screened to Green since the degraded condition of the seismic mountings for the pressurizer instrumentation sensing lines did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. Corrective actions were completed under work order 20502000. This finding has a cross-cutting aspect in the problem identification and resolution area with an associated causal factor of inadequate problem identification.
Inspection Report# : 2005003*(pdf)*

Significance: G Dec 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish Appropriate Measures to Assure the Monitoring Panel for the Compensated Steam Support System is Maintained
A violation of 10 CFR 50 Appendix B, Criterion Xll, "Control of Measuring and Test Equipment," was identified by inspectors when they noted that prior to December 2003 several alarms on the panel for the temperature compensated support system, which monitors a critical dimension between the safety valves and support columns, were "locked in" and the degraded condition had not been investigated and resolved.

This finding is greater that minor, because it is associated with the equipment performance attribute of the initiating events cornerstone and affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions. In accordance with Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Findings for At-Power Situations," the inspectors conducted a Significance Determination Process (SDP) phase 1 screening and determined that the finding is of very low safety significance (Green). The SDP process screened to Green since the degraded condition of the monitoring system does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. This finding did not contribute to the likelihood of a primary or secondary system LOCA initiator, since the critical gaps were found to be acceptable. Additionally, the finding did not increase the likelihood of a fire or internal/external flood. This finding has cross-cutting aspects associated with the failure to properly identify the problem and resolve the situation to produce a timely corrective action. Corrective actions taken included restoring the monitoring system so that it was not causing false alarms.
Inspection Report# : 2004005*(pdf)*

Mitigating Systems

Significance: G Sep 30, 2005
Identified By: NRC
Item Type: FIN Finding
Auxiliary Operators Did Not Properly Monitor the Performance of the Relay Room Air Conditioning Systems
Green. The inspectors identified that auxiliary operators (AOs) during their rounds, did not properly verify the relay room air-conditioning systems were operating as required by procedure P-13, "Auxiliary Operator Tour Guidelines." Specifically, the AOs failed to identify that the "B" relay room air-conditioning system was not functioning properly. As a result of this deficiency, the temperature of the relay room began to increase, and the multiplexor (MUX) cabinets for the plant process computer (PPCS) began to overheat, which could have rendered the system

inoperable. In addition to installing temporary fans, Ginna corrective actions included increasing oversight of AO rounds to ensure degraded conditions are properly documented. The cause of this finding is related to the cross-cutting element of problem identification and resolution.

This finding is more than minor since it affected the reliability objective of the Human Performance attribute of the Mitigating Systems cornerstone. The inspectors assessed the finding using the Significance Determination Process (SDP) and determined the finding to be of very low safety significance. The finding was of low safety significance since the finding did not result in a loss of safety function. Specifically, operators took appropriate compensatory measures to limit the temperature increase of the multiplexor (MUX) cabinets before the PPCS failed. (Section 1R04)

Inspection Report# : 2005004*(pdf)*

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to develop adequate procedures concerning the testing and maintenance of mechanical and hydraulic snubbers
The inspectors identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings" when they noted snubber RHU-36 was removed from the "A" train of the residual heat removal (RHR) system when the system was required to be operable without first performing an engineering analysis as required by procedure IP-IIT-5, "Snubber Inspection and Testing Program."

This finding is more than minor because if left uncorrected, the finding would become a more significant safety concern. This finding, which is under the "Protection Against External Factors" attribute of the Mitigating Systems Cornerstone and affected the objective to ensure availability of systems that respond to initiating events to prevent undesirable consequences, was determined to be of very low safety significance in accordance with Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process." The inspectors conducted a SDP Phase 1 screening using Checklist 3 of Appendix G and determined the finding to be of very low safety significance (Green) since it did not increase the likelihood of a loss of reactor coolant system (RCS) inventory, did not degrade the ability to terminate a leak path or add RCS inventory when needed, and did not degrade the ability to recover decay heat removal systems once lost. (Section 1R19)
Inspection Report# : 2005003*(pdf)*

Significance: G Mar 31, 2005
Identified By: NRC
Item Type: FIN Finding
Failure to Implement Effective Corrective Actions Associated with Component Mispositioning Events
Green. The inspectors identified a finding that Ginna personnel have failed to implement effective corrective actions for conditions adverse to quality associated with component mispositioning events. Numerous mispositioning events have occurred over the past year and efforts to correct the deficiency have been ongoing since the last quarter of 2004. While many of the events have been minor in nature, two of the events which occurred this quarter had the potential to impact the acceptable operating environment for safety significant equipment. Specifically, the isolation valves on a relay room air conditioner service water strainer were found out-of-position rendering the cooler inoperable and the battery room air conditioning unit power switch was found in the off position rendering it inoperable.

This finding is greater than minor because it affects the reactor safety, mitigating systems attribute of equipment performance, and the availability, reliability, and capability objective of the mitigating systems cornerstone. This finding was of very low safety significance because none of the events resulted in the actual loss of a system safety function. The inspectors identified that a contributing cause of this finding was related to the cross-cutting area of problem identification and resolution specifically under the subcategory of effectiveness of corrective actions.
Inspection Report# : 2005002*(pdf)*

Barrier Integrity

Significance: G Sep 30, 2005
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Properly Restore the Blowdown System Resulting in a Shutdown to Correct Steam Generator Chemistry
Green. The inspectors identified a self-revealing finding for a failure of plant operators to use the correct procedure to restore the steam generator blowdown system. As a result of using the incorrect procedure, a steam generator water chemistry excursion occurred, which required a plant shutdown to restore secondary chemistry to acceptable levels. In addition to restoring steam generator water chemistry to within specification, corrective action included implementing a work package review process that would verify all work packages have proper restoration actions. The cause of this finding is related to the cross-cutting element of human performance.

This finding is more than minor since it affected the physical design barriers objective of the Configuration Control attribute of the Barrier

Integrity Cornerstone. This finding is not suitable for the significance determination process evaluation, but was reviewed by NRC management is determined to be a green finding of very low safety significance. The finding was of very low safety significance because there was no evidence that the steam generator tubes had been degraded, and the operators implemented appropriate actions after the chemistry excursion occurred.
Inspection Report# : 2005004*(pdf)*

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: FIN Finding
A bare metal inspection of the lower reactor vessel head was not performed during the spring 2005 refuel outage
A finding was identified by the inspectors that contrary to a commitment outlined in a September 19, 2003, letter to the NRC, Ginna did not perform a bare metal inspection of the lower reactor vessel head during the spring 2005 refueling outage. The performance deficiency associated with this finding was a failure of Ginna to develop adequate inspection procedures for the lower reactor vessel head that could identify pressure boundary leakage. As a result, the ability of Ginna personnel to detect leakage from the lower reactor vessel head could be degraded.

The inspector determined that this finding, which is under the "RCS Equipment and Barrier Performance" attribute of the Barrier Integrity Cornerstone is more than minor because the failure to develop adequate inspection procedures and evaluation guidance could result in a failure to detect a degraded lower reactor vessel head penetration boundary. In accordance with Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted an SDP Phase 1 screening and determined that the finding is of very low safety significance (Green). Using the Reactor Safety SDP, this finding screened to Green and was of very low safety significance, since the reactor coolant system pressure boundary was not actually degraded.
Inspection Report# : 2005003*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Mar 31, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to provide adequate instruction in an RWP to prevent an unintended uptake
Green. The inspector identified a self-revealing, non-cited violation of Technical Specification (TS) 5.4.1.a, because a radiation work permit was not adequate for controlling the manual cleaning of highly-contaminated equipment. This resulted in a worker receiving an unintended uptake of radioactive material. The radiation work permit failed to provide adequate precautionary instructions to work on highly contaminated equipment and to prevent the generation and uptake of airborne radioactivity.

This violation is more than minor because this manual cleaning of a highly-contaminated insert without the use of respiratory protection could have resulted in a significant uptake of radioactive material and affected the radiation safety cornerstone/ occupational radiation safety cornerstone's objective to ensure the adequate protection of the workers' health and safety from exposure to radiation from radioactive material. The violation is of very low safety significance because it did not involve an overexposure, did not constitute a substantial potential for an overexposure, and did not compromise the ability to assess dose.
Inspection Report# : 2005002*(pdf)*

Public Radiation Safety

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to meet surveillance frequency for calibration of an effluent radiation monitor
The inspectors identified a non-cited violation of Technical Specification S.3.1.1 in the Off-site Dose Calculation Manual (ODCM) because the surveillance frequency for the R-22 radioactive liquid effluent monitor was not met. Ginna personnel immediately scheduled the monitor for calibration on the day following identification of the violation.

This violation is more than minor because it is associated with the cornerstone attribute of maintaining properly calibrated radioactive effluent monitors and affected the Radiation Safety Cornerstone/Public Radiation Safety Cornerstone's objective to ensure the adequate protection of public health and safety from exposure to radioactive materials released into the public domain as a result of routine civilian nuclear reactor operation. The violation is of very low safety significance because, while it did impair Ginna's ability to assess dose, Ginna personnel assessed the doses from effluent releases, and the assessed doses did not exceed the dose values in Appendix I to 10 CFR 50. This finding has a cross-cutting aspect in the problem identification and resolution area with a causal factor of effectiveness of corrective actions (Section 2PS1).
Inspection Report# : 2005003*(pdf)*

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

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