Ginna
2Q/2004 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT PROCEDURES FOR SEVERE WEATHER
Green. The inspectors identified that although the Ginna site was experiencing high winds, control room operators did not implement the site adverse weather plan contained in procedures EPIP 1-17, "Planning for Adverse Weather," and ER-SC-1, "Adverse Weather Plan," until prompted by the inspector. Following implementation of ER-SC-1, operators manually tripped the reactor as required by Abnormal Operating Procedure AP-RCS.2, "Loss of Reactor Coolant Pump Flow," when an offsite power supply was lost because of storm-related damage. The failure to implement EPIP 1-17 and ER-SC-1 is a violation of Technical Specification 5.4.1.

This finding is associated with the "Protection Against External Factors" attribute of the initiating events cornerstone. This finding is greater than minor because it affected the objective of limiting the likelihood of those events that upset plant stability during power operation in that the severe weather caused a reactor trip. Since operators responded appropriately to the loss of the 751 line, the finding is of very low safety significance because it did not contribute to the likelihood of a primary or secondary system LOCA initiator, or to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Additionally, the finding did not increase the likelihood of a fire or internal/external flood. (Section 1R01)
Inspection Report# : 2003007*(pdf)*

Mitigating Systems

Significance: G Jun 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Evaluate Emergency Operating Procedure Step Differences
Green. The inspectors identified that contrary to the requirements of Technical Specification 5.4.1(b) and certain Ginna internal procedures, Ginna procedure A-503.1 "Emergency and Abnormal Operating Procedures Users Guide" allowed steps in Emergency Operation Procedures (EOP)s to be performed out of sequence under certain conditions without these step sequence deviations being evaluated and justified in the "Ginna Step Differences Evaluation Document."

This finding is associated with the procedure quality and preventing human performance errors attributes of the Mitigating Systems Cornerstone objectives. It is greater than minor, because procedures which have not been properly evaluated could provide incorrect guidance for operators during transient conditions. The finding is of very low safety significance because once the changes were evaluated by Ginna personnel, they were determined to be acceptable. Further the issue was not a design or qualification deficiency, it did not represent a loss of safety function, and was not potentially risk-significant due to seismic, flood, fire, or weather-related initiating event. (Section 1R02)
Inspection Report# : 2004003*(pdf)*

Significance: G Jun 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Adequate Guidance Was Not Provided for Maintenance Activities
Green. The inspectors identified a non-cited violation for the licensee’s failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." This violation is related to inadequate procedures for assembling the mechanical seal for the turbine-driven auxiliary feedwater direct current (dc) lubricating oil pump.

This finding of inadequate maintenance procedures is greater than minor because if left uncorrected, it would become a more significant safety concern, and could result in degraded reliability of the turbine-driven auxiliary feedwater pump. The finding was determined to be of very low safety significance because the condition was identified and corrected before the pump became inoperable. Further, the issue was not a design or qualification deficiency, it did not represent a loss of safety function, and was not potentially risk-significant due to seismic, flood, fire, or weather-related initiating event. (Section 1R19)
Inspection Report# : 2004003*(pdf)*

Significance: G Dec 31, 2003
Identified By: NRC
Item Type: FIN Finding
FAILURE TO PROPERLY SEQUENCE WORK ACTIVITIES DURING SURVEILLANCE TESTING
Green. The inspectors identified that RG&E had performed maintenance on four main steam safety valves prior to performing required surveillance testing. This practice may mask the as-found condition of the valves, and affect the results of the surveillance tests.

This finding is greater than minor, because it is associated with the "Equipment Performance" (reliability) attribute of the mitigating systems cornerstone, and it would adversely affect the cornerstone objective because failure to conduct as-found testing may mask any valve degradation. This could adversely impact the reliability of the steam generator overpressure protection system to prevent undesirable consequences. The finding is of very low safety significance because it was not a design or qualification deficiency, it did not represent a loss of safety function, and was not potentially risk significant due to seismic, flood, fire, or weather related initiating event. Further, the finding is of very low safety significance since the issue involved inadequate testing, and did not degrade the ability of the main steam safety valves to perform their intended function for the next operating cycle. (Section 1R19)
Inspection Report# : 2003007*(pdf)*

Significance: G Dec 31, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CORRECTLY ASSESS RISK OF MAINTENANCE ACTIVITIES
Green. The inspectors identified a non-cited violation of 10 CFR 50.65 (a)(4) when RG&E personnel installed an incorrect version of the risk analysis program on the plant intranet server. The program incorrectly modeled the impact of removing emergency diesel generators from service. RG&E personnel installed the correct version of the software when the error was identified by the inspectors.

After management review, this finding was determined to be greater than minor, because the plant risk analysis assessments, which RG&E schedulers and operations personnel had performed on several occasions, were incorrect, and in one case on November 18, 2003, unbeknownst to Ginna personnel, the plant was in an elevated risk condition. If left uncorrected, this finding could become a more significant safety concern since with the incorrect software installed, operators could not correctly assess the impact on plant risk of maintenance on mitigating systems. The safety significance of the finding was very low, because the plant was not in a high risk condition at any time during the period that the wrong program was installed. (Section 1R13)
Inspection Report# : 2003007*(pdf)*

Significance: G Dec 31, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
AUXILIARY FEEDWATER FLOWPATH INOPERABLE DURING MODE CHANGES, DUE TO PERSONNEL ERROR, RESULTED IN CONDITION PROHIBITED BY TECHNICAL SPECIFICATIONS
Green. A self-revealing non-cited violation of Ginna Station Technical Specification (TS) Limiting Condition for Operation (LCO) 3.0.4 was identified when plant operators conducted PT-16Q-T after transition to Mode 2 from Mode 4 and found that flow could not be achieved from the turbine driven auxiliary feedwater (TDAFW) pump to the "B" steam generator. The line had been isolated through a sequence of lineups and testing, which was conducted prior to the Mode change that did not properly restore the system to the required line-up for the Mode change. The flow path was immediately restored by RG&E personnel when the deficiency was discovered. Procedures will be revised to minimize the possibility of event recurrence.

This finding, associated with the "Configuration Control" attribute of the mitigating systems cornerstone, is greater than minor because it affected the objective of ensuring the reliability and capability of systems to prevent undesirable consequences in that the TDAFW system was inoperable for three days. The finding is of very low safety significance because it was not a design or qualification deficiency, it did not represent a loss of safety function (the remaining diverse trains of AFW remained operable), and was not potentially risk significant due to seismic, flood, fire, or weather related initiating events. Further, the exposure time was less than the LCO action time of seven days. (Section 4OA3)
Inspection Report# : 2003007*(pdf)*

Significance: G Oct 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROMPTLY IDENTIFY AND TAKE ACTIONS TO ADDRESS A CONDITION ADVERSE TO QUALITY CONCERNING CONTAINMENT SUMP SCREEN BYPASS FLOWPATHS
Green. The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Actions, for RG&E's failure to promplty identify and take actions to address a condition adverse to quality. Specifically, RG&E did not promptly identify and correct several longstanding containment sump screen bypass flowpaths that had the potential to adversely impact emergency core cooling systems (ECCS) during containment recirculation.

The finding was more than minor because it affected the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of ECCS to respond to initiating events (loss-off-coolant accidents (LOCAs)) to prevent undesirable conditions. The finding was associated with the

design control and human performance attributes. The finding was considered to be of very low safety significance, because ECCS remained operable and there was no loss of safety function. Specifically, the finding did not represent an actual loss of ECCS function or of a single train that mitigates internal or external event (e.g., seismic, fire, flooding, or severe weather) core damange accident sequences. (Section 4OA3.1)
Inspection Report# : 2003012*(pdf)*

Significance: G Oct 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROMPTLY IDENTIFY AND TAKE ACTIONS TO ADDRESS A CONDITION ADVERSE TO QUALITY CONCERNING CONTAINMENT SUMP DEBRIS
Green. The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Actions, for RG&E's failure to promptly identify and take actions to address a condition adverse to quality. Specifically, RG&E did not promptly identify and correct containment sump debris that had the potential to adversely impact ECCS during containment recirculation.

The finding was more than minor because it affected the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of ECCS to respond to initiating events (LOCAs) to prevent undesirable conditions. The finding was associated with the procedure quality and human performance attributes. The finding was considered to be of very low safety significance, because ECCS remained operable and there was no loss of safety function. Specifically, the finding did not represent an actual loss of ECCS function or of a single train that mitigates internal or external event (e.g., seismic, fire, floodnig, or severe weather) core damage accident sequences.
Inspection Report# : 2003012*(pdf)*

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: FIN Finding
RG&E did not have procedures to address potential high temperature conditions in the relay room.
The inspectors identified that RG&E did not have compensatory measures in place to prevent the air temperature in the relay room from exceeding the maximum values described in the plant Updated Final Safety Analysis Report (UFSAR). High air temperatures in the relay room would degrade the performance of safety-related components located in that room.
Inspection Report# : 2003006*(pdf)*

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: FIN Finding
The RG&E vendor manual control program did not ensure information regarding maintenance of the lube oil circulation pump for the "A" motor driven AFW pump was supplied to maintenance personnel.
The RG&E vendor manual control program was inadequate in that it did not ensure maintenance personnel were provided with the information needed to properly rebuild the lubricating oil circulation pump for the "A" motor driven auxiliary feedwater pump. As a result, the pump was not properly assembled during maintenance activities.

Inspection Report# : 2003006*(pdf)*

Significance: G Sep 27, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Operators did not shutoff the "B" AFW Pump when the AFW system coss-tie valves are opened resulting in damage to the "B" AFW pump.
A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified due to the operating crew not correctly implementing procedures ES-0.1 "Reactor Trip Response." This resulted in a period of inoperability for the "B" motor driven auxiliary feedwater pump.

A contributing cause of this finding is related to the Human Performance cross-cutting area. Inadequate placekeeping in the procedure by the operating crew resulted in the omission of the step to shutdown the "B" motor driven auxiliary feedwater pump.
Inspection Report# : 2003006*(pdf)*

Barrier Integrity

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Effective Corrective Action to Resolve Seismic Support Issues in The Intermediate Building Sample Hood Area.

Green. The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI when they identified that RG&E did not implement effective corrective actions to ensure that supports for valves in intermediate building sample hood area were properly installed. Degraded supports in the sample hood area had previously been identified by the NRC in November 2001. A subsequent inspection of the area by RG&E personnel identified other seismic-related deficiencies, one of which rendered a containment penetration inoperable.

This finding is associated with the "Design Control" attribute of the barrier integrity cornerstone. It is greater than minor because it affected the objective of maintaining containment integrity during seismic events. The issue is of very low safety significance because it did not represent a degradation of the radiological barrier function provided for the control room, auxiliary building, or the spent fuel or standby gas treatment system. The finding did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere. Additionally, the finding did not represent an actual open pathway in the physical integrity of reactor containment or an actual reduction of the atmospheric pressure control function of the reactor containment. (Section 1R19)
Inspection Report# : 2004002*(pdf)*

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Personnel did not properly sequence work activities and contrary to procedure requirements, allowed work to be performed on the spent fuel pool ventilation system when irradiated fuel was being moved.
While observing maintenance activities on the spent fuel pool system charcoal filtration system, the inspectors identified that contrary to requirements in the applicable maintenance procedure, RG&E personnel were working on the system when spent fuel was being moved in the spent fuel pool. The failure to correctly implement the maintenance procedure was a violation of Technical Specification (TS) 5.4.1.a which states, in part, that procedures shall be established, implemented and maintained.

Inspection Report# : 2003006*(pdf)*

Emergency Preparedness

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Health Physics Technicians Did Not Respond to The Site as Required by The E-Plan During an Event
Green. The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50.47(b)(2) when after the declaration of an Unusual Event (UE) on February 16, 2004, RG&E did not augment the shift crew with a 30-minute Radiation Protection Technician (RPT) responder in a timely manner. The shift crew delayed notification of this responder for 30 minutes. Once the notification was initiated, only one RPT responded to the site, and arrived 62 minutes after the UE declaration was made, instead of the required 30 minutes.

This finding is associated with the "Emergency Response Organization Readiness" attribute of the emergency preparedness (EP) cornerstone. It is greater than minor because it impacts the objective to ensure that RG&E is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The EP Significance Determination Process (SDP) was used to assess this performance. (Section 1R14)
Inspection Report# : 2004002*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : September 08, 2004