October 28, 2002

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

SUBJECT: R. E. GINNA - NRC INTEGRATED INSPECTION REPORT 50-244/02-05

Dear Dr. Mecredy:

On September 28, 2002, the NRC completed an inspection of your R. E. Ginna facility. The enclosed report documents the inspection findings which were discussed on October 8, 2002 with Joe Widay and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your operating license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, the inspectors identified four issues of very low safety significance (Green). Two of the issues were determined to involve violations of NRC requirements. However, because of their very low safety significance and because they have been entered into your corrective action program, the NRC is treating these issues as non-cited violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny these non-cited violations, you should provide a response with the basis of your denial, within 30 days of the date of this inspection report, 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, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Ginna facility.

The NRC has increased security requirements at the Ginna facility in response to terrorist acts on September 11, 2001. Although the NRC is not aware of any specific threat against nuclear facilities, the NRC has issued an Order and several threat advisories to commercial power reactors to strengthen licensee's capabilities and readiness to respond to a potential attack. The NRC continues to inspect the licensee's security controls and its compliance with the Order and current security regulations.

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 Publically Available Records (PARS) component of the NRC's document management system (ADAMS). ADAMS is accessible from the NRC website in the Public Electronic Reading Room, http://www.nrc.gov/reading-rm/adams.html.

Sincerely,

/RA/

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

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

Enclosure: Inspection Report 50-244/02-05

Attachment 1: Supplemental Information

cc w/encl: P. Wilkens, President, Rochester Gas and Electric
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
W. Flynn, President, New York State Energy Research and Development Authority
J. Spath, Program Director, New York State Energy Research and Development Authority
D. Stenger, Ballard Spahr Andrews and Ingersoll. LLP
T. Wideman, Director, Wayne County Emergency Management Office
M. Meisenzahl, Administrator, Monroe County, Office of Emergency Preparedness
T. Judson, Central New York Citizens Awareness Network

Distribution w/encl: H. Miller, RA/J. Wiggins, DRA (1)
H. Nieh, RI EDO Coordinator
S. Richards, NRR (ridsnrrdlpmlpdi)
R. Clark, PM, NRR
P. Milano, PM, NRR (Backup)
K. Kolaczyk, SRI Ginna
C. Welch, - RI Ginna
M. Marshfield, DRP
M. Evans, DRP
N. Perry, DRP
R. Junod, DRP
Region I Docket Room (with concurrences)

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No:	50-244
License No:	DPR-18
Report No:	50-244/02-05
Licensee:	Rochester Gas and Electric Corporation (RG&E)
Facility:	R. E. Ginna Nuclear Power Plant
Location:	1503 Lake Road Ontario, New York 14519
Dates:	June 30 through September 28, 2002
Inspectors:	K. Kolaczyk, Senior Resident Inspector C. Welch, Resident Inspector L. Cheung, Senior Reactor Inspector P. Frechette, Physical Security Inspector P. Kaufman, Senior Reactor Inspector T. Moslak, Health Physicist B. Norris, Senior Reactor Inspector D. Silk, Senior Emergency Preparedness Inspector
Approved by:	M.G. Evans, Chief Projects Branch 1 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000244-02-05, Rochester Gas & Electric; 06/30-09/28/2002; R. E. Ginna Nuclear Power Plant. Fire Protection, Surveillance Testing and Identification and Resolution of Problems**.**

The inspection was conducted by resident inspectors and regional specialists in radiation protection, security, engineering, and emergency planning. This inspection identified four Green issues, two of which were non-cited violations. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process (SDP)." Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. 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.

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- Green. The inspectors identified the natural gas supply isolation valve to the screenhouse had been covered by several inches of gravel and asphalt pavement. Operators would be procedurally directed to close this valve in the event of a fire in the screenhouse.

  The finding was determined to be of very low safety significance (Green) and a non-cited violation of technical specification 5.4.1.d; which requires, in part, that procedures for the fire protection program be established, implemented, and maintained. (Section 1RO5)

- Green. Two out of four reactor protection over-temperature delta-temperature channels were found to be improperly calibrated and outside technical specification requirements. Improper calibration of reactor protection circuitry could result in an unnecessary plant transient.

  The calibration error was determined to be of very low safety significance (Green) and a non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings. (Section 1R22)

- Green. Operator error during performance of surveillance test PT-12.2; "Emergency Diesel Generator B," rendered the B diesel generator inoperable for approximately seven hours due to the resultant troubleshooting activities. The emergency diesel generator output breaker tripped due to an out of phase condition.

  The finding was determined to be of very low safety significance and did not constitute a violation of regulatory requirements. (Section 1R22)

Cornerstone: OTHER

- Green. The inspectors identified that RG&E's prior corrective action for inadequate operator response to primary plant computer system (PPCS) alarms, has not been fully effective.

- This issue was considered greater than minor since inadequate or poor response to primary plant computer alarms could be reasonably viewed a precursor to a significant event or, if left uncorrected, could become a more significant safety concern. The finding is not suitable for SDP evaluation, but was determined to be a green finding of very low safety significance however, not a violation of a regulatory requirement. (Section OA2)

B. Licensee Identified Violation

A violation of very low safety significance, which was identified by the licensee has been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This violation and corrective action tracking number is listed in Section 4OA7 of this report.

Report Details

SUMMARY OF PLANT STATUS

Ginna operated at full reactor power throughout the inspection period.

1. REACTOR SAFETY

Initiating Events, Mitigating Systems, and Barrier Integrity [Reactor - R]

R02 Evaluation of Changes, Tests, or Experiments

a. Inspection Scope

The inspectors reviewed three selected safety evaluations associated with initiating event and mitigating systems cornerstones (no safety evaluations associated with the barrier integrity cornerstone were available for review) to verify those changes to the facility or procedures as described in the Updated Final Safety Analysis Report were reviewed and documented in accordance with 10 CFR 50.59, and that the safety issues pertinent to the changes were properly resolved or adequately addressed. The safety evaluations were completed during the past two years, and were selected based on the safety significance of the changes and the risk to structures, systems and components.

The inspectors also reviewed 16 screen-out evaluations for changes, tests and experiments for which the licensee determined that safety evaluations were not required. This review was performed to verify that the licensee's threshold for performing safety evaluations was consistent with 10 CFR 50.59.

In addition, the inspectors reviewed the administrative procedure that was used to control the screening, preparation, and issuance of the safety evaluations to ensure that the procedure adequately covered the requirements of 10 CFR 50.59.

The listing of the safety evaluations and screen-out evaluations reviewed is provided in Attachment 1.

b. Findings

No findings of significance were identified.

R04 Equipment Alignment

a. Inspection Scope

The inspectors performed partial walkdowns of the following system trains while their redundant trains were out of service for maintenance.

- 4160 and 480-volt electrical systems
- "A and B" trains of the Standby Auxiliary Feedwater System

- "A and B" trains of the Residual Heat Removal system

These inspections verified that alignment of critical valves, and electrical breakers, was correct and as described in plant procedures, technical specifications, and drawings. Control room indications and controls were also verified to be appropriate for the standby or operating status of the system. During the walkdowns, the inspectors evaluated the material condition and general housekeeping of the systems and adjacent spaces. A sample of outstanding maintenance work requests was reviewed to ensure system operability was not adversely affected.

b. Findings

No findings of significance were identified.

R05 Fire Protection

a. Inspection Scope

The inspectors toured the following plant areas to assess RG&E's control of combustible materials and ignition sources, the physical condition of installed fire suppression and detection systems, and the adequacy of compensatory measures when required.

- Intermediate Building Basement
- Turbine Building Operating Floor
- Turbine Building Basement
- Air Handling Building
- Transformer Yard
- Cable Spreading Tunnel
- Auxiliary Building Intermediate Level
- Screenhouse

Additionally, the inspectors reviewed procedures SC-3; "Fire Emergency Plan," A-905; "Open Flame Welding and Grinding Permit," SC-3.2.11; "Immediate Action-Screenhouse Fire," and SC-3.1; "Fire Emergency General Information," to verify that the fire protection program was being implemented in accordance with the conditions stated within the procedures.

b. Findings

Introduction

Green. The inspectors identified a non-cited violation of technical specification 5.4.1.d; which requires, in part, that procedures be established, implemented and maintained covering the fire protection program.

Description

Ginna's screenhouse contains numerous items in one open area including the safety-related service water pumps, the diesel and electric fire main pumps, and the house heating boiler. Fuel for the station house heating boiler and several area heaters in the screenhouse is supplied by a four-inch natural gas line. If a fire occurred in the screenhouse that necessitated shutting off the natural gas supply, step 3.9 of procedure SC-3.2.11, "Immediate Action-Screenhouse Fire," directs the operators to close the header isolation valve which is located ". . . west of the screenhouse and North of the Service Building." When walking down this step of the procedure, the inspectors, with the assistance of the Ginna fire protection coordinator, could not locate the isolation valve. At the close of the inspection period, after conducting an extensive search of the exterior perimeter, RG&E identified the valve was located between two trailers that were positioned west of the screenhouse. Apparently the valve had been covered by several inches of gravel and asphalt pavement.

Analysis

The finding, associated with the Mitigating Systems Cornerstone, was determined to have a credible impact on safety due to its adverse impact on the fire brigade's ability to combat a fire in the screenhouse structure. However, in phase one of the SDP, the finding screened to Green since the screenhouse contains fire detection and suppression equipment, which would detect and control the spread of a fire, and the presence of other valves that could isolate the gas main.

Enforcement

The finding was also determined to be a violation of Technical Specification 5.4.1.d, which requires, in part, that written procedures be established, implemented and maintained for implementing the Fire Protection Program. By not correctly identifying the location of the gas isolation valve, RG&E failed to properly maintain procedure SC-3.2.11. However, because of the very low safety significance of this violation and because RG&E has entered the issue into their corrective action program (AR 2002-2042) this violation is being treated as a non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement policy. **(NCV 50-244/02-05-01)**

R07 Heat Sink Performance

a. Inspection Scope

Biennial Review

The inspectors reviewed RG&E's periodic maintenance, testing, and inspection records for the following safety-related heat exchangers to determine whether RG&E had reasonable assurance that the heat transfer capability for each heat exchanger would remain capable of meeting its design heat removal requirements during plant operations.

- "B" component cooling water (CCW) heat exchanger
- "B" emergency diesel generator jacket water and lube oil coolers
- "A and D" containment recirculation fan cooler.

The inspection comprised a review of RG&E's testing methodology including test frequency, conditions, and acceptance criteria. Test results were reviewed and compared to design criteria. Selected calculations of component performance data were also reviewed to verify that test results reflected heat exchanger design conditions. Heat exchanger inspection, cleaning, and maintenance records were reviewed and the as-found results were assessed against RG&E's frequency for inspection and cleaning. The as-left condition of the heat exchanger tubes were verified to be acceptable. The service water (SW) system reliability optimization program (SWSROP) was discussed with engineering personnel and a chemistry specialist. Heat exchanger performance trending was also assessed.

The inspector reviewed the documented condition of the screenhouse inlet bays, discharge canal, and intake structure as well as ongoing design changes for debris control and the intake structure heater design and bar spacing to minimize an ice buildup. A sample of action reports related to biofouling, intake structure ice formation, and circulating water chemical control was reviewed to verify that RG&E had provided or planned appropriate corrective action.

Annual Review

The inspectors reviewed performance of the PT-60.6A; "CCW Heat Exchanger Performance Test," and reviewed test data to verify that the heat exchangers listed below demonstrated the system's functional capability and operational readiness. The test method and results were discussed with the responsible system engineer. Heat exchanger tube plugging was verified within design limits.

- "A" component cooling water heat exchanger
- "A" emergency diesel generator jacket water and lube oil coolers

b. Findings

No findings of significance were identified.

R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed licensed operator requalification training on August 12, 2002. The evaluation observed was training scenario #ECA1112-10. The inspector reviewed the critical tasks associated with the evaluation, observed the operators' performance during the exercise, and observed the post evaluation critique. The inspector also reviewed and verified compliance with Ginna procedure OTG-2.2, "Simulator Examination Instructions."

b. Findings

No findings of significance were identified.

R12 Maintenance Effectiveness

a. Inspection Scope

The inspectors assessed the effectiveness of maintenance on plant systems to verify that: (1) failed structures, systems and components (SSCs) were properly characterized in the RG&E Maintenance Rule Monthly Reports, (2) goals and performance criteria were appropriate, (3) corrective action plans were appropriate, and (4) performance was being effectively monitored in accordance with RG&E procedures EP-2-P-0167, "Maintenance Rule Monitoring" and, EP-2-P-0168, "Maintenance Rule Scoping." The inspectors selected the following safety significant systems:

- System 66, Emergency Lighting Battery
- System 17C, Fire Doors

b. Findings

No findings of significance were identified

R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

The inspectors evaluated the effectiveness of RG&E's maintenance risk assessments required by paragraph a(4) of 10 CFR 50.65. This inspection included discussions with control room operators and scheduling department personnel regarding the use of RG&E's online risk monitoring software. The inspectors reviewed equipment tracking documentation, daily work schedules, and performed plant tours to gain reasonable assurance that actual plant configuration matched the assessed configuration. Additionally, the inspectors verified that RG&E's risk management actions, for both planned and/or emergent work, were consistent with those described in procedure IP-PSH-2, "Integrated Work Schedule Risk Management." Risk assessments for the following out of service systems, structures, and/or components were reviewed.

- Unplanned maintenance on July 31, 2002, to replace a blown fuse in the power supply for channel one of the reactor protection system.

- Planned maintenance on August 12, 2002, to perform preventive maintenance on the 12A station service transformer.

- Unplanned maintenance on the "B" diesel generator output breaker for Bus 17 following an unexpected trip of the breaker on August 6, 2002.

- A diesel generator surveillance test conducted on September 3, 2002, during a period when high winds were predicted for the Ginna site.

- Planned maintenance on July 15, 2002, for the nuclear instrumentation N-38 drawer, the residual heat removal system, the auxiliary feedwater system, and unplanned trouble shooting for the main turbine electro-hydraulic control system.

b. Findings

No findings of significance were identified.

R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed the following operability evaluations to determine if RG&E had adequately justified operability.

- AR 2001-0890, AOV Deficiencies. This AR identified an inspector discovery that under certain conditions, two air operated valves in the auxiliary feedwater system, AOVs 4297 and 4298 would not fail open in the event actuating air was lost to the valves. The engineering technical evaluation attached to AR 2001-0890 was reviewed to determine why the failure was not detected during IST activities, and to verify adequate corrective action had been implemented.

- AR 2001-1468, Investigation of Ginna's Containment Structure's Tendon System Grease Leakage. This AR documented the results of an RG&E discovery that grease was leaking from the containment tendons. The engineering technical evaluation was reviewed to verify RG&E had implemented adequate corrective action to monitor level of grease in the containment tendons.

- WO 20202, Vital Battery Monitor "B." This work order was initiated to bypass spurious control room alarms that were occurring on the "B" vital battery monitor. The inspectors reviewed the work instructions that disabled the control room annunciator and verified the instructions were adequate to perform the activity.

- AR 2002-2055, Water on top of "B" Condensate Storage Tank Diaphragm. This AR documented a licensee discovery that water had collected on top of the rubber diaphragm located in the "B" Condensate Water Storage Tank, which is an indication that the internal tank diaphragm had failed. RG&E had examined the tank in response to a recent industry event, where a diaphragm failure rendered an auxiliary feedwater pump inoperable. The inspector reviewed an engineering evaluation that evaluated the condition to verify adequate compensatory action was implemented, and the safety significance of the discovery had been adequately assessed.

This inspection included discussion with plant personnel and reviews of applicable technical specifications and design bases information.

b. Findings

No findings of significance were identified.

R16 Operator Workarounds

a. Inspection Scope

The inspectors reviewed the cumulative effects of Ginna's existing operator workarounds/challenges, control room deficiencies, and degraded but operable equipment. The inspection focused on the overall impact to plant systems and operator event response capability. Ginna procedure A-52.16, "Operator Workaround/Challenge Control," technical specifications, system design information, and corrective action program records were referenced. The inspectors also looked for potential operator workarounds/challenges not formally evaluated by RG&E.

b. Findings

No findings of significance were identified.

R17 Permanent Plant Modifications

a. Inspection Scope

Biennial Inspection

The inspectors selected and reviewed ten risk-significant plant modification packages and two set point change packages to verify that: (1) the design bases, licensing bases, and performance capability of risk significant Structures, Systems or Components had not been degraded through modifications and set point changes; and, (2) modifications and set point changes performed during increased risk configurations did not place the plant in an unsafe condition. The modification and set point change packages were selected from among the design changes that were closed within the past two years.

The plant modifications and set point changes were distributed among initiating event, mitigating system, and barrier integrity cornerstones. For these modifications and set point changes, to determine design adequacy, the inspectors reviewed the design inputs, assumptions, and design calculations, such as an instrument set point, instrument uncertainty, and electrical loading calculations. The inspectors also reviewed field change notices that were issued during the installation to confirm that the problems associated with the installation were adequately resolved. In addition, the inspectors reviewed the post-modification testing, functional testing, and instrument calibration records to determine readiness for operations. Finally, the inspectors reviewed the affected procedures, drawings, design basis documents, and Updated Final Safety Analysis Report sections to verify that the affected documents were appropriately updated.

For the accessible components associated with the modifications, the inspectors also walked-down the systems to detect possible abnormal installation conditions.

The listing of the reviewed modifications and set point changes is provided in Attachment 1.

Annual Inspection

The inspectors reviewed SM-2000-042.1, Modification of Containment Narrow Range Pressure Transmitter Loop 944.

b. Findings

No findings of significance were identified.

R19 Post Maintenance Testing

a. Inspection Scope

The inspectors reviewed the post maintenance tests for the following work orders (WO) to verify that RG&E appropriately demonstrated the components' ability to perform their intended safety function.

- WO 20101892, installation of a new quick disconnect on penetration 305D. Tested per PTT-23; "Containment Isolation Valve Leak Rate Testing,"
- WO 20103993, periodic lubrication of service water system valves. Tested per PT-2.3; "Safeguard Power Operated Valve Isolation."
- WO 20103246, replace an N-38 drawer lower section defeat selector switch.
- WO 20202331, troubleshoot the G auxiliary building fan.
- AR 2002-2110, "Smoke Detector Z37D3E Failed Sensitivity Test. Tested per PT-13.11.8, "Testing of Smoke Detector Zone Z-37 Intermediate Building North."
- WO 20100679, perform PM Inspection on "A" Component Cooling Water Pump Breaker (52/CCP1A).

b. Findings

No findings of significance were identified

R22 Surveillance Testing

a. Inspection Scope

The inspectors witnessed the performance and/or reviewed test data for the following activities to verify that the tests met the requirements of the plant technical specifications, and demonstrated the associated system's functional capability, and operational readiness. The inspectors reviewed samples of prior test performance results on the selected equipment to verify that degraded or non-conforming conditions were identified and corrected.

- CPI-FLO-2015A, "Calibration of the Turbine Driven Auxiliary Feedwater Pump Discharge Flow Loop 2015A."
- PT-36Q-C, "Standby Auxiliary Feedwater Pump C - Quarterly."
- PT-12.1, "Emergency Diesel Generator A."
- PT-12.2, "Emergency Diesel Generator B."
- PT-2.8Q, "Component Cooling Water Quarterly Test."
- CPI-SP1-405.10, "Calibration of Delta T Set point 1 Over temperature Channel 1," performed on July 29 and August 20, 2002.
- CPI-SP1-408.10, "Calibration of Delta T Set point 1 Over temperature Channel 4," performed on February 16 and August 21, 2002.

b. Findings

OTDT Calibration Errors

Introduction

Green. The inspectors identified RG&E failed to provide and follow appropriate instructions for the calibration of the OTDT lead-lag circuit as required by 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings.

Description

During the weekly computer checks on August 16 the on-shift control room foreman discovered computer point OT405DEV was set to "Alarm Processing set off." When the point was enabled, repeated alarm activations occurred. This condition was documented in (AR 02-1877). Re-calibration of channel 1, to resolve what was suspected to be a noisy channel input, identified the lead-lag circuit had been improperly set. A check on August 20th of the remaining three channels, an identified channel 4's lead-lag circuit had also been mis-calibrated. Channels 1 and 4 were last calibrated on July 29 and February 16, 2002, respectively.

A proper calibration of the OTDT lead-lag module requires strip-chart data be properly obtained and correctly interpreted. The shape of the lead-lag output curve, shown to be highly dependent on the setting of the test equipment's ramp generator time dial, must be proper to obtain valid results from the data analysis. Because the surveillance test equipment was not properly set up, data plots obtained during the February and July calibrations of channels 1 and 4 were invalid, though not recognized as such. Though

data analysis appeared to show the channels within TS requirements, they in fact were out of specification in a conservative direction by approximately 20 and 5 seconds respectively.

Review of the applicable calibration procedures identified that inadequate guidance existed to ensure that valid data would be obtained. In addition, deficient and outdated instructions were found present. The inspectors determined the technicians lack of procedural adherence and their acceptance of the deficient procedure during this and prior calibrations contributed to the error.

Analysis

This finding affected the Mitigating System Cornerstone and was determined to be more than minor in accordance with MC 0612, Appendix E because improper calibration of reactor protection circuitry could cause an unnecessary plant transient. However, the error was conservative and did not cause a loss of safety function and therefore screened as Green when evaluated in accordance with the SDP, MC-0609.

Enforcement

The finding was determined to be a violation of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, which requires in part that activities affecting quality be prescribed and accomplished in accordance with appropriate procedures. RG&E failed to provide and follow appropriate instructions for the calibration of the OTDT lead-lag circuit. However, because of the very low safety significance of this violation and because RG&E has entered the issue into their corrective action program (AR 2002-1877) this violation is being treated as a non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement policy. **(NCV 50-244/02-05-02)**

Improper EDG Output Breaker Operation

Introduction

Green. Operator error during performance of surveillance test PT-12.2, "Emergency Diesel Generator B," resulted in the "B" diesel generator being rendered inoperable for approximately seven hours. The finding was determined to be of very low safety significance.

Description

On August 6, 2002, during the performance of PT-12.2 "Emergency Diesel Generator B," the output breaker for the "B" diesel generator tripped when a control room operator attempted to parallel the diesel generator to bus 17. An RG&E review of the event concluded the breaker tripped because the operator had attempted to close the breaker when the diesel's electrical output was not in a phase with bus 17. This action caused a high current to occur across the electrical contacts of the breaker, which resulted in the breaker trip. As a result of this event, the diesel was rendered inoperable for approximately seven hours while troubleshooting was conducted on the diesel generator

breaker for bus 17. The diesel generator was restored to service when a spare breaker was installed in bus 17, and PT-12.2 was successfully completed.

The out of phase condition occurred when the operator was attempting to complete step 6.14 of PT-12.2 which states, in part, "With the synchroscope rotating slowly in the FAST (clockwise) direction and approaching the 12 o'clock position, close the Diesel Generator supply breaker to the selected bus, such that the breaker closes at the approximate point of synchronization." When executing this step, the operator attempted to close the breaker when it was approximately five minutes before the 12 o'clock position. This action was premature, which resulted in the breaker tripping.

Analysis

This finding affected the Mitigating Systems Cornerstone and had a credible impact on safety because it resulted in a risk significant component being rendered inoperable for seven hours. The finding screened to Green in phase one of the SDP, Manual Chapter 0609, Appendix A, because the diesel was quickly returned to service following the breaker trip, and the remaining diesel generator and both offsite power sources were operable.

Enforcement

No violation of regulatory requirements occurred.

Emergency Preparedness [EP]

EP4 Emergency Action Level and Emergency Plan Changes

a. Inspection Scope

The inspector conducted an in-office review of RG&E submitted changes for the emergency plan-related documents to determine if the changes decreased the effectiveness of the plan. A thorough review was conducted of documents related to the risk significant planning standards (RSPS), such as classifications, notifications and protective action recommendations. A cursory review was conducted for non-RSPS documents. These changes were reviewed against 10 CFR 50.54(q) to ensure that the changes did not decrease the effectiveness of the plan, and that the changes as made continue to meet the standards of 10 CFR 50.47(b) and the requirements of Appendix E. These changes are subject to future inspections to ensure that the impact of the changes continues to meet NRC regulations. The submitted and reviewed implementing procedures are listed in attachment one.

b. Findings

No findings of significance were identified.

EP6 Drill Evaluation

a. Inspection Scope

On August 12, 2002, the inspector observed a licensed operator training assessment that included an emergency activation level classification. Training scenario #ECA1112-10 was observed. The inspector verified that the appropriate emergency classification was identified and external notifications to responsible parties were simulated in a timely manner.

b. Findings

No findings of significance were identified.

2. RADIATION SAFETY

Occupation Radiation Safety [OS]

OS3 Radiation Monitoring Instrumentation

a. Inspection Scope

During the period July 22 - 25, 2002, the inspector conducted the following activities to evaluate the operability and accuracy of radiation monitoring instrumentation, and the adequacy of the respiratory protection program, relative to maintaining and issuing self-contained breathing apparatus (SCBA). Implementation of these programs was reviewed against the criteria contained in 10 CFR 20, applicable industry standards, and the licensee's procedures.

- The inspector observed technicians performing radioactive source and functional checks on a variety of instruments including the whole body counter, portable survey instruments (RO-20), and contamination survey instruments (SAM-9, MS-3, RM-14). The inspector observed technicians calibrating a high range gamma survey meter (Xetec 330A Telescan).

- The inspector reviewed the calibration records for selected electronic dosimeters, three gas flow proportional counters (Tennelec S5E), and area radiation monitors (R-02, R-04, and R-09).

- The inspector reviewed the maintenance records, safety interlock checks, and current calibration source activity/dose rate determinations for the Shepard Model 89, Model 28, and Model 142-10 instrument calibrators.

- The inspector evaluated the adequacy of the respiratory protection program regarding the maintenance and issuance of self-contained breathing apparatus (SCBA). Training and qualification records for licensed operators, radiation protection technicians, and fire brigade members required to wear SCBA's in the event of an emergency were reviewed. Four (4) SCBA's, staged for use in the control room and at the Health Physics control point, were physically/functionally checked, and maintenance records for these SCBA's were reviewed.

- The inspector evaluated the licensee's program for assuring quality in the radiation monitoring instrumentation and respiratory protection programs by reviewing a departmental self-assessment (SA 2001-0012), Management Observation of Training Reports for SCBA training, and fourteen (14) ACTION reports related to radiation instrumentation, SCBA's, and the monitoring of plant radiation levels to determine if problems were identified in a timely manner and appropriate corrective actions were taken to resolve the related issues.

b. Findings

No findings of significance were identified.

3. SAFEGUARDS

Physical Protection [PP]

PP3 Response to Contingency Events

a. Inspection Scope

The Office of Homeland Security (OHS) developed a Homeland Security Advisory System (HSAS) to disseminate information regarding the risk of terrorist attacks. The HSAS implements five color-coded threat conditions with a description of corresponding actions at each level. NRC Regulatory Information Summary (RIS) 2002-12a, dated August 19, 2002, "NRC Threat Advisory and Protective Measures System," discusses the HSAS and provides additional information on protective measures to licensees.

On September 10, 2002, the NRC issued a Safeguards Advisory to reactor licensees to implement the protective measures described in RIS 2002-12a in response to the Federal government's declaration of threat level "orange." Subsequently, on September 24, 2002, the OHS downgraded the national security threat condition to "yellow" and a corresponding reduction in the risk of a terrorist threat.

The inspectors interviewed RG&E personnel and security staff, observed the conduct of security operations, and assessed RG&E's implementation of the threat level "orange" protective measures. Inspection results were communicated to the region and headquarters security staff for further evaluation.

b. Findings

No findings of significance were identified.

PP4 Security Plan Changes

a. Inspection Scope

An in-office review was conducted of changes to the Physical Security Plan, identified as Revision U, submitted to the NRC on January 31, 2002, in accordance with the provisions of 10 CFR 50.54(p). The review was conducted to confirm that the changes were made in accordance with 10 CFR 50.54(p), and did not decrease the effectiveness of the plan.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES [OA]

OA1 Performance Indicator Verification

a. Inspection Scope

The inspector reviewed implementation of the Occupational Exposure Control Effectiveness Performance Indicator (PI) Program. Specifically, the inspector reviewed Action Reports, and associated documents, for occurrences involving locked high radiation areas, very high radiation areas, and unplanned personnel exposures since the last inspection against the criteria specified in Nuclear Energy Institute (NEI) 99-02, Regulatory Assessment Performance Indicator Guideline, Revision 2, to verify that all occurrences that met the NEI criteria were identified and reported as Performance Indicators.

Accuracy of the safety system functional failure PI data for the period August 2001 to September 2002 was verified based on review of RG&E event reports.

The inspectors also verified the completeness and accuracy of the safety system unavailability PI for the emergency alternating current (AC) power system for the second and fourth quarter of 2001 and second quarter of 2002. The inspection was accomplished by discussion with plant personnel and review of unavailability tracking documentation, operator logs, action reports, work orders, and surveillance procedures. The inspector verified that an identified reporting error (AR 2002-2232) did not create a threshold change in the PI. Correction of the error is not necessary as the affected quarter will be dropped in the forthcoming submittal.

b. Findings

No findings of significance were identified.

OA2 Identification and Resolution of Problems

a. Inspection Scope

To evaluate RG&E's program for identifying and resolving problems, the inspectors reviewed various action reports during the course of this inspection that involved the mitigating system, and initiating event cornerstones.

b. Findings

Introduction

Green. The inspectors identified that RG&E's prior corrective action for inadequate operator response to primary plant computer system (PPCS) alarms were not fully effective.

Description

On July 31 at approximately 1:09 A.M., the control room foreman defeated the primary plant computer system's (PPCS) alarm point OT405DEV in response to repeated activations that he thought was due to maintenance. The alarming condition was not investigated nor documented on an Action Report and resulted in a missed opportunity to identify the improperly calibrated OTDT channels sooner (see section R22).

The PPCS alarm point remained defeated until identified during the weekly PPCS alarm check performed on August 16, per O-6.11, "Surveillance Requirement/Routine Operations Check Sheet." The failure to identify and question the defeated alarm during the prior weekly check on August 6, comprised a second missed opportunity. Upon restoration, the alarm continued to activate and Action report 2002-1877 was generated leading to the ultimate discovery that the OTDT lead-lag circuits for channels 1 and 4 had been improperly calibrated.

On March 11, 2002, Action Report 2002-0454 was issued in response to the operators failure to identify that the 11B under voltage relays had tripped. A PPCS alarm had indicated the failure but was felt to be invalid based on a visual inspection of the relays. The alarm was valid, but the visual inspection was not. The operations manager counseled the operators to regard all PPCS alarms with the same intensity and rigor as would be given a main control board alarm.

On October 16, 2001, Action Report 2001-1805, identified that a loss of the ATWAS Mitigation System and Circuitry had not been identified as a result of the accompanying PPCS alarms significance not being understood or investigated. A long term action to evaluate the nomenclature of the PPCS alarms and discussions with the operating shifts on expectations and maintaining a questioning attitude was the stated corrective action.

Analysis

This issue was considered greater than minor since inadequate or poor response to primary plant computer alarms could be reasonably viewed a precursor to a significant event or, if left uncorrected, could become a more significant safety concern. The finding is not suitable for SDP evaluation, but has been reviewed by NRC management and determined to be a green finding of very low safety significance, however, not a violation of a regulatory requirement.

Enforcement

No violation of regulatory requirements occurred.

OA6 Meetings

a. Exit Meeting Summary

On October 8, 2002, the inspectors presented their overall findings to members of RG&E management led by Joe Widay. RG&E management acknowledged the findings presented. No proprietary information was identified.

c. RG&E/NRC Management Meeting

On August 19, 2002, Mr. Miller, Administrator NRC Region 1 and Ms. Evans, Chief, Reactor Projects Branch 1, conducted a tour of the Ginna facility and met with senior plant managers and station personnel.

On August 20, 2002, NRC Chairman Richard Meserve, accompanied by Mr. Miller, conducted a tour of the Ginna facility and met with senior plant managers and station personnel.

OA7 Licensee-identified Violation

a. Inspection Scope

The following violation of very low safety significance (Green) was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a Non-Cited Violation (NCV):

The licensee conducted a site wide survey to identify contaminated tools and other equipment that were improperly surveyed prior to being removed from radiologically controlled areas (RCA) for storage at other site locations. The results of this survey identified items that were not properly surveyed prior to removal from the RCA, as described in the corrective action program Action Report 2001-2107. Failure to make proper surveys prior to removal of equipment from the RCA is contrary to 10 CFR 20.1501. Since the contaminated equipment was promptly returned to the RCA and no material was released into the public domain, this violation is of very low safety significance and is being treated as a non-cited violation.

Attachment 1

Supplemental Information

a. Key Points of Contact

RG&E

G. Ball	Technician, Respiratory Protection
P. Bamford	Operations Manager
J. Bement	Foreman, Radiation Protection Operations
K. Cona	System Engineer, Radiation Monitoring Instrumentation
M. Flaherty	Nuclear Safety and Licensing Manager
K. Gould	Senior Health Physicist
N. Leoni	Quality Assessment Coordinator, Radiation Protection
F. Mis	Chemistry Manager
P. Perry	Systems Engineer, Radwaste
P. Polfleit	Corporate Emergency Planner
R. Popp	Production Superintendent
J. Smith	Maintenance Superintendent
J. St. Martin	Licensing Engineer
W. Thomson	Manager, Radiation Protection
R. Watts	Nuclear Training Department Manager
J. Wayland	I&C/Electrical Maintenance Manager
T. White	Balance of Plant Engineering Manager
J. Widay	VP, Plant Manager
B. Wood	Technician, Radiation Instrument Calibration

b. List of Items Opened, Closed, and Discussed

Opened

NCV 50-244/02-05-01,	(Green) RG&E failed to maintain the procedure that described the steps for combating a fire in the screenhouse as required by technical specification 5.4.1.d.
NCV 50-244/02-05-02,	(Green) RG&E failed to provide and follow appropriate instructions for the calibration of the OTDT lead-lag circuit as required by 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings.

c. List of Documents Reviewed

O-6.13, Daily Surveillance Log
RP-RES-M-RESP, Rev 4, Maintenance and Care of Respirators
RPA-RES-GEN, Rev 5, Use of Respiratory Protection Equipment - General Requirements
SC-3.16.15.1, Rev 9, Charging of 4.5 Units Using the Breathing Air Compressor
CPI-MON-R2/R9, Rev 18, Calibration of Area Monitor Radiation Monitoring System Channels R-2 through R-9
PT-17.1, Rev 45, Area Radiation Monitors - R1 to R9
RP-INS-C-TELESCAN, Rev1, Calibration of Xetec Model 330A Telescan
RP-JC-PCM-SRC-CHKS, Rev 1, Quality Control of Eberline PCM
RP-INS-C-SAM, Rev 0, Calibration of the N. E. Technology Small Article Monitor
RP-JC-SAM, Rev 0, Operation of the N. E. Technology Small Article Monitor
RP-JC-PCM-SRC-CHKS, Rev 1, Quality Control of Eberline PCM
RP-JC-AIRSAMPLE, Rev 9, Operation of Portable Air Sampling Equipment
RP-INS-O-MODEL89, Rev 2, Shepard Model 89 Calibrator Operation
RP-SUR-SOURCE-USE, Rev 3, Radioactive Source Use
RP-JC-DAILY-SRC-CHKS, Rev 14, Daily Instrument Source Checks
RP-INS-C-RAD51, Rev 5, Calibration of RADOS Electronic Dosimeter PT-2.8Q, Component Cooling Water Pump Quarterly Test
A-905, Open Flame, Welding and Grinding Permit
PT-12.1, Emergency Diesel Generator "A"
SC-3.2.11, Immediate Action- Screenhouse Fire
SC-3.15.17, TRM Firewatch Posting
IP-PSH-2, Integrated Work Schedule Risk Management
IP-REL-5, 10 CFR 50.65(a)4 Program
PT-2.7.1, Service Water Pumps
PT-2.3 Safeguard Power Operated Valve Operation
A-52.16, Operator Work Around Challenge Control
SM-2000-042.1, Modification of Containment Narrow Range Pressure Transmitter Loop 944
A-25.7, Bypass of I&C/Electrical Function and Jumper Control on out of Service Equipment
PT-13.11.8, Testing of Smoke Detection Zone Z-37 Intermediate Building - North
Service Water System Reliability Optimization Program (SWSROP) (Rev. 4)
Spring 2002 Outage Report, "Underwater Inspection of Intake Structure and Screen house Mechanical Equipment."
RG&E Report No. B-13-387, "Rochester Gas & Zebral Mussel Control Program for Ginna Station 2001
PT-60.6A, (Rev 2), CCW Heat Exchanger Performance Test
Performance Monitoring Data Trending Reports A & D CRFCs
DA-ME-2002-028 (Rev 0), CCW Heat Exchanger A & B Thermal Performance Testing Data Reduction, Fouling, and Uncertainty Analysis (Test Date 3/18/2002).
DA-ME-97-016 (Rev. 0), CCW and RHR Heat Exchanger Performance Evaluation
SWSROP (GL 89-13) Heat Exchanger Testing Generic Assumptions, Data Reduction and Methodology, and Fouling Determination
DA-ME-2000-074 (Rev 0), Component Cooling Water Heat Exchanger A & B Thermal Performance Testing Data Reduction, Fouling, and Uncertainty Analysis.

O-6.13, Daily Surveillance Log
W.O. 20101393, CNMT Recirc Fan Cooling Coil C Open/Inspect for Fouling
W.O. 20101394, CNMT Recirc Fan Cooling Coil D Open/Inspect for Fouling.
CMP-10-07-RECIRCFANC (Rev.01), Mario, Model 12Q, Cooling Coil Inspection and Maintenance for ACA01c, ACA01J, and ACA01K.
CMP-10-07-RECIRCFAND (Rev.01), Mario, Model 12Q, Cooling Coil Inspection and Maintenance for ACA01C, ACA01J, and ACA01K.
W.O. 20100875, EDG A Clean/Inspect Jacket Water / Lube Oil Coolers
W.O. 20100876, EDG B Clean/Inspect Jacket Water/ Lube Oil Coolers
CMP-10-04EAC01B (Rev. 02), Atlas Industrial Manufacturing, Type NEN Heat Exchanger Maintenance for EACO1B.
CMP-10-04EAC01B (Rev. 02), Atlas Industrial Manufacturing, Type NEN Heat Exchanger Maintenance for EACO1B.
CMP-10-03-ESW09A(Rev. 02), American Standard, Model 1205CP Heat Exchanger Maintenance for ESW09A.
CMP-10-03-ESW08A (Rev. 02), American Standard, Model 1205-6, CP Heat Exchanger Maintenance for ESW08A.
CMP-10-03-ESW09B (Rev. 01), American Standard, Model 1206, CP Heat Exchanger Maintenance for ESW09B.
CMP-10-03-ESW08B (Rev. 01), American Standard, Model 1205-6, CP Heat Exchanger Maintenance for ESW08B.
W.O. 20100493, CCW A Heat Exchanger Clean/Inspect & Perform Eddy Current Testing
W.O. 20100913, CCW B Heat Exchanger Clean/Inspect & Perform Eddy Current Testing
EPIP 1-5, Notifications, Rev 50
EPIP 1-6, Site Evacuation, Rev 14
EPIP 1-10, Operation Support Center (OSC) Activation, Rev 11
EPIP 1-11, Survey Center Activation, Rev 27
EPIP 1-18, Discretionary Actions for Emergency Conditions, Rev 4, 5
EPIP 2-7, Management of Emergency Survey Teams, Rev 11
EPIP 2-9, Administration of Potassium Iodine (KI), Rev 6
EPIP 2-10, In Plant Radiation Surveys, Rev 4
EPIP 3-1, Emergency Operation Facility (EOF) Activation, Rev 18
EPIP 3-2, Engineering Support Center Activation (ESC), Rev 10
EPIP 5-1, Offsite Emergency Response Facilities and Equipment Periodic Inventory Check and Tests, Rev 26
EPIP 5-2, Onsite Emergency Response Facilities and Equipment Periodic Inventory Check and Tests, Rev 28, 29
EPIP 5-7, Emergency Organization, Rev 38

<u>Calibration Records</u>

Shepard Model 142-10 Calibration
Shepard Model 28 Calibration
Shepard Model 89 Calibration
Xetec Model 330A Telescan
Tennelec S5E (Serial No. 76672)
Tennelec S5E (Serial No. 75331)

Tennelec S5E (Serial No. LB5100-W)
Whole Body Counter (Fastscan) Calibration
Electronic Dosimeter Calibration (Serial Nos. 991726, 991731, 992064)
Area Monitor, Containment, R-2
Area Monitor, Charging Pump Room, R-4
Area Monitor, Letdown Line, R-9
Eight (8) Management Observation of Training Records - SCBA training
Mask Qualification List
Control Room Staffing List for July 24, 2002

Modifications

PCR 2001-0016	SI Pump Discharge Check Valves 878G & 878J Replacement, Revision 0
PCR 99-010	Replace Relieve Valves 9709A and 9709B with a New Style Crosby Relieve Valve, Revision 0
PCR 98-046	Raise Set Pressure of RV 887, Revision 0
PCR 2000-0024	CR HVAC Replacement - Rev. 0 is Electrical 2002 Outage Scope DC Control, Revision 0
PCR 2000-0033	Replacement of Stop-Check Valve 9633A and 9633B with a Globe Stop Valve, Revision 0
PCR 2001-0024	Control Rod Drive Cabinet Cooling Modification, Revision 0
PCR 2002-0006	MCC "C" Molded Case Circuit Breaker Replacements - 2002 Outage, Revision 0
PCR 2002-0008	Instrument Buses A, B, and C Replacement, Revision 0
PCR 2002-0010	Power Supply Connection at MOV 515, Revision 0
PCR 99-045	Convert Delta T Voltage Loop to A Current Loop, Revision 0

Setpoint Change Packages

SPCR 2002-0008	Secure One RHR Pump When Flow Less Than 1200 gpm, Revision 0
SPCR 2002-0012	Anticipatory Manual Reactor Trip at 20% Steam Generator Level with Steam Flow Greater than Feedwater Flow, Revision 0

10 CFR 50.59 Safety Evaluations

SE-2002-0001	SI Pump Discharge Check Valves 878G & 878J Replacement, Revision 0
SE-2001-0004	Control Rod Drive Cabinet Cooling Modification, Revision 0
SE-2001-0005	Pneumatic Controls Modification to Allow Fresh Air into Control Room, Revision 0.

10 CFR 50.59 Screen-out Evaluations

2001-0156	SI Pump Discharge Check Valves 878G & 878J Replacement, Revision 1
2002-0239	System Flow Below Which Two RHR Pumps Should Not Be Operated With the Discharge Crosstie Valve Open, Revision 0
99-010	Replace Relieve Valves 9709A and 9709B with a New Style Crosby Relieve Valve, Revision 0
98-046	Raise Set Pressure of RV 887, Revision 1
20011-0206	Instrument Buses A, B, and C Replacement, Revision 0
2002-0290	Power Supply Connection at MOV 515, Revision 0
99-045	Convert Delta T Voltage Loop to A Current Loop, Revision 0
2001-0151	Containment Spray Jumper Installation for Use During a Loss of MQ-483
2001-0030	Control Rod Drive Cabinet Fans, Revision 0
2001-0208	Control Rod Drive Cabinet Cooling Modification, Revision 0
2001-0266	Control Room HVAC - Install 2 New Trains of CREATS & Emergency Cooling, Revision 0
2002-0070	Add Attachment 7 to PCR 2001-0024, Revision 0, Basis for Control Rod Cabinet High Temperature Alarm Setpoint
2002-0160	MCCC Molded Case Circuit Breaker Replacements - 2002 Outage, Revision 0
2002-0310	Install Light Behind Control Rod Drive Cabinet
2002-0335	Air Distribution Inside Rod Control Cabinets
No unique number	Replacement of Stop-Check Valve 9633A and 9633B with a Globe Stop Valve, Revision 0

Self-Assessments

SA 2001-0016	Change Impact Evaluation Form (CIE) Usage
SA 2001-0035	Design Process Review of PCR 2000-0019 Revision 1
SA 2002-0001	Implementation of the Revised 10 CFR 50.59 Rule Requirements.
AINT-2000-0010-TJD	Radwaste Shipping /Process Control Program Audit, February 9, 2001
SA 2001-0012	Assessment of RP Instrumentation Program for Equipment Upgrades

Action Reports

AR 2000-1222	Changes to Facility SSCs That May Impact Permits, Need to be implemented into the PCR Process
AR 2001-0686	Unexpected MCB Alarms received during holding of Protection Channel 2 for PCR 99-045
AR 2001-1297	Inadequate Procedural Guidance Following R-15A Modification
AR 2002-0771	50.59 Applicability Determination Enhancements
AR 2001-0642	Received Alarm C-30 While Inserting Rods in Manual

AR 2001-0651	Fire Door 37 Opened as a Compensatory Action for Control Rod Cabinets without a 50.59 Evaluation *[related to PCR 2001-0024]*
AR 2001-1585	UFSAR Not Completely Updated Following MRPI Modification
AR 2001-1642	Attention to Detail Deficiencies Associated with Plant Modifications
AR 2002-0286	Operations Procedures Implemented Prior to PCR
AR 2002-1146	Received MCB Alarm C-30 Urgent Failure Rod Stop, from Rod Control Cabinet 1BD
AR 2002-2155	Level of 50.59 Review for PCR 98-046 Questioned
AR 2002-2156	Control Room Turnover Sheet Wording, Associated with PCR 2001-0024
AR 2002-2157	Procedure Updating Issues Associated with PCR 2001-0024
AR 2001-0609	Found Monitor Tank a Level Control Pressure Switch inoperable during Performance of PCR 2000-0026
AR 2002-0093	Error in Equipment Specification in PCR
AR 2001-1640	PCR 2000-0019, For MSIV Bypass Valves, Processing Deficiencies
AR 2001-1929	Compensatory Measure Implemented without 50.59 review
AR 2002-2042	Screenhouse Natural Gas Isolation Valve Location Indeterminate
AR 2002-1762	NUS Alarm Bistables Continually Blow Fuse During Calibration
AR 2002-1809	"B" D/G Bus 17 Supply Breaker Overcurrent Trip
AR 2002-1997	Damper Not Responding to Trip Signal AAD14
AR 2002-2044	Water on top of "B" Condensate Storage Tank Diaphragm
AR 2002-2110	Z37D3E Failed Sensitivity Test

Procedures

IP-DES-2	Plant Change Process, Revision 16
IP-DES-4	Setpoint Change Process, Revision 2
IP-SEV-1	Preparation, Review, & Approval of 50.59 Applicability Determinations and 50.59 Screens, Revision 9
IP-SEV-2	Preparation, Review, & Approval of 50.59 Evaluations, Revision 11
IP-LPC-7	Updated Final Safety Analysis Report Periodic & Continuous Updating, Revision 2