Ginna

Initiating Events

Mitigating Systems

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: FIN Finding
Failure to implement adequate test or preventive maintenance program to ensure that check valves in the floor drain system sumps would prevent flow in the reverse direction
The inspectors identified that RG&E did not implement an adequate test or preventive maintenance program to ensure that check valves in the floor drain system sumps would prevent flow in the reverse direction. When RG&E inspected the sump check valves in December 2002, two valves, one in the "B" Diesel Generator Room sump and the other in the "A" Battery Room sump were found to be inoperable. The potential for this problem to occur was identified in NRC Information Notice 83-44. An action report was written by RG&E to document this deficiency and the inoperable check valves were replaced. This finding associated with the Mitigating Systems Cornerstone was determined to be greater than minor since if a severe flooding condition occurred, or combustible gas collected in the floor drain system and ignited, multiple trains of safety-related equipment could be adversely affected. The finding was determined to be of very low safety significance in accordance with phase 3 of the SDP since the probability of a flood or fire event propagating through the floor drain system and rendering safety-related equipment inoperable was low and a flooding or fire event did not occur. The failure to test the check valves did not constitute a violation of regulatory requirements.
Inspection Report# : 2002006*(pdf)*

Significance: G Sep 28, 2002
Identified By: NRC
Item Type: FIN Finding
Operator error during performance of surveillance test PT-12.2; "Emergency Diesel Generator B," rendered the B diesel generator inoperable for approximately seven hours.
Operator error during performance of surveillance test PT-12.2; "Emergency Diesel Generator B," rendered the B diesel generator inoperable for approximately seven hours due to the resultant troubleshooting activities. The emergency diesel generator output breaker tripped due to an out of phase condition. The finding was determined to be of very low safety significance and did not constitute a violation of regulatory requirements.
Inspection Report# : 2002005*(pdf)*

Significance: G Sep 28, 2002
Identified By: NRC
Item Type: FIN Finding
Operator response to primary plant computer system (PPCS) alarms has not been fully effective.
The inspectors identified that RG&E's prior corrective action for inadequate operator response to primary plant computer system (PPCS) alarms, has not been fully effective. This issue was considered greater than minor since inadequate or poor response to primary plant computer alarms could be reasonably viewed a precursor to a significant event or, if left uncorrected, could become a more significant safety concern. The finding is not suitable for SDP evaluation, but was determined to be a green finding of very low safety significance however, not a violation of a regulatory requirement.
Inspection Report# : 2002005*(pdf)*

Significance: G Sep 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
A natural gas supply isolation valve to the screenhouse had been covered by several inches of gravel and asphalt pavement and could not be operated during a fire.
The inspectors identified the natural gas supply isolation valve to the screenhouse had been covered by several inches of gravel and asphalt

pavement. Operators would be procedurally directed to close this valve in the event of a fire in the screenhouse. The finding was determined to be of very low safety significance (Green) and a non-cited violation of technical specification 5.4.1.d; which requires, in part, that procedures for the fire protection program be established, implemented, and maintained.
Inspection Report# : 2002005*(pdf)*

Significance: G Sep 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Two out of four reactor protection over-temperature delta-temperature channels were found to be improperly calibrated and outside technical specification requirements.
Two out of four reactor protection over-temperature delta-temperature channels were found to be improperly calibrated and outside technical specification requirements. Improper calibration of reactor protection circuitry could result in an unnecessary plant transient. The calibration error was determined to be of very low safety significance (Green) and a non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings.
Inspection Report# : 2002005*(pdf)*

Significance: G May 18, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to formally control and evaluate a compensatory fire protection measure installed to provide a temporary water supply to the containment fire hose reels.
Contrary to the requirements of Technical Specification 5.4.1.d, which required written procedures be established, implemented and maintained covering the Fire Protection Program; RG&E did not evaluate and implement a compensatory measure using an approved procedure, e.g. procedure IP-DES-3, "Temporary Modifications." The finding was determined to be of very low safety significance (Green) because at the time this condition existed, the plant was shutdown and none of the safe shutdown equipment in containment was necessary to support shutdown cooling operations.
Inspection Report# : 2002003*(pdf)*

Significance: G Mar 23, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
INADVERTENT ISOLATION OF THREE OF FIVE REACTOR COOLANT MAKE-UP PATHS.
The inspectors identified a non-cited violation (NCV) involving three of five make-up flow paths to the reactor coolant system being isolated and tagged closed contrary to procedure O-2.3.1, "Draining and Operation at Reduced Inventrory of the Reactor Coolant System."
Inspection Report# : 2002002*(pdf)*

Significance: G Jan 18, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
SOURCE RANGE DETECTOR N-31IMPROPERLY CALIBRATED
Technical specification 5.4.1.a requires that written procedures be established, implemented and maintained for activities recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. On January 18, 2002, source range nuclear instrumentation channel N-31 was improperly calibrated when the technicians failed to properly implement procedure CPI-SR-N31, "Calibration of Source Range N31." Reference Action Report 2002-0530.
Inspection Report# : 2002002*(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: W Jun 29, 2002
Identified By: NRC
Item Type: VIO Violation
Failure to correct problems with the ANS siren feedback system which resulted in a loss of ANS function per 10 CFR 50.47(b)(5).
The inspectors identified, that should emergency planning zone (EPZ) siren failures occur, the ability to notify the public in a timely manner, within the 10 mile EPZ, was compromised. The finding was evaluated using Inspection Manual Chapter (IMC) 0609, Appendix B, "Emergency Preparedness Significance Determination Process." This finding has been determined to be of low to moderate safety significance (White) and a violation of regulatory requirement 10 CFR 50.47(b)(5), which requires in part that licensees establish a means to provide early notification and clear instruction to the populace within the plume exposure pathway EPZ.
Inspection Report# : 2002004*(pdf)*

Significance: G Apr 17, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to correct long standing equipment and human performance issues which affect ANS reliability.
A non-cited violation of 10 CFR 50.54(q) and E-Plan Section 6.3.13 was identified, concerning the reliability of the Alert Notification System to fulfill its notification function within design objectives. Long standing equipment and human performance issues that affect ANS reliability have not been corrected, affecting the licensee's ability to fulfill the public notification function. This finding was of very low safety significance (Green) based on the fact that the siren feedback system alerted the licensee to siren malfunctions, permitting the use of compensatory measures (i.e., route alerting), if necessary.
Inspection Report# : 2002009*(pdf)*

Significance: G Apr 17, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to utilize mobile loudspeakers for notification of the transient population.
A non-cited violation of 10 CFR 50.54(q) and E-Plan Section 6.3.13 was identified, regarding the utilization of mobile loudspeakers to alert the transient population of an emergency. The licensee did not possess this equipment and was not ensuring that this notification function was being met. The finding was of very low safety significance (Green) due to the fact that the sirens alone provided designed coverage for notification of the public in the ten-mile Emergency Planning Zone.
Inspection Report# : 2002009*(pdf)*

Significance: TBD Apr 17, 2002
Identified By: NRC
Item Type: URI Unresolved item
Licensee E-Plan staffing commitments were inconsistent with those prescribed in NUREG-0654, which was a potential failure to meet planning standard 10 CFR 50.47(b)(2).
Licensee E-Plan staffing requirements were inconsistent with those prescribed in NUREG-0654, a licensing standard used by the NRC staff in order to evaluate a plan meeting planning standard 10 CFR 50.47(b)(2). This planning standard states, in part, that adequate staffing to provide initial facility accident response in key functional areas is maintained at all times, and timely augmentation of response capabilities is available. This issue is unresolved pending the referral to NRC headquarters for further review of licensee staffing requirements, certain changes to those requirements since initial NRC approval, and a determination by NRC that those requirements are adequate for emergency response.
Inspection Report# : 2002009*(pdf)*

Occupational Radiation Safety

Significance: N/A May 18, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Licensee Identified Violations
Technical Specification 5.7.2 requires that areas with radiation levels >1000 mrem/hr at a distance of 30 cm be locked or be continuously guarded to prevent unauthorized entry. Contrary to this requirement, the entrance to the Reactor Cavity, a Technical Specification Locked High Radiation Area, was left unlocked and unguarded for a period of about twelve (12) hours. RG&E concluded that no entry was made into this area during the time it was unlocked. Reference ACTION report 02-0358.
Inspection Report# : 2002003*(pdf)*

Public Radiation Safety

Significance: N/A Sep 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
RG&E identified contaminated material had been inadvertantly released and stored in an offsite warehouse.
A violation of very low safety significance, which was identified by the licensee has been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program.
Inspection Report# : 2002005*(pdf)*

Physical Protection

Miscellaneous

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: FIN Finding
Failure to implement all aspects of the fire attack strategy
The inspectors identified that during a fire drill, RG&E did not fully implement all aspects of the fire attack strategy. This deficiency was not identified by RG&E in the post drill critique. An action report was written by RG&E to document this deficiency. This finding, associated with the Mitigating Systems Cornerstone, was determined to be greater than minor because it has a credible impact on safety since incomplete implementation of the fire attack strategy may prevent a fire from being extinguished or cause a fire to propagate leading to a significant event. The finding was determined to be of very low safety significance in accordance with Phase 1 of the fire SDP because the fire brigade is only a single element of the defense-in-depth fire protection strategy.
Inspection Report# : 2002006*(pdf)*

Significance: N/A Oct 25, 2002
Identified By: NRC
Item Type: FIN Finding
The PI&R team concluded that, in general, problems were properly identified, evaluated and corrected.
The team concluded that, in general, problems were properly identified, evaluated, and corrected. The licensee’s effectiveness at problem identification was acceptable overall. However, the NRC identified several minor deficiencies which were not identified or entered into the licensee’s corrective action system. While some minor exceptions were noted, the licensee adequately prioritized and evaluated problems that were entered into the corrective action program. Corrective actions, when specified, were generally implemented in a timely manner. Licensee audits and self-assessments were found to be adequate. On the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the corrective action program.
Inspection Report# : 2002010*(pdf)*

Last modified : March 25, 2003