

February 11, 2000

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

SUBJECT: NRC INTEGRATED INSPECTION REPORT NO. 05000244/1999012

Dear Dr. Mecredy:

On January 23, 2000, the NRC completed an inspection at your R. E. Ginna nuclear power plant. The enclosed report presents the results of that inspection. Preliminary results and conclusions were presented to RG&E management led by Mr. R. Popp of your staff in an exit meeting on January 28, 2000.

During the six weeks covered by this inspection report, your conduct of activities at the Ginna facility was generally characterized by safety-conscious operations, sound engineering and maintenance practices, and careful radiological work controls.

Based on the results of our review, the NRC has determined that a Severity Level IV violation of NRC requirements occurred. This violation is being treated as a Non-Cited Violation (NCV), consistent with Section VII.B.1 of the enforcement policy. The NCV is described in the subject inspection report and involves the failure of your staff to properly translate regulatory requirements into plant procedures for the control room ventilation system. If you contest the violation or the severity level of the NCV, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001, with copies to the Regional Administrator, Region 1; the Director, Office of Enforcement; and the NRC Resident Inspector at the Ginna Station.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

Sincerely,

/RA/

Michele G. Evans, Chief  
Projects Branch 1  
Division of Reactor Projects

Robert C. Mecredy

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Docket No. 05000244

License No. DPR-18

Enclosure: Inspection Report 05000244/1999012

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U.S. NUCLEAR REGULATORY COMMISSION  
REGION I

License No. DPR-18

Report No. 05000244/1999012

Docket No. 05000244

Licensee: Rochester Gas and Electric Corporation (RG&E)

Facility Name: R. E. Ginna Nuclear Power Plant

Location: 1503 Lake Road  
Ontario, New York 14519

Inspection Period: December 13, 1999 through January 23, 2000

Inspectors: H. K. Nieh, Senior Resident Inspector  
C. R. Welch, Resident Inspector  
T. L. Hoeg, Resident Inspector, Calvert Cliffs  
B. S. Norris, Sr. Reactor Inspector Engineering Programs Branch  
G. C. Smith, Senior Physical Security Inspector

Approved by: M. G. Evans, Chief  
Projects Branch 1  
Division of Reactor Projects

## EXECUTIVE SUMMARY

### R. E. Ginna Nuclear Power Plant NRC Integrated Inspection Report 05000244/1999012

This integrated inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a 6-week period of resident inspection, and it includes the results of an announced inspection by regional specialists related to NRC generic letter (GL) 98-02, "Loss of Reactor Coolant Inventory and Associated Loss of Emergency Mitigation Functions While in a Shutdown Condition," and the in-office review of changes to the Ginna Security and Training and Qualification Plans.

#### Operations

In general, the conduct of operations was professional and safety-conscious. The cold weather inspection program was effectively implemented to ensure systems, structures, and components important to the safe operation of the reactor plant were adequately protected from freezing. The weekly walkdown checklist, performed on January 9, 2000, effectively verified the required freeze protection measures were in place. The cold weather walkdown procedure was adequately written and provided clear guidance to the user (Sections O1.1 and O2.1).

The change in philosophy pertaining to testing of the safety injection accumulator isolation valves quarterly vice in cold shutdown (resulting in at power testing) was not rigorously challenged within the organization. Though not prohibited, the decision to test the valves quarterly would have increased to a small extent the overall plant risk with no added safety benefit. The decision, rooted in a narrowly focused interpretation of the guidance contained in NUREG-1482, "Guidelines for Inservice Testing at Nuclear Power Plants," was subsequently reversed when challenged by the inspectors (Section O1.2).

The inspectors concluded that RG&E's corrective actions to prevent recurrence of configuration control and human performance errors (inspector follow-up item 05000244/1997010-01) were adequate. Though not entirely successful in preventing re-occurrence, performance has improved and station management has continued to maintain improvement in human performance a priority (Section O8.1).

#### Maintenance

Personnel effectively performed the observed maintenance and surveillance activities in accordance with approved procedures. Emergent maintenance activities associated with an instrument air leak on a main feedwater regulating valve positioner were adequately evaluated and properly executed (Sections M1.1 and M2.1).

Conduct of surveillance procedure PT-16Q-T, "Auxiliary Feedwater Turbine Pump Operability," was well coordinated, properly controlled, and adequately demonstrated the ability of the turbine driven auxiliary feedwater pump to provide feedwater to the steam generators. However, the inspectors noted that the test sequence did not perform the stroke time test of the turbine steam admission valves in the as-found condition with no pre-test stroking as required by IP-IIT-2, "Inservice Testing Program for Pumps and Valves," (Section M1.2).

## Executive Summary (cont'd)

Maintenance activities on the control room ventilation system placed the plant outside its design basis during numerous occasions partially because system design information was not properly incorporated into maintenance procedures. This violation of NRC requirements was non-cited. Additionally, the root cause analysis presented in the associated licensee event report was narrowly focused since it did not address potential human performance deficiencies. RG&E's immediate and planned corrective actions were adequate (Section M8.1).

## Engineering

RG&E determined that Ginna station was vulnerable to an event referenced in generic letter (GL) 98-02, "Loss of Reactor Coolant Inventory and Associated Loss of Emergency Mitigation Functions While in a Shutdown Condition," and took acceptable corrective actions. RG&E's response to GL 98-02 was timely and complete (Section E2.1).

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## **ATTACHMENTS**

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- Inspection Procedures Used  
- Items Opened, Closed, and Discussed  
- List of Acronyms Used

## Report Details

### Summary of Plant Status

The plant began the period at full power, and remained there throughout the end of the inspection period.

### I. Operations

#### **O1 Conduct of Operations**

##### O1.1 General Comments (71707)

The inspectors conducted frequent observations of ongoing plant operations, including control room walkdowns, log reviews, and shift turnovers. The inspectors also conducted numerous plant tours to observe equipment operation and personnel working in the field. In general, the conduct of operations was professional and safety-conscious.

##### O1.2 Safety Injection (SI) Accumulator Discharge Isolation Valve Testing

###### a. Inspection Scope (71707):

The inspectors reviewed the scheduled testing activity of the SI accumulator discharge isolation motor-operated valves (MOV-841 and 865).

###### b. Observations and Findings:

During the week of January 2, 2000, the inspectors noted that the safety injection accumulator isolation valves had been scheduled for testing with the plant at full power. Testing was to be conducted in accordance with procedure PT-2.3, "Safeguard Motor Operated Valve Operation," and consisted of cycling the valves remotely while measuring the stroke time in the closed direction. Testing at power had not previously been performed. Prior tests were conducted with the plant in a cold shutdown condition. Implementation of the Ginna Station inservice testing (IST) program fourth ten year interval on January 1, 2000, changed the requirements for the valve stroke and timing frequency from cold shutdown to quarterly.

The briefings for entry at power into the vapor containment and testing of the SI accumulator discharge isolation valves were adequate. The ALARA briefing, performed to minimize personnel exposure, was very thorough and addressed key points such as the travel routes to and from the work site, general radiation levels, the areas of lowest and highest radiation, and contingency actions in the event of dosimeter alarms or unexpected conditions.

Test of the isolation valves coincident with the monthly containment entry was considered sound planning, allowing for quick restoration of the valves by local-manual operation should they fail to respond electrically.

Though testing at power is not prohibited and the increase in plant risk was determined to be minor, the inspectors questioned RG&E's change in testing philosophy and the safety benefit gained by testing on-line. Subsequent discussions with RG&E established that:

- testing on-line provided no added safety benefit,
- an overall reluctance to test on-line existed,
- and an overly restrictive interpretation of the guidance provided in NUREG-1482, "Guidelines for Inservice Testing at Nuclear Power Plants," had led to the perception that testing of the safety injection accumulator isolation valves in cold shutdown vice quarterly was unjustified.

RG&E reevaluated the need to test the SI accumulator isolation valves quarterly and determined that a cold shutdown justification was still valid. The test was canceled and a change to the IST program document initiated.

c. Conclusion

The change in philosophy pertaining to testing of the safety injection accumulator isolation valves quarterly vice in cold shutdown (resulting in at power testing) was not rigorously challenged within the organization. Though not prohibited, the decision to test the valves quarterly would have increased to a small extent the overall plant risk with no added safety benefit. The decision, rooted in a narrowly focused interpretation of the guidance contained in NUREG-1482, "Guidelines for Inservice Testing at Nuclear Power Plants," was subsequently reversed when challenged by the inspectors.

## **O2 Operational Status of Facilities and Equipment**

### **O2.1 Review of Cold Weather Freeze Protection Implementation**

a. Inspection Scope (71714)

The inspectors reviewed a sampling of systems and components which were actively controlled by RG&E's winterizing inspection program. The inspectors also reviewed RG&E's adherence to administrative controls contained in Ginna Station procedure A-54.4.1, Revision 36, "Cold Weather Walkdown Procedure."

b. Observations and Findings

RG&E performs weekly walkdowns of safety related systems and components from November 1 through April 1, to ensure that equipment does not become frozen and lose its ability for safe operation. On January 20-21, 2000, the inspectors walked down portions of the turbine building and intake structure including the feed pump room, instrument air compressor area, condensate pump area, service water pump area, and traveling screen area. The inspectors found the associated heat tracing, ventilation, and space heater units were effectively maintaining those systems and components above freezing. Local heat tracing circuit power "on" lights indicated they were energized with

some having amperage meters indicating current flow. Associated windows and outside air dampers were found closed.

The inspector verified RG&E's implementation of cold weather walkdowns by reviewing their checklist completed on January 9, 2000. The inspector found the checklist to be complete and administratively correct with the required station management review signatures in place. The checklist verified systems, structures, and components important to the safe operation of the reactor plant were adequately protected from freezing. The cold weather walkdown procedure was properly written and provided the necessary guidance for the RG&E operator to perform his or her freeze protection tours of the plant.

c. Conclusions

RG&E appropriately implemented their cold weather inspection program. A weekly walkdown checklist was performed on January 9, 2000, which effectively verified the required freeze protection measures were in place. RG&E's cold weather walkdown procedure was adequately written and provided clear guidance to the user.

**O8 Miscellaneous Operations Issues**

- O8.1 (Closed) Inspector Follow-Up Item (IFI) 05000244/1997010-01: Weak Configuration Control. The inspectors opened this item in October, 1997, in response to two inadvertent discharges of reactor coolant to the waste hold up tank on consecutive days as a result of valves being out of their required/expected position. Further concern, identified in the 1997 refueling outage, was documented in NRC inspection report (IR) 1997011. Updates were provided in IRs 1998001, 1999002 and 1999008.

Corrective actions focused on the need to improve attention to detail, self-checking, and communications. Other efforts included:

- procedure changes to enhance and/or correct existing instructions,
- higher expectations/standards for pre-job/pre-evolution briefings,
- enhanced communications between organizations,
- implementation of a work control center with established manning requirements and formal expectations/guidelines concerning duties and responsibilities and,
- periodic training sessions to demonstrate thru examples the potential adverse consequences of improper configuration control.

The inspectors concluded that RG&E's corrective actions to date were adequate. Though not entirely successful in preventing re-occurrence of configuration control and human performance errors, performance has improved. Station management has continued to maintain improvement in human performance a priority.

- O8.2 (Closed) Licensee Event Report (LER) 05000244/1999004, Revision 1: Containment Recirculation Fan Moisture Separator Vanes Incorrectly Installed Results in Plant Being Outside Its Design Basis. The inspectors reviewed RG&E's assessment of this original manufacturing error and determined that it was satisfactory. No actual consequence

resulted and potential consequences were minimal. A reasonable assurance exists that the system was capable of performing its safety-related function following all design basis accidents. No violation of NRC requirements was identified.

## II. Maintenance

### **M1 Conduct of Maintenance**

#### M1.1 General Comments

##### a. Inspection Scope (61726, 62707)

The inspectors watched all or portions of the following maintenance and surveillance activities:

- WO 19902453 nuclear instrument N43 axial offset calibration
- WO 19904720 A main feedwater regulating valve positioner air leak
- WO 19901597 calibrate HCV-624
- PT-36Q-C C standby auxiliary feed pump quarterly test
- PT-12.1 A diesel generator monthly test
- PT-16Q-T turbine driven auxiliary feedwater pump (TDAFWP) quarterly test

##### b. Observations, Findings, and Conclusions

The inspectors observed that RG&E personnel effectively performed the above stated maintenance and surveillance activities in accordance with approved procedures.

#### M1.2 Turbine Driven Auxiliary Feedwater Pump Surveillance Testing

##### a. Inspection Scope (61726)

The inspectors observed portions of surveillance procedure PT-16Q-T, "Auxiliary Feedwater Turbine Pump Operability," and reviewed the completed test results.

##### b. Observations and Findings

Observation of the control room operators' performance of PT-16Q-T found the test was well coordinated and executed in a very controlled fashion. Communications, were clear, concise, and with few exceptions, made with the appropriate repeat backs. Self-checking in addition to peer checking techniques were observed. The operators maintained a good focus on the evolution and delayed other control room activities which posed a potential distraction.

Performance of the A main feedwater regulating valve (MFRV) was closely monitored during the test of the turbine driven auxiliary feedwater pump due to a noted increase in the leak rate of control air from the valve positioner (see M2.1). The valve was monitored in the control room through the plant process computer and locally by a

stationed operator. Contingency plans were appropriately established in the event the MFRV failed to properly respond. The inspectors noted that the operators had reviewed abnormal operating procedure AP-FW.1, "Partial or Complete Loss of Main Feedwater," prior to commencing the test. The MFRV responded well throughout the test.

Review of the test results identified all test values were within the required acceptance criteria.

The inspectors identified that PT-16Q-T did not comply with procedure IP-IIT-2, "Inservice Testing Program for Pumps and Valves," paragraph 3.5.11 which states in part, " valve testing shall be performed with the valve in its as-found condition with no pre-test stroking or maintenance, as practicable." PT-16Q-T sequenced the stroke time test of the TDAFWP steam admission valves MOV-3504A and MOV-3505A immediately following operation of the valves in support of testing the TDAFWP. The inspectors considered this to be a violation of minor significance not subject to formal enforcement action. RG&E acknowledged this finding and initiated action report (2000-0121) to address the issue.

Review of test data for each valve dating back to December of 1997, identified that the stroke times for each valve were reasonably consistent with the established reference values and subsequent test results. Though not in accordance with established guidelines on preconditioning, the inspectors concluded the test sequence did not mask a condition which would have resulted in the valves being declared inoperable or preventing the TDAFWP from performing its safety function.

c. Conclusion

Conduct of surveillance procedure PT-16Q-T, "Auxiliary Feedwater Turbine Pump Operability," was well coordinated, properly controlled, and adequately demonstrated the ability of the turbine driven auxiliary feedwater pump to provide feedwater to the steam generators. However, the inspectors noted that the test sequence did not perform the stroke time test of the turbine steam admission valves in the as-found condition with no pre-test stroking as required by IP-IIT-2, "Inservice Testing Program for Pumps and Valves."

**M2 Maintenance and Material Condition of Facilities and Equipment**

M2.1 Main Feedwater Regulating Valve Positioner Air Leak

a. Inspection Scope (62707, 71707, 40500)

The inspectors observed selected maintenance activities associated with an air leak on the A main feedwater regulating valve's (MFRV) positioner.

b. Observations and Findings

On December 17, 1999, an equipment operator identified that the A MFRV had abnormal air leakage from its positioner. This resulted in frequent swings in MFRV position along with numerous feedwater flow deviation alarms on the plant process computer. None of the swings resulted in significant changes to steam generator water level. Additionally, high frequency oscillations in air supply pressure were observed on the associated air pressure regulator. Operations department personnel determined that the MFRV was operable but degraded. This determination was confirmed with a subsequent engineering department technical evaluation. The inspectors reviewed the operability assessments and did not note any problems.

On December 23, 1999, RG&E personnel installed a temporary modification to the A MFRV's air supply system. The modification consisted of a pressure regulator in parallel to the existing regulator, and was intended to be used if the existing regulator failed. The inspectors reviewed the temporary modification's documentation, and determined that it was properly prepared according to station requirements. The inspectors also verified that the modification was installed as designed, and that it did not adversely affect the MFRV's ability to close upon receipt of an engineered safety feature actuation signal.

Instrument and controls (I&C) technicians subsequently performed additional adjustments on the MFRV's positioner, which reduced the air leakage and substantially lessened the swings in MFRV position. The inspectors observed that these activities were appropriately coordinated with the control room and that the I&C technicians were knowledgeable of the system's operation. At the end of the inspection period, station management was still evaluating the ideal plant conditions and time for performing permanent repairs.

c. Conclusions

Emergent maintenance activities associated with an instrument air leak on a main feedwater regulating valve positioner were adequately evaluated and properly executed.

**M8 Miscellaneous Maintenance Issues**

- M8.1 (Closed) Licensee Event Report (LER) 05000244/99012: opening control room ventilation system for filter replacement resulted in plant being outside design basis. The inspectors performed an onsite review of the noted event and verified the completion of selected corrective actions. This LER described fourteen previous instances (dating from 1995) where the control room boundary was made inoperable during inspections and replacement of ventilation filters. In each instance, the duration of the inoperable condition was much less than the technical specification (TS) allowed outage time; nonetheless, RG&E personnel did not recognize that performance of the activities compromised TS requirements. The cause of the events was attributed to inadequate work procedure guidance. The inspectors believed that the cause analysis presented in the LER was narrowly focused and did not address human performance factors. In particular, the inspectors felt that each previous occurrence was a missed

opportunity for identification, and collectively indicated a control ventilation system knowledge deficiency. RG&E personnel agreed with the inspectors' assessment and initiated an action report (2000-0050) to investigate human performance and process deficiencies further that may have contributed to this event.

RG&E personnel have administratively prohibited the performance of any further control room ventilation filter inspections until completion of a system modification and an associated procedure change that will permit inspections without affecting control room integrity. No actual safety consequences resulted from the events, and the inspectors concluded that RG&E's corrective actions were adequate. This failure to correctly translate regulatory requirements into plant procedures is a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control." This severity level IV violation is being treated as a Non-Cited Violation, consistent with section VII.B.I of the NRC Enforcement Policy. **(NCV 50-244/99-12-01)**

### **III. Engineering**

#### **E2 Engineering Support of Facilities and Equipment**

##### **E2.1 Response to Generic Letter 05000244/1998002**

###### **a. Inspection Scope (Temporary Instruction 2515/142)**

The inspectors assessed RG&E's activities related to NRC generic letter (GL) 98-02, "Loss of Reactor Coolant Inventory and Associated Loss of Emergency Mitigation Functions While in a Shutdown Condition." The inspectors reviewed RG&E's written response to GL 98-02 and associated corrective actions, independently verified that potential flow paths were properly identified, and interviewed operators and other station personnel.

###### **b. Observations and Findings**

In 1994, the Wolf Creek nuclear station experienced a loss of reactor coolant system (RCS) inventory while in a shutdown condition. The event occurred when operators attempted to change the residual heat removal (RHR) system lineup while unrelated RHR valve maintenance was in progress. As a result, over 9000 gallons of hot RCS inventory were drained to the refueling water storage tank (RWST) through common RHR and emergency core cooling system (ECCS) suction piping. In addition to reducing the RCS inventory, the hot water in the RWST suction piping had the potential to steam bind the ECCS pumps, which would have been required to supply core cooling and makeup.

In response to GL 98-02, RG&E determined that the only possible means for the Ginna station to experience a transient similar to the Wolf Creek event was if one of two flow paths was open. Specifically: (1) the RHR pump discharge to the RWST suction piping of the safety injection and containment spray pumps (via motor operated valves 857A/B/C); or (2) the RHR pump discharge to the C safety injection pump (via valves 1816A/B).

Corrective actions included: (1) procedural enhancements cautioning the operators of the potential for drain down, (2) similar cautions in the maintenance planning computer program, and (3) training of applicable station personnel. The inspectors noted that necessary 10 CFR 50.59 safety evaluation reviews were conducted and documented.

The inspectors determined that RG&E's response to GL 98-02 was acceptable, and the corrective actions taken at the Ginna station should be adequate to prevent an event similar to that experienced at Wolf Creek.

c. Conclusions

RG&E determined that Ginna station was vulnerable to an event referenced in generic letter (GL) 98-02, and took acceptable corrective actions. RG&E's response to GL 98-02 was timely and complete.

#### IV. Plant Support

**P8 Miscellaneous Emergency Preparedness (EP) Issues**

P8.1 Year 2000 (Y2K) Rollover Activities

a. Inspection Scope (71750, 40500)

The inspectors performed onsite observations of station activities during the transition from December 31, 1999 to January 1, 2000.

b. Observations and Findings

During the Y2K rollover, control room operators carefully monitored plant parameters and did not observe any unusual or unexpected indications. RG&E personnel also staffed the Ginna technical support center (TSC) with station managers, additional plant operators, maintenance technicians, and computer support personnel. The TSC received updates from RG&E's offsite emergency response center, which was monitoring the status of Y2K rollover activities throughout the world. The inspectors reviewed RG&E's contingency procedures, and found them to contain sufficient detail and instruction for dealing with potential Y2K-related problems. No significant problems were encountered during the rollover. Chemistry technicians did note one minor problem. The trending software for an automated secondary chemistry sampling system stopped plotting sample results on its associated computer monitor for dates after December 31, 1999. RG&E personnel adjusted the date in the software to restore the trending capabilities, and are pursuing permanent resolution with the software's vendor. This problem did not affect RG&E's ability to operate the Ginna facility safely.

c. Conclusions

RG&E personnel were adequately prepared for transition into the year 2000 (Y2K). One minor Y2K-related software problem was properly managed by station personnel.

- P8.2 (Closed) Inspector Follow-Up Item (IFI) 05000244/1998003-03: Poor Response During Plume Exposure Exercise. Following an emergency preparedness exercise in March 1998, RG&E personnel identified several significant problems with the emergency response organization's response. The inspectors determined that RG&E's corrective actions concerning those problems were adequate. This conclusion was based on a review of the subsequent May 1998 post-exercise critique, and the results of the November 1999 evaluated exercise. Neither of these subsequent exercises revealed problems similar to those identified in March 1998.
- P8.3 (Closed) IFI 05000244/1997010-03: Scope Of 10 CFR 50.54(t) Reviews. In 1997, the inspectors noted that a quality assurance (QA) audit of the emergency preparedness (EP) program did not include a review of drills and exercises. 10 CFR 50.54(t) requires, in part, that an independent review of EP drills and exercises be performed at least every twelve months. RG&E had satisfied this requirement with other independent reviews, and took actions to ensure that these reviews will be performed as part of future annual QA audits of the EP program. The inspectors reviewed RG&E's 1998 and 1999 QA audit reports for the EP program and noted that they adequately assessed drills and exercises.

**S3 Security and Safeguards Procedures and Documentation**

S3.1 Security Program Plans

a. Inspection Scope (81700)

An in-office review was conducted of changes to the Ginna Security and Training and Qualification Plans, identified as Revisions Q, R, S, and 7, submitted to the NRC on April 29, May 13, and September 30, 1999, in accordance with the provisions of 10 CFR 50.54(p).

b. Observations, Findings and Conclusions

Based on a limited review of the changes, as described in the plan revisions, no NRC approval of these changes is required, in accordance with 10 CFR 50.54(p). These changes will be subject to future inspection to confirm that the changes, as implemented, have not decreased the overall effectiveness of the security plan.

## **V. Management Meetings**

### **X1 Exit Meeting Summary**

After the inspection was concluded, the inspectors presented the results to members of licensee management on January 28, 2000. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

### **X3 Management Meeting Summary**

#### **X3.1 Deputy Division Director Visit**

On January 20, 2000, Brian E. Holian, Deputy Division Director, Division of Reactor Safety, Region 1, conducted a tour of the Ginna Station and met with plant management.

ATTACHMENT I

PARTIAL LIST OF PERSONS CONTACTED

Licensee

J. Widay	VP, Plant Manager
G. Graus	I&C/Electrical Maintenance Manager
G. Hermes	Acting Primary Systems Engineering Manager
J. Hotchkiss	Mechanical Maintenance Manager
G. Joss	Results and Test Supervisor
R. Popp	Production Superintendent
J. Pascher	Electrical Systems Engineering Manager
R. Ploof	Secondary Systems Engineering Manager
P. Polfleit	Emergency Preparedness Manager
J. Smith	Maintenance Superintendent
W. Thomson	Chemistry & Radiological Protection Manager
T. White	Operations Manager
G. Wrobel	Nuclear Safety & Licensing Manager

## INSPECTION PROCEDURES USED

IP 37551:	Onsite Engineering
IP 40500:	Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
IP 61726:	Surveillance Observation
IP 62707:	Maintenance Observation
IP 64704:	Fire Protection Program
IP 71707:	Plant Operations
IP 71714:	Cold Weather Preparations
IP 71750:	Plant Support
IP 81700:	Physical Security Program for Power Reactors
IP 92700:	Onsite Follow-up of Written Reports of Nonroutine Events at Power Reactor Facilities
IP 92901:	Follow-up - Operations
TI 2515/142:	Draindown During Shutdown and Common-Mode Failure (NRC Generic Letter 98-02)

## ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

NCV	05000244/1999012-01	Opening control room ventilation system for filter replacement resulted in plant being outside design basis.
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Closed

IFI	05000244/1997010-01	Weak configuration control.
IFI	05000244/1997010-03	Scope of 10 CFR 50.54(t) reviews.
IFI	05000244/1998003-03	Poor response during plume exposure exercise.
LER	05000244/1999004, Rev 1	Containment Recirculation Fan Moisture Separator Vanes Incorrectly Installed Results in Plant Being Outside Its Design Basis.
LER	05000244/1999012	Opening control room ventilation system for filter replacement resulted in plant being outside design basis.

## LIST OF ACRONYMS USED

AFW	Auxiliary Feedwater
ALARA	As Low As Reasonably Achievable
CFR	Code of Federal Regulations
ECCS	Emergency Core Cooling System
EP	Emergency Preparedness
GL	Generic Letter
I&C	Instrument and Controls
IFI	Inspector Follow-up Item
IR	Inspection Report
IST	Inservice Test
LER	Licensee Event Report
MFRV	Main Feedwater Regulating Valve
MOV	Motor-Operated Valve
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PT	Periodic Test
QA	Quality Assurance
RG&E	Rochester Gas and Electric Corporation
RHR	Residual Heat Removal
RWST	Refueling Water Storage Tank
SI	Safety Injection
TDAFWP	Turbine-Driven Auxiliary Feedwater Pump
TSC	Technical Support Center
Y2K	Year 2000