December 13, 2004

Mrs. Mary G. Korsnick
Vice President R. E. Ginna Nuclear Power Plant
R. E. Ginna Nuclear Power Plant, LLC
1503 Lake Road
Ontario, NY 14519

SUBJECT: R. E. GINNA NUCLEAR POWER PLANT - NRC PROBLEM IDENTIFICATION & RESOLUTION INSPECTION REPORT 05000244/2004007

Dear Mrs. Korsnick:

On November 5, 2004, the NRC completed an inspection at the R. E. Ginna Nuclear Power Plant. The enclosed report documents the inspection findings which were discussed on November 5, 2004, with Mr. Joe Widay and members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, 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 samples selected for review, no findings of significance were identified during this inspection. The team concluded that problems were properly identified, evaluated, and resolved within the problem identification and resolution program. However, the backlog for Priority 1 and 2 Action Reports (ARs) was somewhat high. In some instances, corrective actions were not being completed in a timely manner. The immediate and/or most important corrective actions taken were effective and complete. Ginna management was aware of this issue and was taking actions to address it.

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Sincerely,

/RA/

Christopher G. Cahill, Chief (Acting)
Performance Evaluation Branch
Division of Reactor Safety

Docket No. 50-244
License No. DPR-18

Enclosure: Inspection Report No. 05000244/2004007
w/Attachment: Supplemental Information

cc w/encl:
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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No:	50-244
License No:	DPR-18
Report No:	05000244/2004007
Licensee:	Constellation Energy, R.E. Ginna Nuclear Power Plant, LLC
Facility:	R. E. Ginna Nuclear Power Plant
Location:	1503 Lake Road Ontario, New York 14519
Dates:	October 18, 2004 - November 5, 2004
Inspectors:	Neil Perry, Senior Project Engineer (Team Leader) Suresh Chaudary, Reactor Inspector Mark Marshfield, Resident Inspector (Ginna) Jorge Hernandez, Reactor Engineer Tekia Govan (Observer)
Approved by:	Christopher G. Cahill, Chief (Acting) Performance Evaluation Branch Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

IR 05000244/2004-007; 10/18/04 - 10/22/04 and 11/1/04 - 11/5/04; R. E. Ginna Nuclear Power Plant; biennial baseline inspection of the identification and resolution of problems.

This inspection was conducted by three regional inspectors and one resident inspector. 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 NRC team determined that Constellation was effective at identifying discrepant conditions at an appropriate threshold and entering them into the corrective action program. Once entered into the system, issues were typically prioritized appropriately and in a timely fashion; and were properly evaluated commensurate with the safety significance. Overall, the evaluations reasonably identified the causes of the problem, the extent of the condition, and provided for corrective actions to address the causes. However, the backlog for Priority 1 and 2 Action Reports (ARs) was somewhat high. In some instances, corrective actions were not being completed in a timely manner. The immediate and/or most important corrective actions taken were effective and complete. Ginna management was aware of this issue and was taking actions to address it. On the basis of interviews conducted, the team determined that plant staff personnel were familiar with and utilized the corrective action program to identify problems.

A. NRC-Identified and Self-Revealing Findings

No findings of significance were identified.

B. Licensee-Identified Violations

None.

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 program (CAP) at the R. E. Ginna Nuclear Power Plant. The team reviewed items selected from various Constellation processes and activities to determine whether personnel were properly identifying, characterizing and entering problems in the CAP for evaluation and resolution. Constellation's formal CAP utilizes action reports (ARs) to identify and document problems at Ginna. The team reviewed a sample of ARs to cover the cornerstones of safety identified in the NRC Reactor Oversight Process (ROP). In addition, the team considered risk insights from the individual plant examination report and the probabilistic risk assessment to focus the sample selection and system walkdowns on risk significant components. The ARs are classified by priority level (1, 2, 3, 4) with level 1 requiring the most rigorous review due to higher safety and/or risk significance.

The team reviewed control room deficiencies, operator work-arounds, temporary modifications, operating experience reviews, and procedures. The team selected items from Constellation's maintenance, operations, engineering, emergency planning, radiological controls and oversight processes for entry into the CAP. In addition, the team interviewed plant staff and management to determine their understanding of, and involvement with, the CAP, and to determine whether personnel were familiar with and utilized the CAP to identify problems. The specific documents reviewed and referenced during the inspection are listed in the attachment to this report.

The team reviewed a sample of quality assurance audits and surveillances, and departmental self-assessments. The review was to determine whether the problems identified by these assessments were entered into the CAP, and whether the corrective actions were properly completed to resolve the self-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 also conducted plant walkdowns of safety-related equipment areas and risk significant areas, including: the control room, the auxiliary feedwater pump room, the emergency diesel generator rooms, the safety injection pump/containment spray pump room, the screenhouse, the standby auxiliary feedwater pump room, the vital battery rooms, and the residual heat removal pump room. These walkdowns were to determine if observable system equipment and plant material adverse conditions were identified and entered into the CAP. Team members attended daily review and management meetings where ARs were reviewed for screening, priority, and assignment. The team

attended these meetings to understand the threshold for identifying problems and to assess management involvement with the CAP. The team also assessed the interface between the CAP and the work control process.

The team reviewed the industry Operational Experience (OE) Program through plant procedures, self assessments, and interviews with key personnel in the Nuclear Operations Group (NOG). Several NRC generic communications were selected to determine if the licensee had screened these items and documented them with an AR. In addition, general review of the AR documentation was performed for selected ARs.

(2) Observations and Findings

No findings of significance were identified.

The team identified only minor deficiencies where ARs had not been previously initiated; and for those identified by the team, Constellation promptly initiated ARs to address the deficiencies. Accordingly, the team concluded that plant staff identified deficiencies at an appropriate threshold, and entered them in the CAP. The team also found that self-assessments and audits were sufficiently self-critical and provided relevant performance observations and insights.

The team reviewed IP-SEP-4, Revision 2, "Operating Experience Program," Self Assessment 2003-0018, "Effectiveness Review of the Operational Experience Program," and conducted several interviews with key personnel within the NOG. The team noted that the staff actively identified and screened industry events reports in accordance with the program procedures. The team concluded that, overall, the licensee's implementation of the OE Program was adequate.

The team also reviewed Ginna's Boric Acid Corrosion Monitoring Program and concluded that it appeared to be implemented effectively. There was a notable sensitivity and low threshold for identification of boric acid leaks in both safety and nonsafety-related equipment.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The team reviewed the ARs listed in the attachment to this report to assess whether Constellation adequately prioritized and evaluated problems. These reviews evaluated, when required, the causal assessment of each issue (i.e., root cause analysis, apparent cause evaluation); and for significant conditions adverse to quality, the extent of condition and determination of corrective actions to preclude recurrence. The team selected the ARs to cover the cornerstones of safety identified in the NRC ROP. The team also considered risk insights from the Ginna probabilistic risk assessment to help focus the inspection sample. Throughout the inspection, the team attended periodic meetings to observe the AR review process and to understand the bases for assigned category and root cause level.

The team selected a sample of ARs associated with previous NRC non-cited violations (NCVs) and findings to determine whether Constellation evaluated and resolved problems associated with compliance with applicable regulatory requirements and standards. The team reviewed Constellation's evaluation of industry operating experience for applicability to Ginna. The team also reviewed Constellation's assessment of equipment operability and reportability requirements associated with ARs.

(2) Observations and Findings

No findings of significance were identified.

Overall, the team found that ARs were appropriately prioritized and evaluated. The quality and completeness of root cause evaluations and apparent cause analyses were generally good. In addition, the team observed that the AR Management Review Committee was effective in reviewing and prioritizing ARs

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 cause(s) of the problems. The team also reviewed Constellation's timeliness for implementing the corrective actions, and their effectiveness in precluding recurrence for significant conditions adverse to quality. Additionally, the team assessed the backlog of outstanding corrective actions to determine if they, individually or collectively, represented an increased risk to the plant. The team also reviewed the NCVs and findings issued since the last inspection of the Ginna CAP to determine if issues placed in the CAP had been properly evaluated and corrected.

(2) Observations and Findings

No findings of significance were identified.

The team determined that generally, corrective actions associated with ARs were timely, appropriate and effective. However, the backlog for Priority 1 and 2 ARs was somewhat high; at the time of the inspection there were 22 Priority 1, and 81 Priority 2 ARs. The team determined that, for the most part, the immediate and/or most important corrective actions taken were effective and complete. In some instances, corrective actions were not being completed in a timely manner, resulting in a number of the ARs being held open for more than one year. The licensee was aware of this issue and was taking actions to address it. Two specific examples were identified where old ARs were still open due to corrective actions not being complete. Details for each of these examples are provided below.

- A Priority 2 AR, regarding three senior reactor operator licenses which inadvertently expired, has been open for approximately two years. Immediate corrective actions taken were complete; however, two procedure changes were not complete. One of the procedures was finalized during the inspection, and the other was in draft form.

- A Priority 2 AR, regarding a valve found closed in the auxiliary feedwater system, has been open for approximately one year. The procedures, which are outage related, had not been changed yet, though a procedure change notice for one of the procedures was completed in July 2004.

The team reviewed the details associated with each of the two items above, and determined that in each case Constellation was pursuing an appropriate corrective action plan.

The team identified that the process for identifying common cause deficiencies was not well defined in plant documents. Numerous groups have responsibility for evaluating whether a new AR is a repeat deficiency or possibly a common cause failure. However, lack of defined overall responsibility and methodologies could allow some issues to be missed. In one instance, the Equipment Out of Service (EOOS) monitor system had suffered numerous ARs which was indicative of an inability of the scheduling and operations personnel to operate the system and obtain similar results. An AR was initiated by Ginna personnel when this issue was pointed out, in order for it to be evaluated for repetitive problems. Common cause evaluations were not defined in the Ginna CAP which would provide another alternative to evaluating maintenance and operation challenges at the site.

d. Assessment of Safety-Conscious Work Environment (SCWE)

(1) Inspection Scope

The team conducted interviews with various plant personnel to develop a general perspective of the safety-conscious work environment at the site. The interviews were also to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. Additionally, the team reviewed use of Ginna's Employee Concerns Program (ECP) to determine if employees were knowledgeable of the program and used it to resolve concerns.

(2) Observations and Findings

No findings of significance were identified.

The team concluded that Ginna management's efforts to maintain a healthy SCWE appeared to be effective. Individuals were aware of the importance of nuclear safety, demonstrated a willingness to raise safety issues to management without fear to retaliation, and had an adequate knowledge of the CAP.

The ECP has not been used at Ginna in the past two years for nuclear safety issues. However, based on interviews with employees at all levels, the team concluded that issues were generally being resolved at an informal level, thereby obviating the need for use of the ECP. Plant personnel appeared motivated and had positive attitudes, but were cautiously optimistic regarding upcoming changes due to Constellation fleet initiatives. Communications at the plant, between all working levels, appeared very good.

4OA6 Meetings, including Exit

The team presented the inspection results to Joe Widay and other members of Constellation management and staff on November 5, 2004. Constellation acknowledged that no proprietary information was involved.

ATTACHMENT

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

S. Adams, Manager, Gina Production
A. Allen, Director, Nuclear Assessment
P. Bamford, Operations Director
R. Forgensi, Director Operations Review
R. Fraile, Director, Quality Assurance
T. Harding, Licensing Engineer
R. Marchionda, Director, Fleet Corrective Action Program
T. Marlow, Plant General Manager
L. Stavalone, Trending Analyst
J. Widay, Vice President (Acting) R. E. Ginna Nuclear Power Plant
G. Wrobel, Director, Nuclear Safety and Licensing

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

NONE

LIST OF DOCUMENTS REVIEWED

Procedures

AR-PPCS-WS150Q, Rev. 0, Alarm Response Procedure
AR-PPCS-WS250Q, Rev. 0, Alarm Response Procedure
ER-SC.1, Rev. 15, Adverse Weather Plan
ER-SC.6, Rev. 5, Near of On-Site Toxic or Flammable Gas Release
IDP-DES-3, Rev. 11 Temporary Modifications
IP-CAP-1, Rev. 18 Abnormal Condition Tracking Initiation Or Notification (ACTION) Report
IP-CAP-101, Rev. 3: Technical Evaluation for Current Operability and Past Operability Determination Checksheet
IP-IIT-7, Rev. 2 Boric Acid Corrosion Monitoring Program
IP-IRG-1, Rev. 9 NRC Correspondence
IP-NPD-4, Rev. 11 Nuclear Operations Group Work Prioritization
IP-SEP-4, Rev. 2 Operating Experience Program
M-7.9, Rev. 8, Spent Fuel and Decon Pit Exhaust System Plenum Installation/Removal of Media Filters/Blanking Plates/Frames
ND-CAP, Rev. 7 Corrective Action Program
OPS-SHIFT-RESP:1, Authority and Responsibilities of Shift Crew
OTG-9.2, Rev. 0, Operator License Application Guide
SC-3.15.15, Rev. 80, Emergency Fire Equipment Locker Inventory and Inspection
SC-3.16.13, Rev. 10, Operating Instruction- Smoke Ventilation/Cooling

Action Reports (all are prefixed with AR)

2001-0783	2002-0073	2002-0162
2002-0491	2002-2316	2002-2318
2002-2372	2002-2485	2002-2547
2002-2570	2002-2571	2002-2572
2002-2725	2002-2794	2002-2795
2003-0025	2003-0084	2003-0161
2003-0162	2003-0804	2003-1120
2003-1699	2003-1745	2003-1821
2003-1936	2003-2006	2003-2108
2003-2170	2003-2196	2003-2213
2003-2286	2003-2372	2003-2603
2003-2667	2003-2681	2003-2703
2003-2714	2003-2743	2003-3293
2004-0242	2004-0420	2004-0508
2004-0509	2004-0520	2004-0587
2004-1017	2004-1097	2004-1488
2004-1599	2004-2215	2004-2298
2004-2365	2004-2437	2004-2438
2004-2442	2004-2479	2004-2690
2004-2741	2004-2794*	2004-2832
2004-2954*	2004-2959*	2004-2960*

(Note " * " = AR was generated as a result of NRC inspection)

Operating Experience ARs

2003-0077
2003-0078
2003-0079
2003-0080

Procedure Change Notices (all are prefixed with PCN)

2003-0020
2003-2625
2004-2413

Audits and Self-Assessments

AINT-2003-0001-BKS, Continuous Audit Report for 3rd Trimester
AINT-2004-0005-AZP, Audit of Corrective Action Program
Corrective Action Program Performance Indicator Criteria, 05/01/04 - 08/31/04
SA# 2002-0021, Self-Assessment of NOG Trending Processes
SA# 2002-0037, Effectiveness of the Ginna Station Program for Prevention of Boric Acid Corrosion

SA# 2003-0019, Self-Assessment Process
SA# 2003-0045, Loss of Grid/Reactor Trip Engineering Self Assessment for the Event of August 14, 2003
SA# 2004-0009, Mid-Cycle Evaluation

Work Order

2030-0069 and REPTASK P-002211

LIST OF ACRONYMS

ADAMS	Agencywide Documents Access & Management System
AR	Action Report
CAP	Corrective Action Program
CFR	Code of Federal Regulations
EOOS	Equipment Out of Service
NCV	Non-Cited Violation
NOG	Nuclear Operations Group
NRC	Nuclear Regulatory Commission
OE	Operational Experience
PARS	Publically Available Records
PCN	Procedure Change Notice
QA	Quality Assurance
RHR	Residual Heat Removal
ROP	Reactor Oversight Process
SCWE	Safety-Conscious Work Environment