Ginna
1Q/2006 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)*

Mitigating Systems

Significance: G Mar 31, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CONTROL OF TRANSIENT COMBUSTIBLE MATERIAL
The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 5.4.1.d, which requires, in part, that written procedures be established, implemented, and maintained for the fire protection program. Contrary to TS 5.4.1.d, during a fire walkdown of the auxiliary building operating floor the inspectors identified four drums of charcoal which were not identified as a transient combustible load and did not have a transient combustible permit in violation of Ginna fire protection procedure FPS-16. Ginna entered this performance deficiency into their corrective action program for resolution

The inspectors determined that the failure to properly implement procedure FPS-16 was more than minor because it affected the objectives of availability and reliability for systems which respond to mitigate events under the protection against external hazards attribute of the Mitigating Systems cornerstone and because the amount of charcoal exceeded the transient combustible limit of the Fire Hazards Analysis for that area of the plant. The inspectors assessed the finding using Appendix F of the Significance Determination Process (SDP) and determined the finding to be of very low safety significance. The finding is of very low safety significance because the charcoal in question has a fairly high ignition point (350°C) and they were stored in approved containers resulting in a Degradation Rating of Low, which screens to Green in the fire protection SDP. A contributing cause of this finding is related to the cross-cutting element of human performance. (Section 1R05)

Inspection Report# : 2006002*(pdf)*

Significance: G Mar 31, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
SIMULATOR INCORRECTLY REPLICATED PLANT DESIGN
The inspectors identified a non-cited violation (NCV) of 10 CFR 55.46 (c)(1) which requires a plant-referenced simulator used for the administration of an operating test or to meet experience requirements must demonstrate the expected plant response to operator input and to normal, transient, and accident conditions to which the simulator has been designed to respond. Contrary to the above, on January 25, 2006, the inspectors identified that Ginna failed to ensure that the simulator correctly replicated the expected plant response to accident conditions as a result of an improperly implemented modification to add PPCS to the simulator in 2001. This error was entered into the Ginna corrective action

program.

The inspectors determined that this simulator fidelity issue was more than minor because it affected the capability objective of the human performance attribute under the Mitigating Systems cornerstone. The finding was evaluated using the Operator Requalification Human Performance SDP (MC 0609 Appendix I). In the SDP, Appendix I, Block 12, the inspectors is required to determine if deviations between the plant control room and the plant reference simulator negatively impact operator actions or result in the potential for negative training. The inspectors determined that negative training was the result of this condition which screens to a finding of very low safety significance. (Section 1R11)
Inspection Report# : 2006002*(pdf)*

Significance: G Mar 31, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
MISSED FIRE BRIGADE DRILLS
The inspectors identified a non-cited violation (NCV) of 10 CFR 50, App. R III.I.3.b which requires that drills shall be performed at regular intervals not to exceed 3 months for each shift fire brigade. Contrary to the requirement, four of five shift fire brigades were not drilled during the fourth quarter of 2005. This finding was entered into Ginna's corrective action program.

The inspectors determined that the failure to meet the fire brigade drill requirement was more than minor because it affected the reliability and capability objectives of the protection against external factors attribute under the Mitigating Systems cornerstone. The finding was evaluated using Fire Protection Significance Determination Process (Manual Chapter 0609, App F). The finding category is Fire Prevention and Administrative Controls with an assigned degradation factor of low which screens to Green in Step 1.3.1. A contributing cause of this finding is related to the cross-cutting element of human performance. (Section 4OA2)
Inspection Report# : 2006002*(pdf)*

Significance: G Dec 31, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain Fire Protection Procedures as Required by Technical Specification 5.4.1
The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 5.4.1, which requires, in part, that fire protection procedures be established, implemented, and maintained. Contrary to TS 5.4.1, during a walkdown of fire protection procedure SC-3.16.1, the inspector noted that the procedure contained incorrect operating instructions for the diesel-driven and motor-driven fire pumps.

The inspectors determined that the procedure errors in SC-3.16.1, were more than minor because they were associated with the procedure quality attribute of the Mitigating System Cornerstone and affected the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. The inspectors assessed the finding using the fire protection Significance Determination Process (SDP) and determined the finding to be of very low safety significance. The finding was of very low safety significance because the procedure errors did not result in a loss of safety function. Specifically, the fire pumps were not rendered inoperable by the procedure errors. As a result, the procedure issues were assigned a degradation rating of low, which screens to Green in the fire protection SDP. The cause of this finding is related to the cross-cutting area of problem identification and resolution.
Inspection Report# : 2005005*(pdf)*

Significance: G Oct 07, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Battery Test Procedure Resulted in Use of Inaccurate Test Instrumentation
The inspectors identified a nont-cited violation of 10 CFR 50, Appendix B, Criterion XI, "Test Control," for failure to assure that the station battery test procedure incorporated acceptance limits and that test results were evaluated to assure that the test requirements had been satisfied. During the period 2000-2005, the licensee performed three Technical Specification surveillances on each safety-related station battery to verify the Operability of the safety-related components. The inspection team found that the results from the battery test procedure were not adequatey assessed. Test results from this period indicated erratic readings on several battery cells; however, the licensee failed to evaluated the impact these readings had on the Operability of the batteries. In response to the team's questions, the licensee entered the issue into their corrective action program (CAP) and was able to show via subsequent test results that the batteries were Operable.
Inspection Report# : 2005006*(pdf)*

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)*

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

Public Radiation Safety

Significance: 

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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