November 18, 2002

Dr. Robert C. Mecredy
Vice President, Nuclear Operations
Rochester Gas and Electric Corporation
89 East Avenue
Rochester, New York 14649

SUBJECT: GINNA - NRC PROBLEM IDENTIFICATION & RESOLUTION INSPECTION REPORT 50-244/02-010

Dear Mr. Mecredy:

On October 25, 2002, the NRC completed a team inspection at the R. E. Ginna Facility. The enclosed inspection report documents the inspection findings, which were discussed with you and members of your staff during an exit meeting conducted on October 25, 2002.

The inspection was an examination of activities conducted under your license as they related to the identification and resolution of problems, and compliance with the Commission's rules and regulations and the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, there were no findings of significance identified during this inspection. The team concluded that problems were properly identified, evaluated, and resolved withing the problem identification and resolution programs. However, during the inspection, several examples of minor problems were identified, including conditions adverse to quality that had not been entered into the corrective action program, narrowly focused Action Report evaluations, and some ineffective corrective actions.

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Sincerely,

/RA/

David C. Lew, Chief
Performance Evaluation Branch
Division of Reactor Safety

Docket No. 50-244
License No. DPR-18
Enclosure: Inspection Report 50-244/02-010

cc w/encl:

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REGION I

Docket No:	50-244
License No:	DPR-18
Report No:	02-010
Licensee:	Rochester Gas and Electric Corporation (RG&E)
Facility:	R. E. Ginna Nuclear Power Plant
Location:	1503 Lake Road Ontario, New York 14519
Dates:	October 7 - 25, 2002
Inspectors:	Stephen M. Pindale, Senior Reactor Inspector Barry S. Norris, Senior Reactor Inspector William E. Holland, Contractor
Approved by:	David C. Lew, Chief Performance Evaluation Branch Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000244/02-010; on October 7 - 25, 2002; R. E. Ginna Nuclear Power Plant; biennial baseline inspection of the identification and resolution of problems.

The inspection was conducted by two regional inspectors and one contractor. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

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.

No findings of significance were identified.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope

The inspection team reviewed the procedures describing the corrective action process at the R. E. Ginna Nuclear Power Plant. The team reviewed a sample of action reports (AR) and deficiency tags to determine the threshold for identification of problems. The team reviewed logs, control room deficiencies and operator work-arounds, system health reports, work orders, temporary modifications, operating experience reviews, and procedures related to specific issues. In addition, the team interviewed staff and management to determine their understanding of the corrective action program. The specific documents reviewed and referenced during the inspection are listed in the attachment to this inspection report.

The team reviewed a sample of quality assurance (QA) audits and surveillances, and departmental self-assessments in the areas of operations, maintenance, engineering, radiation protection, security, emergency preparedness, training, and the corrective action program itself. The review was to determine if assessment findings were entered into the corrective action program, and if the corrective actions were properly completed to resolve identified deficiencies. The team evaluated the effectiveness of the audits and self-assessments by comparing the associated results against self-revealing and NRC-identified findings.

The team conducted several plant walk-downs of safety-related, risk significant areas to verify that observable system equipment and plant material adverse conditions were identified and entered into the corrective action program. The team also attended routine work control and management meetings to understand the interface between the corrective action program and the work control process.

(2) Findings

Overall, the licensee's effectiveness at problem identification was acceptable. The QA audits were self-critical and generally consistent with the team's findings. However, the team identified several minor deficiencies which were not identified or entered into the licensee's corrective action system. Some examples for which the licensee subsequently initiated ARs are as follows.

- The team found an auxiliary operator's key ring lying on a structural support near a valve in the 'B' diesel generator room. One of the keys on this ring operated locked valves and breakers throughout the plant. The key ring did not contain security or high radiation area keys, however, this set of keys was not identified as missing for about the one week they were subsequently determined to have been missing. The licensee initiated AR 2002-2272 in response to this discovery, and confirmed the proper alignment of components, as appropriate.

- The team identified that the bend radius for one of the cables associated with the 'B' safety-related battery was smaller than the acceptance limit. This particular cable was notably shorter in length than other battery cables. The operability of the battery was not impacted, however, the configuration did not conform to the design and installation criterion (AR 2002-2283 written).

The team also identified several other minor problems, such as implementation problems associated with the classification and storage of Precursor reports (for events of very low significance that require no investigative or corrective action); a small amount of boric acid on a safety injection system instrument fitting; and the presence of a screen covering the open end of the standby auxiliary feedwater test tank vent, contrary to the associated drawing. Regarding the details associated with the uncontrolled key ring described above, the team identified some broader concerns relative to key control and accountability. Inventory control for this type of key set, as well as other keys controlled by operations, was weak. There were prior individual key control deficiencies that had been identified via ARs (2001-1325 and 2001-1325), but the lack of an effective key control program was not recognized or addressed. As indicated by the noted examples, the team concluded that the licensee exhibited some weaknesses with regard to problem identification.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The team reviewed the ARs and work orders listed in the attachment to this report to assess whether the licensee adequately prioritized and evaluated the identified problems. This review included the causal assessment of each issue (e.g., a root cause analysis or an apparent cause evaluation); and for significant conditions adverse to quality, the extent of condition and determination of corrective actions to preclude recurrence. The team also evaluated the ARs for potential impact on equipment or system operability, reliability or unavailability.

The team reviewed the backlog of operations, maintenance and engineering issues to determine if issues were properly prioritized, and if individually or collectively, they represented an increased risk due to the delay of corrective actions. The team also reviewed the status and plans to correct equipment problems identified in system health reports and the Maintenance Rule documents. The team attended the daily screening and management meetings to evaluate the licensee's ability to assess AR significance and identify if the initial determination of operability and reportability were correct.

The team observed portions of the onsite Plant Operations Review Committee (PORC) and the offsite Nuclear Safety Audit Review Board (NSARB), and reviewed the minutes of past meetings, to determine if the associated reviews were critical of the site's activities.

(2) Findings

The team concluded that, in general, the licensee adequately prioritized and evaluated the issues and concerns entered into the AR process. Operability and reportability determinations were accurately performed in a timely fashion. Overall, the root cause analyses reviewed were thorough, determined the root cause and contributing causes, and recommended corrective actions that correlated to the identified causes. As required, corrective actions were generally identified and implemented to preclude recurrence for significant conditions adverse to quality. The overall backlog of issues appeared reasonable and properly evaluated for risk.

Notwithstanding the overall acceptable performance in this area, the team identified some minor instances where the Ginna staff had not properly prioritized or evaluated conditions adverse to quality. These examples are described as follows.

- AR 2002-0613 discussed a plant configuration where three of the five possible make-up paths were isolated from the reactor coolant system (RCS) while in a reduced inventory condition. This issue was previously characterized as a non-cited violation for the failure to follow procedures. During this inspection, the team noted the following with respect to the AR: 1) the event was not considered to be a Significant Condition Adverse to Quality; 2) the AR was prioritized improperly low as a Priority 3 with an evaluation due date in June 2002; 3) the AR was improperly determined to be "non-consequential" from a human impact consideration; and (4) an Extension Request was submitted and approved to extend the investigation completion date to November 2002, which would be about eight months after the event. The extension basis focused on clarifying the valve line-up procedures; and the safety significance was noted as "None" as the licensee considered this to be only a refueling outage concern.

  The team determined the licensee's actions taken to date and planned addressed the specific valve issue and not the human performance nature of why the Work Control Supervisor allowed the tags to be hung. Also, the team judged that the licensee's event classification, prioritization, and human impact consideration minimized the potential safety impact. A more appropriate characterization likely would have necessitated a more rigorous and timely root cause analysis. Further, while the AR noted that an apparent cause was to be performed for a human performance event, the evaluation had not been completed as of the time of this inspection. Because the human performance causal analysis was not yet completed in a timely manner, the potential exists that relevant information may not be captured or recalled. Finally, the team considered the original issue to be a Significant Condition Adverse to Quality because it resulted in a reduced number of available make-up sources designed to mitigate the consequences of a draindown event while already in a reduced RCS inventory configuration. Although a similar or repeat occurrence had not resulted due to the ineffective processing and evaluation (including corrective actions) of this AR, the team concluded that the licensee's overall response to this condition did not display a conservative safety focus. The licensee initiated AR 2002-2427 to address these concerns.

- In some cases, the priority level was not in alignment with event significance and procedure guidance. For example, AR 2002-2097 involved an equipment problem that resulted in a reactivity excursion (99.5% to slightly greater than 100%) due to an

unexpected dilution, but was assigned Priority 4 (trending). Consistent with the guidance provided in procedure IP-NPD-4, "Nuclear Operations Group Work Prioritization," it should have been Priority 2 ("unexpected reactivity excursion such as a significant dilution"). The team concluded that although the priority was incorrect, the licensee adequately evaluated and corrected the associated condition. The licensee initiated AR 2002-2461 to address the incorrect priority assignment.

- The team concluded that AR evaluations involving human performance appeared less detailed and probing than those evaluations involving equipment performance. As an example, AR 2002-1809 (diesel generator breaker closed out of phase during testing) emphasized process and procedure weaknesses and enhancements over the potential human performance problems (e.g., self-check techniques, supervisory oversight).

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The team reviewed the corrective actions associated with selected ARs to determine whether the actions had addressed the identified causes of the problems. The team also reviewed the licensee's timeliness for implementing the corrective actions, and their effectiveness in precluding recurrence for significant conditions adverse to quality. The team also reviewed the non-cited violations issued since the last inspection of the Ginna corrective action program to determine if issues placed in their program had been properly evaluated and corrected.

(2) Findings

Overall, the inspectors determined that corrective actions associated with ARs were effective; and as applicable, corrective actions were adequate to prevent problem recurrence (for significant conditions adverse to quality). The team found that, in general, the corrective actions were completed or scheduled to be completed in a timely manner commensurate with the significance of the issue. The team did not identify corrective actions in the backlog of work that represented an adverse impact on safety.

Notwithstanding, the team identified some minor instances where the licensee's corrective actions were weak, and examples are described below.

- In a period of less than two years, there were four occurrences where service air header pressure was decreased due to the use of an air-operated vacuum cleaner. This was an undesirable condition that could potentially challenge the instrument air system, which is normally cross-connected to service air and provides motive force for several safety and risk significant systems (e.g., main steam isolation valves and feedwater regulating valves). Some of the licensee's corrective actions included various administrative controls to ensure that personnel split the service and instrument air headers (prior to using the vacuum). However, these actions were repeatedly ineffective until the licensee implemented a corrective action to lock the vacuum cleaner, with the key in the control of the Shift Supervisor. The team determined that the use of the vacuum

cleaner had not caused a plant transient, and neither the service air nor the instrument air system is safety related. Thus the failure to implement effective corrective actions was not a violation of NRC regulations. However, the lack of effective actions for these occurrences was noteworthy because the condition could have contributed to or caused a plant transient. The licensee initiated AR 2002-2428 in response to these concerns.

- Several ARs have been initiated following NRC's identification of deficiencies associated with tracking equipment unavailability time for the NRC performance indicators (PI). The errors were minor in nature and magnitude, and none of the errors would have changed the affected PI color (threshold). However, the team determined that the licensee's actions to date have not been effective in preventing continued errors (AR 2002-2463 written).

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

During the inspection, the team interviewed plant staff to determine if conditions existed at the site which would result in personnel being hesitant to raise safety concerns to Ginna management and/or the NRC.

(2) Findings

No findings of significance were identified.

4OA6 Meetings

a. Exit Meeting Summary

On October 25, 2002, the team presented the inspection results to Dr. R. Mecredy and members of his staff. During the inspection, no proprietary material was examined or retained by the team.

Attachment: Partial List of Persons Contacted
Items Opened & Closed
List of Documents Reviewed
List of Acronyms

ATTACHMENT

A. PARTIAL LIST OF PERSONS CONTACTED

RG&E:

P. Bamford	Manager, Operations
M. Flaherty	Manager, Nuclear Safety & Licensing
R. Forgensi	Manager, Operational Review
J. Germain	Operational Review Analysis
T. Harding	Licensing Engineer
J. Hotchkiss	Manager, Mechanical Maintenance
T. Laursen	Manager, Emergency Preparedness & Training Support
M. Lilley	Manager, Quality Assurance
R. Marchionda	Department Manager, Nuclear Assessment
K. McCarthy	Operational Review Engineer
R. McMahon	Operating Experience Engineer
R. Mecredy	Vice President, Nuclear Operations
T. Miller	System Engineer
N. Olivia	Senior Electrical Engineer
P. Polfleit	Corporate Nuclear Emergency Planner
M. Ruby	Licensing Engineer
M. Smith	System Engineer
L. Stavalone	Trending Analyst
R. Teed	Manager - Nuclear Security
R. Watts	Department Manager, Nuclear Training
J. Wayland	Manager, I&C/Electrical Maintenance
T. White	Manager, Balance of Plant Systems
J. Zapetis	Maintenance Rule Coordinator

NRC:

K. Kolaczyk	Senior Resident Inspector, Ginna
D. Lew	Branch Chief, Performance Evaluation Branch, Region I
C. Welch	Resident Inspector, Ginna

B. ITEMS OPENED & CLOSED

None

C. LIST OF DOCUMENTS REVIEWED

Procedures:

A-205	Plant Operations Review Committee Operating Procedure, Rev. 53
AP-RCP.1	Reactor Coolant Pump Seal Malfunction, Rev. 14
AR-AA-3	Alarm Response Procedure - Standby AFW Tank, Rev. 6
AR-B-17	Alarm Response Procedure - Seal Flow, Rev. 12
EP-2-P-0168	Maintenance Rule Monitoring, Rev. 5
FR-C.2	Response to Degraded Core Cooling, Rev. 16
FR-H.1	Response to Loss of Secondary Heat Sink, Rev. 27
FR-I.3	Response to Voids in Reactor Vessel, Rev. 16
GC-76.10	Installation, Testing and Inspection of Wire and Cable, Rev. 5
IP-CAP-1	Abnormal Condition Tracking Initiation or Notification (Action) Report, Rev. 14
IP-DES-1	Technical Staff Request, Rev. 3
IP-IIT-5	Snubber Inspection and Testing Program, Rev. 1
IP-NPD-4	Nuclear Operations Group Work Prioritization, Rev. 6
IP-NPD-6	Nuclear Safety Audit and Review Board (NSARB), Rev. 4
IP-RDM-3	Ginna Records, Rev. 5
IP-SEP-2	Self Assessment, Rev. 4
IP-SEP-3	Ginna Station Management Observation, Coaching and Tours Program, Rev. 2
S-16.13	RWST Water Makeup to Accumulators, Rev. 30
T-44.1	Condensate Test Tank for Standby AFW Pumps Filling or Draining, Rev. 17
A-1603.0	Overview of the Ginna Station Work Control System, Revision 19
A-1603.1	Work Request / Trouble Report Initiation, Revision 14
A-1603.2	Work Order Initiation, Revision 15
A-1603.6	Post Maintenance / Modification Testing, Revision 8
A-1603.8	Work Order Processing for Emergency and/or After Hours Maintenance, Revision 7
A-52.12	Inoperability of Equipment Important to a Safety, Revision 41
A-52.4	Control of Limiting Conditions for Operating Equipment, Revision 119
G-ORS-01	Screening Committee Guideline, Revision 50
IP-CAP-1.1	Operability and Past Operability Determination Checklist, Revision 2
IP-CAP-1.4	AR Extension Request, Revision 1
IP-CAP-1.8	Effectiveness Review Form, Revision 0
IP-CAP-2	Root Cause Analysis for Equipment Failures, Revision 4
IP-CAP-4	Problem Solving, Revision 1
IP-CAP-5	Event Trending Process, Revision 1
IP-CAP-6	10CFR021 Screening, Evaluating, and Reporting, Revision 2
IP-HPE-1	Human Performance Event Evaluation Process, Revision 3
IP-NPD-4	Nuclear Operations Group Work Prioritization, Revision 6
IP-PSH-1	Integrated Work Schedule, Revision 6
IP-PSH-2	Integrated Work Schedule Risk Management, Revision 6
OP-2.3.1	Draining & Operation at Reduced Inventory of the Reactor Coolant System, Revision 71
SPG-02	Integrated Work Schedule Scheduler’s Handbook, Revision 11

Non-Cited Violations:

NCV 2001-06-01	Failure to Perform Flow Rate Determinations as per ODCM
NCV 2001-08-01	Failure to Include Acceptance Criteria in Procedures
NCV 2001-08-02	Failure to Implement MSIV Surveillance Requirement
NCV 2001-09-01	Inappropriate Procedures During Service Water Pump Motor Replacement
NCV 2001-10-01	Failure to Identify Seismic Issue with Containment Isolation Valve
NCV 2002-02-01	RCS Make-up Flow Paths Were Inappropriately Isolated
NCV 2002-02-02	Improper Source Range Detector Calibration
NCV 2002-03-01	Failure to Control/Evaluate Compensatory Fire Protection Measure
NCV 2002-03-02	Unlocked Technical Specification High Radiation Area
NCV 2002-09-01	Failure to Utilize Mobile Loudspeakers for Transient Population
NCV 2001-09-02	Failure to Correct Equipment & Human Performance Problems

Quality Assurance Audits:

2000-0014-BKS	Corrective Action & Operating Experience Programs
2001-0004-DHK	Emergency Response Plan
2001-0009-JMT	Engineering and Configuration Control Audit
2001-0010-RTD	Problem Identification and Resolution Process Audit
2001-0013-TGT	Operations Audit
2001-0017-PJH	Audit of Ginna Station Technical Specifications
2002-0001-JMT	ODCM and REMP Audit
2002-0002-TGT	Maintenance Audit
2002-0003-BKS	Cooperative Management Assessment Program
2002-0004-RTD	Emergency Preparedness Audit
2002-0006-DHK	Radiation Protection Audit

Self-Assessments:

2001-0025	Corrective Action Process Effectiveness
2002-0023	Effectiveness of Corrective Actions for Areas for Improvement Identified During January 2001 Self-Evaluation
2002-0031	Effectiveness Review of Contamination Control During Reactor Cavity Decontamination
2002-0041	Quality Control Program Preparedness
2002-0042	Self-Assessment of NCV Related to Reduced Inventory
2002-0043	Self-Assessment of NCV Related to the Alert Notification System

Action Reports: (* Denotes CR generated as a result of this inspection; P denotes a Precursor Report)

1997-1447	2001-1702	2002-0150P	2002-0878	2002-1997
2000-0188	2001-1749	2002-0161	2002-0904	2002-2035
2000-1176	2001-1757	2002-0163	2002-0931	2002-2035
2000-1268	2001-1764	2002-0193	2002-0948	2002-2060
2000-1301	2001-1767	2002-0193	2002-0976	2002-2097
2000-1489	2001-1774	2002-0195	2002-1014	2002-2116
2000-1630	2001-1802	2002-0195	2002-1022	2002-2260
2001-0001P	2001-1840	2002-0237P	2002-1028	2002-2261
2001-0013P	2001-1867	2002-0244P	2002-1028	2002-2271*
2001-0131P	2001-1879	2002-0266	2002-1146	2002-2272*
2001-0141P	2001-1888	2002-0371	2002-1146	2002-2273*
2001-0326P	2001-1921	2002-0371	2002-1149	2002-2277
2001-0393P	2001-1921	2002-0417	2002-1151	2002-2283*
2001-0457P	2001-1943	2002-0421	2002-1151	2002-2286*
2001-0517P	2001-1969	2002-0479	2002-1170	2002-2287*
2001-0676	2001-2091	2002-0492	2002-1202	2002-2288*
2001-0740P	2001-2131	2002-0530	2002-1362	2002-2289*
2001-0783	2001-2140	2002-0530	2002-1508	2002-2290*
2001-0862	2001-2227	2002-0530	2002-1564	2002-2300*
2001-0923	2001-2245	2002-0538	2002-1593	2002-2303*
2001-1070P	2001-2245	2002-0541	2002-1596	2002-2304*
2001-1148	2001-4355	2002-0595P	2002-1634	2002-2308*
2001-1325	2002-0038	2002-0661	2002-1663	2002-2309*
2001-1341	2002-0070	2002-0670P	2002-1753	2002-2311*
2001-1365	2002-0101	2002-0730P	2002-1759	2002-2405
2001-1395	2002-0109	2002-0756	2002-1770	2002-2405*
2001-1465	2002-0126	2002-0766	2002-1809	2002-2411*
2001-1632	2002-0127	2002-0821	2002-1849	
2001-1691	2002-0142	2002-0822	2002-1941	

Work Orders:

WO-20103571	Repair Lug Crimps on the “B” Service Water Pump
WO-20103583	Repair Lug Crimps on the “A, C, & D” Service Water Pumps
WO-20200848	Trouble shoot and repair AOV-371, Indicates Mid-Position but 25% Open (related to AR 2002-0756)
WO-20201827	Repair “A” Containment Sump Pump Level Switch (LS-2039)
WO-20202034	Operations Suspects That V-214 Leaks By
WO-20202266	Install PCR 2002-0027, Replace Emergency Siren System
WO-20202387	Reach Rod to V-214 Needs to Be Replaced

Miscellaneous Documents:

PORC Meeting Minutes for meetings 2001-0041; 2001-0042; 2001-0049; 2002-0004; 2002-0007; 2002-0014; 2002-0021; 2002-0024; 2002-0028; 2002-0035; 2002-0040; 2002-0042; 2002-0045; 2002-0048

Nuclear Safety Audit Review Board (NSRB) Minutes for meetings 243, 244, and 245

Modification PCR-2002-0012, Relocate the Siren Central Control Unit to Ginna
Modification PCR-2002-0027, Replace Emergency Siren System

Temporary Modification 2000-0007, "A" S/G Blow-down Corrosion Product Sampler, Rev. 1
Temporary Modification 2001-0012, Temporary SI Accumulator Makeup Pump, Rev. 1

Updated Final Safety Analysis Report

5059SCRN-2002-0524, Replace Emergency Siren System (related to WO-20202266)

Maintenance Department Monthly Performance Indicator Report (i.e. - backlog), September 2002

Nuclear Emergency Response Plan, Revision 20

ProActive Assessment of Workplace Factors (PAOWF), August 2002

D. ACRONYMS

ADAMS	Agencywide Documents Access and Management System
AFW	Auxiliary Feedwater
AOV	Air Operated Valve
AR	Action Report
CFR	Code of Federal Regulations
EDG	Emergency Diesel Generator
I&C	Instruments & Controls
MSIV	Main Steam Isolation Valve
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
NSARB	Nuclear Safety Audit Review Board
ODCM	Offsite Dose Calculation Manual
PAOWF	ProActive Assessment of Workplace Factors
PARS	Publicly Available Records System
PCR	Plant Change Request
PI	Performance Indicator
PORC	Plant Operations Review Committee
QA	Quality Assurance
RCS	Reactor Coolant System
REMP	Radiological Environmental Monitoring Program
RG&E	Rochester Gas and Electric Corporation
RWST	Reactor Water Storage Tank
SDP	Significance Determination Process
TM	Temporary Modification
TS	Technical Specification
WO	Work Order