September 22, 2000

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

SUBJECT: R. E. GINNA NUCLEAR POWER STATION - NRC INSPECTION REPORT NO. 05000244/2000-004

Dear Dr. Mecredy:

On August 11, 2000, the NRC completed a team inspection at the R. E. Ginna Nuclear Power Station. The enclosed report presents the results of that inspection. The preliminary results were discussed with you, Messrs. P. Wilkens and J. A Widay, and other members of your staff at an exit meeting held at the station on August 11, 2000.

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

The team did not identify any findings during this inspection. They concluded that problems were properly identified, evaluated and resolved within the problem identification and resolution programs.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Wayne D. Lanning, Director
Division of Reactor Safety

Docket No. 05000244
License No. DPR-18

Enclosure: Inspection Report 05000244/2000-004

cc w/encl:
P. Wilkens, Senior Vice President, Generation
P. Eddy, Electric Division, Department of Public Service, State of New York
C. Donaldson, Esquire, State of New York, Department of Law
N. Reynolds, Esquire
F. William Valentino, President, New York State Energy Research
and Development Authority
J. Spath, Program Director, New York State Energy Research
and Development Authority
T. Judson, Central NY Citizens Awareness Network

Distribution w/encl (**VIA E-MAIL)**
H. Miller, RA
J. Wiggins, DRA
J. Shea, RI EDO Coordinator
E. Adensam, NRR (ridsnrrdlpmlpdi)
G. Vissing, NRR
D. Thatcher, NRR
J. Wilcox, NRR
H. Neih, SRI - Ginna
M. Evans, DRP
W. Cook, DRP
R. Junod, DRP
Region I Docket Room (with concurrences)
M. Oprendek, DRP
W. Lanning, DRS
W. Ruland, DRS
M. Evans, DRS
A. Della Greca, DRS
D. Lew, DRS

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OFFICE	RI/DRS		RI/DRS		RI/DRS		RI/DRP		RI/DRS	
NAME	ADellaGreca		MEvans (WAC for)		DLew		MEvans (WAC for)		WLanning	
DATE	9/18/00		09/21/00		09/21/00		09/21/00		09/22/00	

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No:	05000244
License No:	DPR-18
Report No:	05000244/2000-004
Licensee:	Rochester Gas and Electric Corporation (RG&E)
Facility:	R. E. Ginna Nuclear Power Plant
Location:	1503 Lake Road Ontario, New York 14519
Dates:	July 24 - August 11, 2000
Inspectors:	A. L. Della Greca, Senior Reactor Inspector A. Lohmeier, Senior Reactor Inspector T. A. Moslak, Health Physicist C. R. Welch, Resident Inspector
Approved By:	W. H. Ruland, Chief Electrical Branch Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000244-00-04; on 07/24 - 8/11/2000: Rochester Gas and Electric Corporation; R. E. Ginna Nuclear Power Plant; Annual baseline inspection of the Identification and Resolution of Problems.

The inspection was conducted by a Region-based team including a resident inspector, a health physics specialist, and two reactor inspectors. The significance of identified issues is indicated by their color (green, white, yellow, red) and is determined by the Significance Determination Process. The team identified no significant issues during this inspection.

Identification and Resolution of Problems

The Ginna Nuclear Power Plant had an acceptable problem identification and resolution process. The multi-tier problem identification system was adequately integrated and the threshold for reporting equipment and personnel performance issues was low. Assigned priorities for problem assessment and identification of required corrective actions were acceptable; operability and reportability evaluations were reasonable. Root cause analyses were also reasonable with occasional weaknesses in the evaluation of and reporting on human performance. Corrective actions were commensurate with the safety significance of the issue and timely. Work environment was safety conscious with plant personnel showing no reluctance in reporting plant issues.

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4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

Inspection Scope:

The team reviewed items selected across the seven cornerstones of safety to determine if plant issues were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. Specifically, the team selected a sample of approximately 200 Action Requests (ARs). A partial listing of the ARs is included in Attachment 2 to this report. The samples were selected from a list of more than 3000 ARs that had been issued since July 1998 (the 1998 ARs were reviewed primarily to identify the potential existence of common cause issues or problems).

The team also evaluated the licensee's effort in establishing the scope of problems by reviewing pertinent control room logs, work orders, design change packages, self-assessment results, system health reports, operating experience (OE) program implementation, and results from surveillance tests and preventive maintenance tasks. A partial listing of the other pertinent documents reviewed is included in Attachment 2.

The team conducted walkdowns of various plant areas and selected systems to evaluate equipment conditions and confirm that issues and problems were properly identified. The team also interviewed plant personnel to identify other processes that may be used by them for reporting problems and issues. The team reviewed work requests and attended selected management and work control meetings to understand the interface between the corrective action program and the work control process.

Issues and Findings:

The team identified no significant findings in the area of problem identification. The team found that, in general, Rochester Gas and Electric Corporation (RGE) appropriately identified plant problems and issues and entered them into their corrective action program. No significant time lag was observed between the discovery of a problem and the issuance of the associated AR.

The licensee's primary means for identifying conditions adverse to quality and for developing corrective actions was the Action Request process described in procedure IP-CAP-1. A broad review by the team of the AR list and the detailed evaluation of selected lower-classification ARs determined that the threshold for reporting problems was low. For instance, in the area of primary and secondary system chemistry controls numerous ARs were written to address anticipated and unanticipated chemistry parameter changes and to maintain such parameters within conservative tolerances.

Plant issues were also addressed through a lower tier, complementary process, the work request/trouble report (WR/TR), that was primarily aimed at identifying and controlling plant activities. The team's review of selected WR/TRs found that the WR/TR process was for the most part acceptably applied.

The station had an acceptable Operating Experience (OE) Program that identified and processed information for distribution from sources both outside and inside the station. The team found that OE items were discussed daily during the morning management meeting and properly processed via the AR system.

.2 Prioritization and Evaluation of Issues

Inspection Scope:

The team conducted interviews of responsible personnel and reviewed selected issues (See Attachment 2) to determine if such issues were properly evaluated and prioritized and if an appropriate cause analysis was performed for conditions adverse to quality. The team also evaluated the licensee's review and disposition of each issue with respect to operability and reportability; the efforts to identify and capture issues that could affect the unavailability of equipment tracked by the performance indicators and the maintenance rule; and the method for determining the risk significance of individual issues as well as combinations of the various issues contained in the corrective action backlog.

Issues and Findings:

The team identified no significant findings in this area. The team found that, in general, the licensee's review and analysis of the individual issues were acceptable and that the operability and reportability determinations as well as the timeliness for conducting these determinations were reasonable.

The licensee used three classification levels (A, B, and C) to establish the priority and depth of review of identified issues. A fourth level, D, was used to report and trend minor issues, also defined by the licensee as precursors. The team's review of the ARs listed in Attachment 2 identified no significant discrepancies in the classification level assigned by the screening committee to each issue. Root cause investigation were usually reasonable and commensurate with the significance of the issues, although the team identified occasional weaknesses in the licensee's evaluation of and reporting on human performance. For instance:

a. In AR 99-0974 regarding an inadvertent start of the turbine driven auxiliary feedwater pump, the team observed that the level I investigation did not specifically evaluate the process used by Operations to determine when it was appropriate to restore the system to service, following the system maintenance and testing. Additionally, although a procedure adherence concern was identified in the body of the report, the concern was not highlighted in the report summary conclusions.

b. In AR 2000-0579 regarding the inadvertent local tripping of the service water pump breaker, the level II evaluation concluded that the root cause of the event was "administrative controls incomplete," due to a lack of double verification for local breaker operation. In this case, the failure by an individual to perform self-checking was not identified as a significant contributing cause. This was also recognized in the report barrier analysis and, later, by management reviews.

c. In AR 2000-0398 concerning failure to post a firewatch when the Halon fire protection system for the relay room was disabled, the level II evaluation referred to the disconnection of power to fire zone S08 as inadvertent and attributed the root cause to "procedure change less than adequate." In this case, the team believed that the procedure weakness was only a contributing cause and that the licensee did not address potential human performance issues regarding: (1) determination of fire watch requirements; (2) initial review of work documents; and (3) implementation of station procedure SC-3.15.17, "TRM Firewatch Posting."

The licensee had recognized the existence of weaknesses in this area and was using a complementary AR tracking program to improve their manipulation of input data and gain a better understanding of human and equipment performance trends.

.3 Effectiveness of Corrective Actions

Inspection Scope:

The team reviewed the effectiveness of corrective actions. Specifically, the team evaluated the process for developing corrective actions, and verified that the corrective actions were commensurate with the safety significance of the problem or issue and were implemented in a timely manner. For significant conditions adverse to quality, the review also evaluated whether the licensee considered extent of condition, generic implications, common cause, root and contributing causes, and previous occurrences. A partial listing of the Action Reports selected for review is included in Attachment 2.

Issues and Findings:

The team identified no significant findings in this area. In particular, the team determined that the licensee's resolution of identified issues was acceptable and that the corrective actions were implemented in a timely manner.

.4 Effectiveness of Licensee Audits and Assessments

Inspection Scope:

The team reviewed selected audits and self-assessments to determine whether the existing programs were effectively implemented, identified deficiencies and weaknesses were entered in the corrective action program, and appropriate corrective actions were developed to address findings. The review included internal audits and self-assessments performed by most disciplines, meeting minutes, and audit and surveillance reports performed by various oversight organizations, including Quality Assurance (QA), Plant Operation Review Committee (PORC), and the Nuclear Safety Audit Review Board (NSARB).

Issues and Findings:

The team identified no significant findings in this area. Specifically, the team found that the audits and self-assessments were well focused and that, for the most part, they provided good insights on the effectiveness of the various programs and plant activities. Findings and observations were typically documented in ARs for evaluation and corrective action.

.5 Assessment of Safety Conscious Work Environment

Inspection Scope:

The team conducted interviews of selected plant personnel to assess whether licensee personnel (permanent or contracted) may be reluctant to report safety issues. The interviews were conducted among plant personnel from various disciplines and at different levels within the organization. The team also evaluated the program that had been established to foster a safety conscious work environment.

Issues and Findings:

No significant findings were identified.

The team found that there were no indications that plant personnel were not reluctant to raise plant safety issues. The team also determined that, although an employee concern program had existed for at least two years, the scope of the program and the responsibilities of the officer in charge were not well known among the plant staff. No plant safety concerns had been processed by the responsible officer during the period the program had been in existence.

4OA6 Management Meetings

.1 Exit Meeting Summary

The team periodically met with cognizant licensee personnel during the inspection to discuss inspection issues and findings. On August 11, 2000, the team conducted an exit meeting at the Ginna plant with Messrs. P. Wilkens, R. Mecredy, and J. Widay and other members of the licensee staff to present the inspection results.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

P. Wilkens	Senior Vice President
R. Mecredy	Vice President Nuclear Operations
J. Widay	Vice President, Plant Manager
H. Aurand	Nuclear Safety and Licensing
P. Bamford	Manager, Primary/Reactor Systems Engineering
J. Bement	Foreman, RP operations
A. Butcavage	Engineering
G. Cain	Engineering
F. Cordaro	Emergency Planning
B. Dahl	Principal Chemist, Plant Systems
J. Dibiase	Manager,. Computer Systems
J. Dunne	Engineer, Reactor Engineering and Analysis
R. Eliasz	Engineer, Reactor Engineering and Analysis
M. Flaherty	Manager, Configuration, Support Engineering
R. Forgenci	Manager, Operational Review
J. Germain	Operational Review
D. Gomes	Shift Supervisor
P. Gorski	Systems Team Engineering
K. Gould	Senior Health Physicist
T. Harding	Nuclear Safety and Licensing
G. Hermes	Manager, Reliability
C. Hook	Security Self-Assessment Coordinator
J. Hotchkiss	Manager, Mechanical Maintenance
G. Jones	Radiochemist, Primary Systems
J. Jones	Engineer, Systems Team Engineering
D. Klemz	Engineer, Reactor Engineering and Analysis
T. Laursen	Training
N. Leoni	QA Coordinator, Radiation Protection & Chemistry
M. Lilley	Manager, Quality Assurance
R. Lingl	Operations Supervisor
C. Meighan	ALARA manager
R. Merchionda	Department Manager, Nuclear Assessment
T. Miller	Engineer, Systems Team Engineering
F. Mis	Principal Health Physicist
G. Palmer	Nuclear Security Operations Coordinator
R. Ploof	Manager, Secondary Systems Engineering
R. Popp	Production Superintendent
W. Rapin	Engineer, Systems Team Engineering
W. Schneider	Senior Chemist, Secondary Systems
P. Sidelinger	EOP Coordinator
M. Smith	Manager, Balance of Plant Systems
B. Standfield	Quality Assurance Engineer, Independent Assessment
L. Sucheski	Engineer, Systems Team Engineering
P. Swift	Procurement
R. Teed	Manager, Nuclear Security
W. Thomson	Manager, Radiation Protection & Chemistry
G. Verdin	Engineer, Reactor Engineering and Analysis

J. Walden	Engineer, Reactor Engineering and Analysis
R. Watts	Manager, Nuclear Training
T. White	Manager, Operations
D. Winter	Engineering
G. Wrobel	Manager, Nuclear Safety & Licensing

INSPECTION PROCEDURE USED

71152	Identification and Resolution of Problems

ITEMS OPENED, CLOSED, AND DISCUSSED

None

LIST OF ACRONYMS USED

AR	Action Report
EOOS	Equipment out of service
LER	Licensee Event Report
NRC	Nuclear Regulatory Commission
NSARB	Nuclear Safety Audit Review Board
OE	Operating Experience
PORC	Plant Operations Review Committee
QA	Quality Assurance
RGE	Rochester Gas and Electric Corporation
TR	Trouble Report
WO	Work Order
WR	Work Request

ATTACHMENT 1

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety	Radiation Safety	Safeguards
● Initiating Events	● Occupational	● Physical Protection
● Mitigating Systems	● Public	
● Barrier Integrity		
● Emergency Preparedness		

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings indicate issues that, while they may not be desirable, represent very low safety significance. WHITE findings represent issues with low to moderate safety significance, which may require additional NRC inspections. YELLOW findings represent issues with substantial safety significance, which would require the NRC to take additional actions. RED findings represent issues with high safety significance and an unacceptable loss of safety margin, which would result in the NRC taking significant actions that could include ordering the plant shut down.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. The color for an indicator corresponds to levels of performance that may result in increased NRC oversight (WHITE), performance that results in definitive, required action by the NRC (YELLOW), and performance that is unacceptable but still provides adequate protection to public health and safety (RED). GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, as described in the matrix. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.

ATTACHMENT 2

LIST OF DOCUMENTS REVIEWED

PROCEDURES

IP-CAP-1, Rev 9	Abnormal Condition Tracking Initiation or Notification (Action) Report
IP-CAP-2, Rev 3	Root Cause Analysis
IP-HPE-1, Rev 1	Human Performance Event Evaluation Process
IP-NPD-4, Rev 4	Nuclear Operation Group Work Prioritization
IP-PSH-1, Rev 3	Integrated Work Schedule
IP-PSH-2, Rev 5	Integrated Work Schedule Risk Management
SC-3.15.17, Rev 18	TRM Firewatch Posting
SC-3.16.2.8, Rev.26	Fire Signaling System Maintenance
A-1603.1, REV 11	Work Request/Trouble Report Initiation
A-1603.2, Rev 11	Work Order Initiation
A-1603.3, Rev 24	Work Order Planning
A-1603.9, Rev 5	Work Control System Performance Indicators
A-1605, Rev 6	Safety Classification of Maintenance Work Activities
ND-PSH, Rev 3	Planning and Scheduling of Maintenance Activities

ACTION REQUESTS

AR 96-0780	Motor Driven Auxiliary Feedwater Low Oil Temperature Concerns
AR 98-0518	Breaker and Relays for EDG Not Optimally Coordinated.
AR 98-0520	Battery Room Temperature Exceeds 77 ^{0}F.
AR 98-0554	Flood Barrier in Screen House Separated in Several Locations.
AR 98-0700	ES-1.3 Guidance Not Consistent with DA-ME-97-066
AR 98-0716	ER-SC-.4 Not in Agreement with UFSAR
AR 98-1018	A AFW Train Flow Instrument Disparity
AR 98-1450	Higher Steam Flow/Feed Mismatch in SG B than Steam Generator A.
AR 98-1475	Pin Hole Leak in a Regeneration Waste Line Threaded Fitting.
AR 99-0127	RCS Lithium Concentration Decreasing.
AR 99-0207	Westinghouse Notification of Errors in MSL Break Analysis.
AR 99-0290	SEP-4F Breaker No. 2 Tripped
AR 99-0314	B Reactor Coolant Pump Failed to Close
AR 99-0418	Bus 14 Normal Feeder Breaker Failed to Close in Test
AR 99-0549	Agastat Relays Fail Time Delay Calibration Testing.
AR 99-0589	RCP High Oil Level Set-point out of Tolerance.
AR 99-0602	Possible Protected Area Barrier Deficiency.
AR 99-0636	Posting of a Locked High Radiation Area During Fuel Transfer
AR 99-0646	Foreign Object in Refueling Cavity.
AR 99-0664	Unplanned Exposures During Reactor Cavity Decontamination
AR 99 0658	Safety Injection Pump C Supply Breaker Failed to Close
AR 99 0659	Bus Tie Breaker 17-18 Failed to Close
AR 99-0674	Condenser Tubes Have Corrosion Pits Exceeding 70% thru Wall.
AR 99 0699	Auxiliary Feedwater Pump A Failed to Start
AR 99 0725	MDAFW A Oil Pump Started when Breaker for AFW Pump A Closed in Test, Then Tripped
AR 99-0771	RHR Isolated Before RCS Cleanup Completed
AR 99-0794	Inadvertent Start of Turbine Driven Auxiliary Feedwater Pump
AR 99-0795	Indication Received on PPCS That 2 Main Steam Safety Valves Open

AR 99-0998 Motor Bearing Temperature Increases after Greasing
AR 99-10101 A EDG Bus 14 Feeder Breaker Failed to Close during PT-12-1
AR 99-1088 Follow up Items from OSRE Inspection.
AR 99-1097 NERP Responders Respirator Qualifications Lapsed
AR 99-1150 NERP Responders Respirator Qualifications Lapsed
AR 99-1169 Reactor Makeup Water Tank Chloride Level Increasing at Higher Rate
AR 99-1305 DB-50 Breaker, Westinghouse Technical Bulletin W-TB-99-05
AR 99-1451 INPO Chemistry Assist Visit Suggestions for Improvements.
AR 99-1627 Steam Generator Heat Treatment Documentation Incorrect.
AR 99-1642 14-195H-14 Shipping Cask Does Not Have a Blanket Order Release Number
AR 00-0054 Steam Generator Sulfate Levels Exceeded CHA-SEC-GUIDE Limiting Values
AR 00-0105 AOV 4310 Did Not Respond During PT-16Q-B
AR 00-0133 Dead Time Found at Zero on Two Friskers
AR 00-0138 RCS Hydrogen Concentration below Desired Range
AR 00-0174 SPDES Circulating Water Delta Temperature Limit Exceeded
AR 00-0187 Temporary Modification Installation Deviated from Safety Review.

AR 00-0195 Entered ER-SC.3 for Low Screenhouse Water Level
AR 00-0196 Circulating Sater Delta Temperature SPDES Limit Exceeded
AR 00-0217 Relief Valve Would Not Lift at Maximum Test Pressure During Testing.
AR 00-0223 High Vibrations on RHR Pump During Pt-2-pt-2. 2q.
AR 00-0232 Radio-Chemistry Sampling and Analysis Activities Unnecessarily Rescheduled
AR 00-0250 Field Calibrator Source Stuck Open
AR 00-0266 RCS Lithium below Desired Range
AR 00-0267 Silt Buildup in Service Water Supply Line to MDAFW pumps.
AR 00-0269 Security Officer Entered Posted Radiography Area Without Permission
AR 00-0279 Records Management File Room Door Locks Do Not Perform as Designed.
AR 00-0304 Main Feedwater Copper Level Exceeded CHA-SEC-GUIDE Limiting Value
AR 00-0312 Leak Sealant in System Damaged Valve Seats
AR 00-0320 Portable Instruments Found in the Field with Calibration Date Expired
AR 00-0326 Cycle 27 Refueling Outage Hideout Return Data Predict Highly Basic Steam Generator Crevice
AR 00-0328 Fire System Inadvertently Disconnected (Relay Room Halon S-08)
AR 00-0332 Unstable Secondary Chemical Feeds Increase Corrosion Product Transport
AR 00-0338 Instruments Not Source Checked Used to Perform Survey
AR 00-0339 Cable Closet Door Will Not Unlock, Cannot Locate Proper Keys or Lock Broken.
AR 00-0344 Unexpected Dose Rate Alarm
AR 00-0359 Numerous Secondary Chemistry Parameters Outside Desired Range During Load Reduction
AR 00-0381 Main Feedwater Iron/Copper Exceeded CHA-SEC-GUIDE Limiting Values
AR 00-0413 Main Feedwater Iron/Copper Values Exceed CHA-SEC-GUIDE Limiting Values
AR 00-0418 Feedwater Pump Recirculation Valve Failed Open.
AR 00-0469 Reactor Baffle Bolts with Ultrasonic Test Indications
AR 00-0491 Improper Safety Classifications of Reactor Coolant Pump Oil Collection.
AR 00-0511 Condensate Dissolve Oxygen Exceeds CHA-SEC-GUIDE Limiting Values
AR 00-0526 Multiple Failure of Air Ejector Grab Sampler Heater
AR 00-0542 Main Feedwater Hydrazine Outside CHA-SEC-GUIDE Limits
AR 00-0546 Circulating Water Total Residual Chlorine Data Logger Malfunctioning
AR 00-0548 Released Wrong Gas Decay Tank
AR 00-0571 Procedure Problems with Chemistry Procedures

AR 00-0579 Inadvertent Trip of Service Water Pump D Breaker
AR 00-0593 Corrosion Product Filter Analysis Weakness at Main Chem Lab
AR 00-0617 RCS Lithium Concentration below Desired Range.
AR 00-0643 Repeat Breaker Tripping
AR 00-0653 RCS Lithium Concentration Exceeded Desired Range.
AR 00-0687 Potential for Elevated Radioactive Gas Release During Water Transfer
AR 00-0688 Review Millstone-2 Chemistry Event for Site Applicability
AR 00-0713 Vital Battery Monitor Held Greater than one Year.
AR 00-0722 Main Feedwater Iron/copper Values Exceeded Limiting Values.
AR 00-0826 Evaluate the Effectiveness in Controlling Safeguards Information.

WORK ORDERS

WO 99-1158 Missing Racking Knob Left Breaker Rail A MDAFW Pump
WO 99-1459 Pressurizer Pressure Low Alarm Comes in Early
WO 00-1344 LT-935 Calibration Changes When Pressurized
WO 00-1681 Recirc Valve Leaks by Seat 6 GPH
WO 00-2043 Motor Driven Auxiliary Feedwater Pump Strainer Solenoid Valve Trips
WO 00-2064 PI-8627 Calibration Not Current Gage Used to Charge Accumulators

AUDITS/SELF-ASSESSMENTS

SQUA-1999-0018-HMG Reactor Vessel Inservice Inspection
SQUA-1999-0019-HMG Baffle Bolt Replacement
SQUA-1999-0097-HMG Steam Generator Inservice Inspection
SQUA-2000-0003-TGT Security Training Records Deficiency Closeout
SQUA-2000-0010-TGT Security Contingency Drills
SQUA-2000-0016-AZP Vehicle Barrier System
SQUA-2000-0017-TGT Security Weapons Qualifications
SQUA-2000-0019-DHK Security Response to a Medical Emergency
SQUA-2000-0021-TGT Security Force on Force Drills
AINT-2000-0001-JMT Chemistry Audit
AINT-2000-0003-PJH Engineering and Configuration Control Audit Report
AINT-2000-0005-RTD Maintenance Rule Audit Report
Self-Assessment 99-53 ALARA Process Mapping
Self-Assessment 99-64 Radiation Protection Outage Critique Comments
Self-Assessment 99-77 Off-site Dose Calculation Manual Evaluation
Self-Assessment 99-80 1999 ALARA Post Outage Assessment
Self-Assessment 99-81 Peer assisted Chemistry Self-Assessment
Self-Assessment 00-10 Corrective Action Process Effectiveness
Self-Assessment 00-12 Radiation Protection Technician Training Program Evaluation
Periodic Assessment of the R.E. Ginna Maintenance Rule Program for the Period November 1997 Through April 1999

NSARB/PORC/ISEG REPORTS AND MINUTES

Plant Operations Review Committee - Meeting No. 2000-0024 -05/18/00
Nuclear Safety Audit Review Board - Meeting 234 - 06/23-24/99

Non-Cited Violations (NCV)

AR 99-0970	Performance Indicators in NOG Monthly Report Have Exceeded Goals
AR 99-0959	99-0890 Action Report on Main Steam Line Check Valve Should Have Classified Condition as Non-Conforming
AR 99-0974	Event Evaluations Do Not Always Include a Review of Processes for Weaknesses
AR 99-1000	Potentially Inadequate 10CFR50.59 for Changes to PT-2.10.19
AR 99-1208	Engineering Analysis used Improper Input

OTHER INFORMATION

Quality Improvement Suggestion Records (1/4/00 - 6/19/00)
Trend Analysis Reports dated November 4, 1999; January 25, 2000; and July 11, 2000