UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
2100 RENAISSANCE BLVD., SUITE 100
KING OF PRUSSIA, PA 19406-2713

February 4, 2015

EA-14-235
EA-15-004

Mr. Joseph E. Pacher
Site Vice President
R.E. Ginna Nuclear Power Plant, LLC
Exelon Generation Company, LLC
1503 Lake Road
Ontario, NY 14519

SUBJECT: R.E. GINNA NUCLEAR POWER PLANT, LLC - NRC INTEGRATED INSPECTION REPORT 05000244/2014005, PRELIMINARY SEVERITY LEVEL III FINDINGS, AND EXERCISE OF ENFORCEMENT DISCRETION

Dear Mr. Pacher:

On December 31, 2014, the United States Nuclear Regulatory Commission (NRC) completed an inspection at your R.E. Ginna Nuclear Power Plant, LLC (Ginna). The enclosed inspection report documents the inspection results, which were discussed on January 14, 2014, with you and other members of your staff.

The 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 license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, two related apparent violations (AVs) of NRC requirements were identified that are being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC's Web site at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html.

The AVs are related to Ginna providing information to the NRC pertaining to (1) Ginna submitting an operator's license application to the NRC that was not complete and accurate in all material respects and was the basis for the NRC making an incorrect regulatory decision; and (2) Ginna not notifying the NRC within 30 days of a change in the operator's medical condition and requesting a conditon be placed on the same operator's license upon identification of a known potentially disqualifying medical condition during licensed operator requalification reviews. These AVs, preliminarily determined to be Severity Level III, are described in detail in the enclosed report. The NRC notes that, upon identifiying the issue, Exelon Generation Company, LLC (Exelon) took the appropriate immediate corrective action of informing the NRC and requesting the license condition, such that the AVs do not represent an immediate safety concern. On August 28, 2014, the NRC issued a license amendment with the new restriction for the operator which restored full compliance for both AVs.

The circumstances surrounding the AVs, the significance of the issue, and the need for lasting and effective corrective action were discussed with members of your staff at an inspection exit meeting on January 14, 2015. As a result, the NRC does not require a pre-decisional enforcement conference (PEC) in order to make an enforcement decision. In addition, since Exelon identified the AVs and based on our understanding of your corrective actions, a civil penalty may not be warranted in this case, in accordance with Section 2.3.4 of the Enforcement Policy.

Before the NRC makes its enforcement decision, we are providing you an opportunity to provide your perspective on this matter, including the significance, cause, and corrective actions, as well as any other information that you believe the NRC should take into consideration by: (1) requesting a PEC to meet with the NRC and provide your views in person; (2) responding to the AVs in writing; or (3) accepting the violations as characterized in this letter and the inspection report (in which case the NRC will proceed with its enforcement decision). Please contact Dan Schroeder, Chief, Projects Branch 1, Division of Reactor Projects, Region I, NRC, at 610-337-5262 within 10 days of the date of this letter with your decision on whether you are interested in attending a PEC, providing a written response, or accepting the violations.

If you choose to request a PEC, the meeting should be held in our office in King of Prussia, PA, within 30 days of the date of this letter. The PEC will afford you the opportunity to provide your perspective on the AVs and any other information that you believe the NRC should take into consideration before making an enforcement decision. The topics discussed during the conference may include the following: information to determine whether any violations occurred, information to determine the significance of any violations, information related to the identification of any violations, and information related to any corrective actions taken or planned to be taken. If a PEC is held, it will be open for public observation and the NRC will issue a press release to announce the conference time and date.

If you choose to provide a written response, it should be sent to the NRC within 30 days of the date of this letter. Your response may reference or include previously docketed correspondence and should include for each AV: (1) the reason for the AV; (2) the corrective steps that have been taken and the results achieved; and (3) the corrective steps that will be taken. It should be clearly marked as a “Response to Apparent Violations in Inspection Report No. 05000244/2014005; EA-14-235,” and sent to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001 with a copy to the Regional Administrator, Region I, 2100 Renaissance Boulevard, King of Prussia, PA 19406.

In addition, please be advised that the number and characterization of AVs described in the enclosed inspection report may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

The inspectors also reviewed Licensee Event Report 05000244/2014-003-00, which describes the ‘A’ emergency diesel generator output breaker failing to close during routine surveillance testing, resulting in a condition prohibited by technical specifications and a potential inability to fulfill a safety function. The manufacturer determined that the breaker failed due to lack of free movement of the operating mechanism trip shaft. The inspectors concluded that it was not reasonable for Exelon to foresee and prevent this issue since neither preventive maintenance

instructions nor vendor guidance directed the licensee to measure the amount of free movement, and there were no external indicators to alert the licensee that the breaker had not reset. Accordingly, the NRC did not identify a licensee performance deficiency. The NRC performed a risk evaluation of the issue and determined it to be of very low safety significance. Based on these facts, I have been authorized, after consultation with the Director, Office of Enforcement, and the Regional Administrator, to exercise enforcement discretion in accordance with Section 3.5 of the Enforcement Policy and refrain from issuing enforcement for the violation.

This report also contains two licensee-identified traditional enforcement violations, which were determined to be Severity Level IV violations. However, because of the very low safety significance, and because they are entered into your correction action program, the NRC is treating these findings as non-cited violations (NCVs), consistent with Section 2.3.2.a of the NRC Enforcement Policy. If you contest the NCVs in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the United States Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspectors at Ginna.

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding," of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room or from the Publicly Available Records component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Ho K. Nieh
Director
Division of Reactor Projects

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

Enclosure: Inspection Report 05000244/2014005
w/Attachment: Supplementary Information

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Sincerely,

/RA/

Ho K. Nieh
Director
Division of Reactor Projects

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

Enclosure: Inspection Report 05000244/2014005
w/Attachment: Supplementary Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.	50-244
License No.	DPR-18
Report No.	05000244/2014005
Licensee:	Exelon Generation Company, LLC
Facility:	R.E. Ginna Nuclear Power Plant, LLC
Location:	Ontario, New York
Dates:	October 1, 2014, through December 31, 2014
Inspectors:	N. Perry, Senior Resident Inspector D. Dodson, Resident Inspector E. Andrews, Project Engineer T. Fish, Senior Operations Engineer T. Hedigan, Operations Engineer S. Horvitz, Reactor Engineer K. Kolaczyk, Senior Resident Inspector K. Mangan, Senior Reactor Inspector A. Rosebrook, Senior Project Engineer
Approved by:	Daniel L. Schroeder, Chief Reactor Projects Branch 1 Division of Reactor Projects

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SUMMARY

IR 05000244/2014005; 10/01/2014 – 12/31/2014; R.E. Ginna Nuclear Power Plant, LLC (Ginna); Licensed Operator Requalification Program and Licensed Operator Performance.

This report covered a 3-month period of inspection by resident inspectors and announced inspections performed by regional inspectors. Two traditional enforcement apparent violations (AVs) were identified. A finding's significance is indicated by a color (i.e., greater than Green, or Green, White, Yellow, Red) and determined using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," dated June 2, 2011. Cross-cutting aspects are determined using IMC 0310, "Aspects Within the Cross-Cutting Areas," issued December 4, 2014. All violations of United States Nuclear Regulatory Commission (NRC) requirements are dispositioned in accordance with the NRC's Enforcement Policy dated July 9, 2013. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 5.

Cornerstone: Mitigating Systems

- Apparent Violations. Exelon Generation Company, LLC (Exelon) identified two apparent violations (AVs): (1) An AV of Title 10 of the *Code of Federal Regulations* (10 CFR) 50.9, "Completeness and Accuracy of Information;" and (2) An AV of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, on October 8, 2008, Ginna submitted certified copies of an NRC senior operator license application that did not specify that the applicant required a restriction (to take medication as prescribed for high blood pressure) in order to maintain medical qualifications. The NRC issued the senior operator's initial license on December 5, 2008, but without the necessary medical restriction (AV #1). From October 8, 2008, until July 16, 2014, Ginna had several additional opportunities to identify that the blood pressure medication was required to compensate for a disqualifying medical condition and that a license condition was required during the licensee's biennial licensed operator requalification program reviews and medical examinations. On July 16, 2014, a period that exceeded 30 days from when the condition was identified, the facility notified the NRC of the medical condition via a letter requesting amendment to the operator's license to include the restriction (AV #2). On August 28, 2014, the NRC issued the license amendment with the new restriction. This issue was entered into Exelon's corrective action program (CAP).

  The inspectors determined that Exelon's failure to provide complete and accurate information to the NRC in the senior operator license application and to notify the NRC of a change in a senior operator's status for a condition which was known by the licensee and were a performance deficiencies that were within their ability to foresee and correct and should have been prevented. The inspectors determined that traditional enforcement applies, as the issue affected the NRC's ability to perform its regulatory function. Namely, the NRC relies upon Exelon to ensure all licensed operators meet the medical conditions of their licenses. If, during the term of the individual operator license, an operator develops a permanent physical or mental disability that causes the operator to fail to meet the requirements of 10 CFR 55.21, "Medical Examination," the licensee shall notify the NRC within 30 days of learning of the diagnosis, in accordance with 10 CFR 50.74(c). Additionally, the NRC issued a senior operator license to the applicant based on information that was not complete and accurate in all material aspects. The performance deficiencies were screened against the Reactor Oversight Process per the guidance of IMC 0612, Appendix B, "Issue Screening." No associated Reactor Oversight Process finding was

identified and no cross-cutting aspect was assigned. These issues constitute AVs in accordance with the NRC's Enforcement Policy, and their final significance will be dispositioned in separate future correspondence. (Section 1R11)

Other Findings

Two violations of very low safety significance that were identified by Exelon were reviewed by the inspectors. Corrective actions taken or planned by Exelon were entered into Exelon's CAP. These violations and their corrective action tracking numbers are listed in Section 4OA7 of this report.

REPORT DETAILS

Summary of Plant Status

R.E. Ginna Nuclear Power Plant (Ginna) began the inspection period operating at 100 percent power. On October 25, 2014, operators reduced power to approximately 75 percent to complete repairs to the number 3 turbine control valve. Following repairs, operators returned the unit to 100 percent early on October 26. The unit remained at or near 100 percent power for the remainder of the inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R01 Adverse Weather Protection (71111.01 – 2 samples)

.1 Readiness for Seasonal Extreme Weather Conditions

a. Inspection Scope

The inspectors performed a review of Exelon's readiness for the onset of seasonal cold temperatures. The review focused on the screen house, emergency diesel generator (EDG) rooms, auxiliary building, intermediate building, standby auxiliary feedwater (AFW) pump buildings, and turbine building. The inspectors reviewed the Updated Final Safety Analysis Report (UFSAR), technical specifications (TSs), control room logs, and the corrective action program (CAP) to determine what temperatures or other seasonal weather could challenge these systems and to ensure Exelon personnel had adequately prepared for these challenges. The inspectors reviewed station procedures, including Exelon's seasonal weather preparation procedure and applicable operating procedures. The inspectors performed walkdowns of the selected systems to ensure station personnel identified issues that could challenge the operability of the systems during cold weather conditions. Documents reviewed for each section of this inspection report are listed in the Attachment.

b. Findings

No findings were identified.

.2 Readiness for Impending Adverse Weather Conditions

a. Inspection Scope

The inspectors reviewed Exelon's preparations for the onset of high wind conditions on December 24, 2014. The inspectors reviewed the implementation of adverse weather preparation procedures before the onset of this adverse weather condition. The inspectors verified that operator actions defined in Exelon's adverse weather procedure maintained the readiness of essential systems. The inspectors discussed readiness and staff availability for adverse weather response with operations and work control personnel.

b. Findings

No findings were identified.

1R04 Equipment Alignment

Partial System Walkdowns (71111.04Q – 3 samples)

a. Inspection Scope

The inspectors performed partial walkdowns of the following systems:

- 'B' AFW while 'A' AFW was out of service (OOS) on October 16, 2014
- 'A' component cooling water (CCW) while the 'B' CCW heat exchanger was OOS on October 21, 2014
- 'A' EDG while the 'B' EDG was OOS on October 29 and 30, 2014

The inspectors selected these systems based on their risk-significance relative to the reactor safety cornerstones at the time they were inspected. The inspectors reviewed applicable operating procedures, system diagrams, the UFSAR, TSs, action requests (ARs), and the impact of ongoing work activities on redundant trains of equipment in order to identify conditions that could have impacted system performance of their intended safety functions. The inspectors also performed field walkdowns of accessible portions of the systems to verify system components and support equipment were aligned correctly and were operable. The inspectors examined the material condition of the components and observed operating parameters of equipment to verify that there were no deficiencies. The inspectors also reviewed whether Exelon staff had properly identified equipment issues and entered them into the CAP for resolution with the appropriate significance characterization.

b. Findings

No findings were identified.

1R05 Fire Protection

Resident Inspector Quarterly Walkdowns (71111.05Q – 3 samples)

a. Inspection Scope

The inspectors conducted tours of the areas listed below to assess the material condition and operational status of fire protection features. The inspectors verified that Exelon controlled combustible materials and ignition sources in accordance with administrative procedures. The inspectors verified that fire protection and suppression equipment was available for use as specified in the area pre-fire plan, and passive fire barriers were maintained in good material condition. The inspectors also verified that station personnel implemented compensatory measures for OOS, degraded, or inoperable fire protection equipment, as applicable, in accordance with procedures.

- Standby AFW building on October 22, 2014
- EDG 'B' vault on October 28, 2014
- Intermediate building clean side fan floor on December 30, 2014

b. Findings

No findings were identified.

1R11 Licensed Operator Requalification Program and Licensed Operator Performance (71111.11Q – 2 samples; 71111.11B – 1 sample)

.1 Quarterly Review of Licensed Operator Requalification Testing and Training

a. Inspection Scope

The inspectors observed licensed operator simulator training on November 19, 2014, which included a failed pressurizer pressure channel and a steam generator tube leak, which progressed into a tube rupture. The inspectors evaluated operator performance during the simulated event and verified completion of risk-significant operator actions, including the use of abnormal and emergency operating procedures. The inspectors assessed the clarity and effectiveness of communications, implementation of actions in response to alarms and degrading plant conditions, and the oversight and direction provided by the control room supervisor. The inspectors verified the accuracy and timeliness of the emergency classification made by the shift manager and the TS action statements entered by the shift technical advisor. Additionally, the inspectors assessed the ability of the crew and training staff to identify and document crew performance problems.

b. Findings

No findings were identified.

.2 Quarterly Review of Licensed Operator Performance in the Main Control Room

a. Inspection Scope

The inspectors observed and reviewed control room operators increasing power from approximately 75 percent to full power on October 25, 2014. The inspectors observed pre-shift briefings and reactivity control briefings to verify that the briefings met the criteria specified in procedures CNG-OP-1.01-1000, "Conduct of Operations," Revision 01000, and CNG-OP-3.01-1000, "Reactivity Management," Revision 00802. Additionally, the inspectors observed the power increase to verify that procedure use, crew communications, and coordination of activities between work groups similarly met established expectations and standards.

b. Findings

No findings were identified.

.3 Biennial Review

a. Inspection Scope

The following inspection activities were performed using NUREG-1021, "Operator Licensing Examination Standards for Power Reactors," Revision 9, Supplement 1, and Inspection Procedure Attachment 71111.11, “Licensed Operator Requalification Program and Licensed Operator Performance,” issued December 6, 2011.

Examination Results

Requalification exam results (operating tests only) for year 2014 were reviewed to determine if pass/fail rates were consistent with the guidance of IMC 0609, Appendix I, “Operator Requalification Human Performance Significance Determination Process (SDP).”

The review verified the following:

- Zero out of 34 licensed operators failed at least one section of the annual exam. The overall individual failure rate was 0.0 percent.
- Zero out of seven crews failed the simulator test. The crew failure rate was 0.0 percent.

Operating Test Quality

The inspectors reviewed the operating tests (scenarios and job performance measures) associated with the onsite examination week.

Licensee Administration of Operating Tests

The inspectors observed facility training staff administer dynamic simulator exams and job performance measures during the week of November 17, 2014. These observations included facility evaluations of crew and individual operator performance during the simulator exams and individual performance of job performance measures.

Exam Security

The inspectors assessed whether Exelon staff properly safeguarded exam material and whether test item repetition guidelines were met.

Conformance with License Conditions

License reactivation and license proficiency records were reviewed to ensure that Title 10 of the *Code of Federal Regulations* (10 CFR) 55.53 license conditions and applicable program requirements were met. The inspectors also reviewed a sample of records for requalification training attendance and a sample of medical examinations for compliance with license conditions and NRC regulations.

Simulator Performance

Scenario-based tests and simulator performance tests were reviewed for conformance and fidelity to the plant control room. A sample of simulator deficiency reports was also reviewed to ensure facility staff addressed any identified modeling problems.

Problem Identification and Resolution

The inspectors reviewed recent operating history documentation found in inspection reports, licensee event reports (LERs), Exelon's CAP, NRC end-of-cycle and mid-cycle reports, and the most recent NRC plant issues matrix. The inspectors focused on events associated with operator errors that may have occurred due to possible training deficiencies.

b. Findings

Introduction. Exelon staff identified two apparent violations (AVs). The first, an AV of 10 CFR 50.9, "Completeness and Accuracy of Information," for Exelon's failure to submit complete and accurate information regarding an application for a senior operator's license. The second is an AV of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status," associated with Exelon's failure to notify the NRC within 30 days of a change in a licensed senior operator's medical condition.

Description. On July 8, 2008, an applicant for a senior operator license reported to the Exelon physician a new diagnosis of hypertension (high blood pressure) and that he had been prescribed medication for this condition. The Exelon physician did not recognize that this condition warranted NRC notification or that prescribed medication required a license restriction. On July 22, Exelon submitted NRC Form 396, "Certification of Medical Examination by Facility Licensee," to the NRC on behalf of the senior operator applicant. However, this form did not disclose that the applicant needed a license restriction to take prescribed medication. On October 8, Exelon submitted NRC Form 398, "Personal Qualification Statement – Licensee," to the NRC. However, this application did not include a revised NRC Form 396 to indicate the need for a license restriction to address the applicant's hypertension. Subsequently, on December 5, the NRC issued a senior operator license that did not contain restrictions to take medication as prescribed. Thus, the inaccurate NRC Forms 396 and 398 affected the regulatory process in that the NRC was not permitted an opportunity to review this medical condition and, consequently, issued a license that did not contain all of the necessary restrictions.

On July 3, 2014, an internal audit conducted by Exelon identified Ginna staff's failure to report the diagnosis of hypertension as well as the associated restriction "shall take medication as prescribed to maintain medical qualifications." (This audit also noted the operator had reported his condition during subsequent biennial physical exams on July 22, 2010, and again on July 26, 2012.) On July 16, 2014, Exelon submitted a letter to the NRC with a revised NRC Form 396 that reflected a new restriction to take medication as prescribed. On August 28, the NRC issued a license amendment with the new restriction.

As stated on NRC Form 396, the overriding purpose of licensed operator medical qualification is that the individual "would not be expected to cause operational errors endangering public health and safety." The guidance contained in industry consensus standards, specifically versions of American National Standards Institute (ANSI)/American

Nuclear Society (ANS)-3.4 forms the basis in reaching this determination. Exelon is committed to ANSI/ANS-3.4-1983, "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants." Based on medical documentation from the operator's treating physician, the operator's blood pressure has been adequately controlled since his original diagnosis. The operator's condition is and has been stable, and his diagnosis has not interfered with his ability to perform his licensed operator duties.

Analysis. Exelon's failure to submit complete and accurate information in a license application to the NRC regarding the applicant's medical condition and the failure to notify the NRC within 30 days of a change in a senior operator's medical condition and request a condition be placed on the operator's license are performance deficiencies that were reasonably within the licensee's ability to foresee and prevent. These performance deficiencies adversely affected the regulatory process, because the NRC used the inaccurate information as a basis for an incorrect regulatory decision. Specifically, the NRC issued a senior operator's license which did not include the necessary restriction on the senior operator's license to take medication as prescribed, a condition required to ensure the applicant was medically qualified and did not have the opportunity to amend this regulatory decision because the information was not reported to the NRC as required. Because the regulatory process was affected, traditional enforcement was applicable.

Section 6.4.c.4 of the NRC Enforcement Policy describes an example of a Severity Level III violation that involves:

> "A nonwillful compromise (see 10 CFR 55.49, "Integrity of Examinations and Tests") of an application ... or examination required by 10 CFR Part 55, or inaccurate or incomplete information inadvertently provided to the NRC, subsequently contributes to the NRC making an incorrect regulatory decision, such as the following: (a) In the case of initial operator licensing, contributes to an individual being granted an operator or senior operator license or (b) In the case of operator requalification, contributes to an individual being permitted to perform the functions of an operator or senior operator or (c) contributes to a medically unqualified individual performing the functions of a licensed operator or senior operator.

Therefore, the inspectors preliminarily determined that these violations appear to be Severity Level III because Exelon failed to report a condition that would have required the addition of a license restriction. In this case, the senior operator required a license restriction to take medication, as prescribed, to maintain medical qualifications. The AVs affected both the initial licensing action and subsequent licensed operator requalification in 2010 and 2012.

In accordance with IMC 0612, Appendix B, "Issue Screening," this performance deficiencies were also evaluated for significance under the Reactor Oversight Process. During the period between receiving his prescription from his personal physician and the amending of his license to include this restriction, this individual took the prescribed medication to address his disqualifying medical condition. No operational issues resulted from this individual's performance. As a result, there is not a more than minor Reactor Oversight Process violation; therefore, no cross-cutting aspects are assigned to the AVs.

Enforcement.

1. 10 CFR 50.9, “Completeness and Accuracy of Information,” requires, in part, that information provided to the NRC by a licensee shall be complete and accurate in all material respects.

   10 CFR 55.21 requires, in part, that individual licensed operators and licensed senior operators shall have a medical examination by a physician every 2 years and that the physician shall determine that the licensee meets requirements of Section 55.33(a)(1).

   10 CFR 55.33(a)(1) requires, in part, that an applicant’s medical condition and general health will not adversely affect the performance of assigned operator job duties or cause operational errors endangering public health and safety. 10 CFR 55.33(b) states, in part, that if the applicant’s general medical condition does not meet the minimum standards under 10 CFR 55.33(a)(1), the NRC may approve the application and include conditions in the license to accommodate the medical defect.

   10 CFR 55.23, “Certification,” requires, in part, that to certify the medical fitness of the applicant, an authorized representative of the facility licensee shall complete and sign NRC Form 396, "Certification of Medical Examination by Facility Licensee." NRC Form 396, when signed by an authorized representative of the facility licensee, certifies that based on the results of the physical examination, including information furnished by the applicant, the physician has determined that the applicant’s physical condition and general health are such that the applicant would not be expected to cause operational errors endangering public health and safety and documents whether the applicant’s license should be conditioned with restrictions.

   Contrary to the above, on October 8, 2008, Exelon staff provided information to the NRC that was not complete and accurate in all material respects. Specifically, Exelon staff submitted an NRC licensed senior operator application with an NRC Form 396 that certified the medical fitness of the applicant and that the only necessary restricting license condition was for corrective lenses. This information was inaccurate in that the applicant had high blood pressure, a medical condition that does not meet the minimum standards of 10 CFR 55.33(a)(1) and that requires a restricting license condition to take medication, as prescribed, to maintain medical qualifications. Compliance was restored on July 16, 2014, when Exelon submitted a letter to the NRC with a revised NRC Form 396 indicating the new restriction to take prescribed medication. On August 28, 2014, the NRC issued a license amendment with the new restriction. This issue was entered into Exelon’s CAP as condition report (CR)-2014-003981. **(AV 5000244/2014005-01, Incomplete and Inaccurate Medical Information Provided by Exelon Which Resulted in Issuance of an Initial Senior Operator License without a Required Medical Restriction)**

2. 10 CFR 55.3, “Licensee Requirements,” requires, in part, that a person must be authorized by a license issued by the Commission to perform the function of a licensed operator or a licensed senior operator as defined in Part 55.

   10 CFR 50.74(c), “Notification of Change in Operator or Senior Operator Status,” requires, in part, that each facility licensee notify the appropriate NRC Regional Administrator within 30 days of a permanent disability or illness as described in 10 CFR 55.25, “Incapacitation Because of a Disability or Illness,” involving a licensed operator or senior operator. 10 CFR 55.25 requires, in part, that if a licensed operator or licensed senior operator

develops a permanent physical condition that causes the licensee to fail to meet the requirements of 10 CFR 55.21, "Medical Examination," the facility must notify the NRC within 30 days of learning of the diagnosis. For conditions where a license condition is required, the facility licensee must provide medical certification on NRC Form 396, "Certification of Medical Examination by Facility Licensee."

10 CFR 55.21 requires, in part, that individual licensed operators and senior operators shall have a medical examination by a physician every 2 years and that the physician shall determine that the operator meets requirements of Section 55.33(a)(1), "How to Apply." 10 CFR 55.33(a)(1) requires, in part, that an applicant's medical condition and general health will not adversely affect the performance of assigned operator job duties or cause operational errors endangering public health and safety. 10 CFR 55.33(b), "Disposition of an Initial Application," states, in part, that if the general medical condition of an applicant does not meet the minimum standards under 10 CFR 55.33(a)(1), the NRC may approve the application and include conditions in the license to accommodate the medical defect.

Contrary to the above, from January 4, 2009, (this date is 30 days from the date of his initial license) until July 16, 2014 (a period greater than 30 days), Exelon failed to notify the NRC of a permanent disability of a licensed senior operator. Specifically, Exelon staff was informed in July 2008 that the operator was taking prescribed medication for hypertension. Exelon did not report this permanent medical condition to the NRC when they submitted NRC Form 396 as part of the senior operator license application in October 2008, nor did they request an amended license with a condition to account for the medical issue until July 16, 2014. The condition was reported to Exelon by the operator as part of each subsequent biennel medical examination and licensed operator requalification program which provide several additional opportunities to report the condition and request a license condition. Compliance was restored on July 16, 2014, when Exelon submitted a letter to the NRC with a revised NRC Form 396 indicating the new restriction to take prescribed medication. On August 28, 2014, the NRC issued a license amendment with the new restriction. This issue was entered into Exelon's CAP as CR-2014-003981. **(AV 5000244/2014005-02, Failure to Report a Permanent Change in a Licensed Operator's Medical Status and Request a Condition be Placed on the Operator's License)**

1R12 Maintenance Effectiveness (71111.12Q – 4 samples)

a. Inspection Scope

The inspectors reviewed the samples listed below to assess the effectiveness of maintenance activities on structure, system, and component (SSC) performance and reliability. The inspectors reviewed system health reports, CAP documents, and maintenance rule (MR) basis documents to ensure that Exelon was identifying and properly evaluating performance problems within the scope of the MR. For each sample selected, the inspectors verified that the SSC was properly scoped into the MR in accordance with 10 CFR 50.65 and verified that the (a)(2) performance criteria established by Exelon staff were reasonable. As applicable, for SSCs classified as (a)(1), the inspectors assessed the adequacy of goals and corrective actions to return these SSCs to (a)(2). Additionally, the inspectors ensured that Exelon staff were identifying and addressing common cause failures that occurred within and across MR system boundaries.

- Instrument air system deficiencies on November 12 and 13, 2014
- Radioactive waste processing system check valve issues that occurred on January 30 and March 11, 2014
- Radiation monitoring system on December 29, 2014
- CCW system on December 31, 2014

b. Findings

No findings were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13 – 5 samples)

a. Inspection Scope

The inspectors reviewed station evaluation and management of plant risk for the maintenance and emergent work activities listed below to verify that Exelon performed the appropriate risk assessments prior to removing equipment from service. The inspectors selected these activities based on potential risk significance relative to the reactor safety cornerstones. As applicable for each activity, the inspectors verified that Exelon personnel performed risk assessments as required by 10 CFR 50.65(a)(4) and that the assessments were accurate and complete. When Exelon performed emergent work, the inspectors verified that operations personnel promptly assessed and managed plant risk. The inspectors reviewed the scope of maintenance work and discussed the results of the assessment with the station's probabilistic risk analyst to verify plant conditions were consistent with the risk assessment. The inspectors also reviewed the TS requirements and inspected portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met.

- Planned maintenance on the 'B' EDG and 'D' standby AFW pump on October 27, 2014
- Planned maintenance on the relay room halon suppression system (S08) during reactor protection system channel two calibrations on November 5, 2014
- Planned maintenance on the 'C' standby AFW system during planned bus 14 and bus 18 undervoltage testing and high-solar flare activity on November 10 and 12, 2014
- Planned maintenance on the turbine-driven AFW system during planned reactor protection system channel two and channel four calibrations on November 18 and 19, 2014, respectively
- Planned maintenance on the 'B' containment spray system followed by planned maintenance on the 'B' CCW system on December 15, 2015

b. Findings

No findings were identified.

1R15 Operability Determinations and Functionality Assessments (71111.15 – 3 samples)

a. Inspection Scope

The inspectors reviewed operability determinations for the following degraded or non-conforming conditions:

- ‘B’ EDG air start receivers on October 29, 2014
- ‘C’ standby AFW check valve failures on November 20, 2014
- ‘B’ CCW pump non-conforming mechanical seal on December 19, 2014

The inspectors selected these issues based on the risk significance of the associated components and systems. The inspectors evaluated the technical adequacy of the operability determinations to assess whether TS operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred. The inspectors compared the operability and design criteria in the appropriate sections of the TSs and UFSAR to Exelon’s evaluations to determine whether the components or systems were operable. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled by Exelon. The inspectors determined, where appropriate, compliance with bounding limitations associated with the evaluations.

b. Findings

No findings were identified.

1R18 Plant Modifications (71111.18Q – 1 sample)

Permanent Modification

a. Inspection Scope

The inspectors evaluated engineering change package (ECP)-14-000016, “Replace Service Water Copper Piping to Turbine-Driven AFW Pump Outboard Bearing Cooler and Lube Oiler Cooler with Stainless Steel Tubing and Perform System Upgrades As Necessary.” The inspectors verified that the design bases, licensing bases, and performance capability of the affected systems were not degraded by the modification. The inspectors reviewed calculations, drawings, work orders (WOs), and 10 CFR 50.59 screenings associated with the modification. Additionally, the inspectors interviewed engineering personnel familiar with the modification.

b. Findings

No findings were identified.

1R19 Post-Maintenance Testing (71111.19 – 7 samples)

a. Inspection Scope

The inspectors reviewed the post-maintenance tests for the maintenance activities listed below to verify that procedures and test activities ensured system operability and functional capability. The inspectors reviewed the test procedure to verify that the procedure adequately tested the safety functions that may have been affected by the maintenance activity, that the acceptance criteria in the procedure were consistent with the information in the applicable licensing basis and/or design basis documents, and that the procedure had been properly reviewed and approved. The inspectors also witnessed

the test or reviewed test data to verify that the test results adequately demonstrated restoration of the affected safety functions.

- Safety injection valve 1815A planned maintenance on October 3, 2014
- 'A' EDG planned maintenance on October 15, 2014
- 'B' CCW heat exchanger planned maintenance on October 24, 2014
- 'B' EDG air start check valve planned maintenance on October 28, 2014
- 'B' EDG planned maintenance on October 31, 2014
- 'C' standby AFW pump unplanned maintenance on November 14, 2014
- 'D' standby AFW pump planned modification on December 4, 2014

b. Findings

No findings were identified.

1R22 Surveillance Testing (71111.22 – 3 samples)

a. Inspection Scope

The inspectors observed performance of surveillance tests and/or reviewed test data of selected risk-significant SSCs to assess whether test results satisfied TSs, the UFSAR, and Exelon procedure requirements. The inspectors verified that test acceptance criteria were clear, tests demonstrated operational readiness and were consistent with design documentation, test instrumentation had current calibrations and the range and accuracy for the application, tests were performed as written, and applicable test prerequisites were satisfied. Upon test completion, the inspectors considered whether the test results supported that equipment was capable of performing the required safety functions. The inspectors reviewed the following surveillance tests:

- S-12.4, Reactor Coolant System (RCS) Leakage Surveillance Record Instructions on November 4, 2014 (RCS leak detection)
- WO C92884626, Leakage test for V-9706A on November 12, 2014 (containment isolation valve)
- S-12.4, RCS Leakage Surveillance Record Instructions on December 16, 2014 (RCS leak detection)

b. Findings

No findings were identified.

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution (71152 – 5 samples)

.1 Routine Review of Problem Identification and Resolution Activities

a. Inspection Scope

As required by Inspection Procedure 71152, "Problem Identification and Resolution," the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to verify that Exelon entered issues into the CAP at an appropriate threshold, gave adequate attention to timely corrective actions, and identified and addressed adverse trends. In order to assist with the identification of repetitive equipment failures and specific human performance issues for follow-up, the inspectors performed a daily screening of items entered into the CAP and periodically attended AR screening meetings.

b. Findings

No findings were identified.

.2 Semi-Annual Trend Review

a. Inspection Scope

The inspectors performed a semi-annual review of site issues, as required by Inspection Procedure 71152, to identify trends that might indicate the existence of more significant safety issues. In this review, the inspectors included repetitive or closely related issues that may have been documented by Exelon outside of the CAP, such as trend reports, performance indicators, major equipment problem lists, system health reports, MR assessments, and maintenance or CAP backlogs. The inspectors also reviewed Exelon's CAP database of the third and fourth quarters of 2014 to assess ARs written in various subject areas (equipment problems, human performance issues, etc.), as well as individual issues identified during the NRC's daily AR review (Section 4OA2.1). The inspectors reviewed Exelon's quarterly trend report for the second quarter of 2014, department trend reports for the third quarter 2014, and Exelon's nuclear oversight groups most recent site status report (October 30, 2014) to verify that Exelon personnel were appropriately evaluating and trending adverse conditions in accordance with applicable procedures.

b. Findings and Observations

No findings were identified.

The inspectors evaluated a sample of issues and events that occurred over the course of the past two quarters to determine whether issues were appropriately considered as emerging or adverse trends. The inspectors verified that these issues were addressed within the scope of the CAP or through department review.

As part of Ginna's transition from Constellation Energy Nuclear Group, LLC (CENG) to Exelon, in the second quarter of 2014, Ginna staff adopted and implemented Exelon fleet procedures for system monitoring and trending. The quarterly trend reports used to be

prepared by the performance improvement group, and were discontinued and replaced by department trend reports prepared by each department's CAP coordinator, which are rolled up and presented to plant management. The inspectors reviewed the training plans for the CAP coordinators for their new roles and responsibilities, and the inspectors determined the training was timely and appropriate.

The review did not reveal any new trends that could indicate a more significant safety issue. The inspectors assessed that Exelon personnel were identifying issues at a low threshold and entering them into the CAP for resolution and appropriately prioritizing investigation reviews. The inspectors noted minor adverse trends identified by Exelon staff in the areas of maintenance control of quality material components (AR 02402430), inadequate component verification practices (CR-2014-005012, CR- 2014-003198, and CR-2014-002625), operations department administrative control of temporary changes (CR-2014-004892 and CR-2014-004923), testing of security equipment (AR 02393185), inadequate corrective actions to improve quality of engineering work products (AR 02395877), verification of worker qualification (CR-2014-003730), and an operations department decline in professional standards prior to proceeding with work activities (AR 02393564). In addition, Exelon wrote a number of trend ARs to document potential or emerging equipment performance trends to ensure equipment performance was being monitored appropriately (CR-2014-004880, AR 02320362, AR 02402294, and AR 02402157). The inspectors also noted that the site's nuclear oversight organization continued to identify negative trends at an appropriate level and elevated issues when necessary.

The inspectors identified two instances where engineering personnel developed inadequate test acceptance criteria for plant modifications (AR 02415776 and AR 02417843). In both cases, the issues were identified and corrected prior to the modification being accepted and placed in service. Exelon classified these issues as additional examples of the previously identified trend related to inadequate corrective actions to improve quality of engineering work products (AR 02395877). The inspectors agreed with Exelon's classification of this potential trend.

There were no adverse safety consequences as a result of these low-level trend issues. Based on the overall results of the semi-annual trend review, the inspectors determined that Exelon was properly identifying adverse trends at Ginna before they became more safety-significant problems. The inspectors independently evaluated the deficiencies noted above for significance in accordance with the guidance in IMC 0612, Appendix B, "Issue Screening," and Appendix E, "Examples of Minor Issues." The inspectors determined these conditions were deficiencies of minor significance and, therefore, are not subject to enforcement action in accordance with the NRC's Enforcement Policy.

.3 Annual Sample: Review of the Operator Workaround Program

a. Inspection Scope

The inspectors reviewed the cumulative effects of the existing operator workarounds, operator burdens, existing operator aids and disabled alarms, and open main control room deficiencies to identify any effect on emergency operating procedure operator actions, and any impact on possible initiating events and mitigating systems. The inspectors evaluated whether station personnel had identified, assessed, and reviewed operator workarounds as specified in CENG procedure, CNG-OP-1.01-2010, "Operator Workaround/Challenge

Control," Revision 00000. The inspectors also reviewed Exelon procedure OP-AA-102-103, "Operator Work-Around Program (CM-1)," Revision 004, and OP-AA-102-103-1001, "Operator Burden and Plant Significant Decisions Impact Assessment Program (CM-1)," Revision 005, which was effective at Ginna on December 9, 2014, to verify Exelon personnel were in the process of implementing the requirements contained in the documents which will supersede CNG-OP-1.01-2010.

The inspectors reviewed Exelon's process to identify, prioritize, and resolve main control room distractions to minimize operator burdens. The inspectors reviewed the system used to track these operator workarounds and recent Exelon self-assessments of the program. The inspectors also toured the control room and several other vital areas and discussed the current operator workarounds with operations personnel to ensure the items were being addressed on a schedule consistent with their relative safety significance.

b. Findings and Observations

No findings were identified.

The inspectors determined that the issues reviewed did not adversely affect the capability of the operators to implement abnormal procedures or emergency operating procedures. The inspectors also verified that Exelon entered operator workarounds and burdens into the CAP at an appropriate threshold and planned or implemented corrective actions commensurate with their safety significance.

.4 Annual Sample: Effectiveness of the Preventive Maintenance (PM) Program

a. Inspection Scope

The inspectors performed an in-depth review of Exelon's evaluations and effectiveness of corrective actions associated with the PM program. Recent equipment failures have occurred due to inadequacies associated with the PM program. The inspectors assessed Exelon's problem identification threshold, associated analyses and evaluations, and prioritization and timeliness of corrective actions pertaining to this issue.

The inspectors performed the review to determine whether Exelon personnel were appropriately identifying, characterizing and correcting problems associated with the issue, and whether the planned and completed corrective actions were appropriate. The inspectors compared the actions taken to the requirements of Exelon's CAP and 10 CFR 50, Appendix B. In addition, the inspectors reviewed CRs, procedures, and apparent cause evaluations as well as conducted interviews with Exelon staff to assess the adequacy, effectiveness, and timeliness of the implemented corrective actions.

b. Findings and Observations

No findings were identified.

Recently, the deficiencies within PM programs and lack of PM programs on components resulted in equipment failures. The failure of the turbine-driven AFW direct current lube oil pump switch and failure of a service water pump motor were documented in previous integrated inspection reports as a finding (FIN 05000244/2013005-03) and non-cited violation (NCV 05000244/2014002-01), respectively. Exelon's apparent causes

associated with these issues identified weaknesses within the PM program. Specifically, one of the causal factors for the turbine-driven AFW direct current oil pump failing to auto start was an inadequate PM scope for the control switch. Without an adequate PM scope, the component failed due to age-related issues. One of the causal factors for the service water pump motor cited an inadequate frequency of motor repair that resulted in the failure.

Corrective actions included performing vulnerability reviews for various systems to evaluate the appropriateness of the current PM frequencies, adapting existing maintenance processes to identify and mitigate age-related vulnerabilities, and continuing the process of transitioning from the CENG PM program to the Exelon PM program. As part of the corrective actions, Exelon staff expanded the scope of the PM program to include passive components in addition to the previously scoped active components.

The inspectors determined Exelon staff's overall response was timely and included appropriate corrective actions. The inspectors determined that the corrective actions were reasonable to resolve the previous PM program issues.

.5 Annual Sample: Configuration Control

a. Inspection Scope

Ginna had several configuration control events in calendar year 2014. Exelon performed individual evaluations for each event and also performed a root cause analysis to address the adverse trend and identify any common causes for the configuration control events in 2014.

The inspectors performed an in-depth review of the common cause evaluation and the other apparent cause evaluations and assessed the following attributes: identification of the root and contributing causes, extent-of-condition reviews, and previous occurrences. The inspectors also assessed the timeliness of corrective actions and whether they will preclude repetition of the events. The inspectors performed reviews of the documents noted in the Attachment to this report to assess the effectiveness of the planned, scheduled, and completed corrective actions to resolve the identified deficiencies.

b. Findings and Observations

No findings were identified.

Exelon completed a category 1 root cause analysis (RCA) under CR-2014-003135. Ginna had six configuration control events during the first half of 2014, five of which were during the 2014 refueling outage. Exelon's RCA team determined the root cause to be "Operations and Maintenance leadership did not ensure that configuration control event precursors were recognized, tracked and corrected, which is critical to eliminating the behaviors that could result in more significant configuration control events." The corrective actions focused on improving the configuration control program effectiveness by revising the program to identify, track, and correct all component precursors and actual mispositioning events. An additional corrective action was to conduct three focused configuration control observations for each operator, maintenance technician, and chemistry technician.

The inspectors determined that Exelon appropriately evaluated the cause of the adverse trend related to configuration control events and properly evaluated the matter in accordance with Exelon procedures. The inspectors reviewed Exelon's RCA report, and several of the related CRs and guidance documents, and concluded that Exelon had appropriately evaluated the problems, the conclusion was reasonable and well supported, Exelon developed appropriate corrective actions, and the implementation schedule for these corrective actions appeared to be timely. The inspectors determined that the corrective actions were reasonable and addressed the root and contributing causes. The inspectors observed that the number of configuration control events has exhibited a positive lowering trend, with six issues in the first half of 2014 compared to one issue in the last two quarters.

Overall, the inspectors found that the configuration control issues had been accurately documented within the CAP. Exelon performed appropriate extent-of-condition reviews, as well as internal and external operating experience reviews, to assess the potential impact on the station. Based on the documents reviewed, job walkdowns, observations, and interviews, the inspectors noted that corrective actions have been effectively implemented and station personnel have an appropriately low threshold for reporting and documenting precursor human performance issues.

.6 Annual Sample: Maintenance Rule Equipment Scoping

a. Inspection Scope

The inspectors performed an in-depth review of Exelon's evaluation and corrective actions associated with the scoping of equipment as required by 10 CFR 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants." The inspectors reviewed CRs and corrective actions associated with the failure to identify components as MR components in equipment data bases; failure to include components that should have been in-scope in the MR program; and finally, the re-scoping of components following changes to industry guidance that were now in scope for the MR program. Specifically, the inspectors reviewed the actions taken by Exelon to address in-scope components that had not been properly flagged in the component data base as MR components. Exelon used this flagging method in order to assure these components received MR functional failure evaluations when deficiencies associated with the component were identified. The inspectors also reviewed actions taken by Exelon following the identification of components described in emergency procedures that were incorrectly excluded from the MR scope (NCV 0500244/2013005-02) during the initial MR scoping efforts. Finally, the inspectors reviewed actions taken by Exelon to address revised MR scoping requirements described in NUMARC 93-01, "Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," Revision 4A, which revised the requirements for inclusion of all equipment that could be considered mitigation equipment in emergency procedures.

The inspectors assessed Exelon's evaluation, extent-of-condition review, completed and proposed corrective actions, and the prioritization and timeliness of actions to evaluate whether the corrective actions were appropriate. The inspectors reviewed the planned actions to revise the MR functional failure evaluation review requirements from a component level evaluation to a functional based evaluation of the systems. The inspectors evaluated whether this change would ensure that in-scope equipment deficiencies were evaluated in accordance with MR requirements. The inspectors also

reviewed Exelon's actions to determine what components described in emergency procedures should be included within the scope of the MR as discussed in NUMARC 93-01, Revision 4A. The inspectors interviewed engineers and reviewed Exelon's evaluation of the issue and corrective actions taken to ensure that the scope of the review and criteria for inclusion of equipment in emergency procedures ensured that the MR scoping requirements would be met. Specifically, the inspectors reviewed the revisions to procedure EP-3-S-0308, "Maintenance Rule Scoping," Revision 1, to determine if the requirements of the procedure were aligned with the NUMARC guidance and interviewed site engineering staff to determine what corrective actions had been taken to identify and incorporate components in emergency operating procedures, emergency contingency actions, and attachments that had previously been excluded from the MR program.

b. Findings and Observations

No findings were identified.

The inspectors determined that Exelon's evaluation and extent-of-condition review were thorough, and the causes were appropriately identified. The inspectors also determined that the corrective actions were reasonable and would address the scoping requirements for the MR.

Exelon's engineering evaluation identified that the failure to incorporate some equipment in the MR was due to an original assumption that offsite power would not be available during a design basis accident and, therefore, any equipment requiring offsite power would not be available in emergency procedures. Based on this assumption, such equipment did not meet the MR scope requirement for emergency procedure mitigating systems. However, as documented in NCV 0500244/2013005-02, this assumption is not consistent with the scoping requirements stated in 10 CFR 50.65 (b)(2)(i). The inspectors found that Exelon was in the process of reviewing all emergency operating procedures, emergency contingency actions, and associated attachments to identify mitigating equipment not previously included in the MR program. The inspectors verified that the criteria for inclusion had been changed to meet the requirements in NUMARC 93-01, Revision 4A, and the MR expert panel would review the results of each procedure review.

Finally, the inspectors determined that the plan to transition from a component-based to a functional-based MR program was consistent with industry practices and would enable Exelon to evaluate in-scope MR equipment for compliance with the MR. The inspectors concluded that Exelon's evaluation and corrective actions, completed and planned, associated with the scoping of equipment were appropriate and thorough.

4OA3 Follow-Up of Events and Notices of Enforcement Discretion (71153 – 1 sample)

(Closed) LER 05000244/2014-003-00: 'A' Emergency Diesel Generator Output Breaker Fails to Close during Routine Surveillance Testing Resulting in a Condition Prohibited by Technical Specifications and a Potential Inability to Fulfill a Safety Function

On September 10, 2014, during performance of a routine scheduled surveillance test, STP-O-12.1, "Emergency Diesel Generator 'A'," Revision 01600, the output supply breaker to safeguards bus 14 failed to close on demand. Initial troubleshooting revealed no obvious issues with the breaker, and the output supply breaker functioned as required during a second test. A spare breaker was installed and tested satisfactorily on

September 11, and the 'A' EDG was restored to operable. Exelon concluded that the 'A' EDG had been inoperable since the last successful performance of STP-O-12.1 on August 13, 2014. This 29 day period exceeded the TS allowable outage time of 7 days.

Exelon's subsequent troubleshooting revealed no electrical issues with the circuit breaker, and the failure modes and effects analysis concluded that the most likely cause of the circuit breaker failing to close was the breaker did not properly reset after performance of the surveillance test on August 13, 2014. The breaker could not be verified to be reset without an internal inspection. The original equipment manufacturer was also requested by Exelon to investigate the cause of the breaker failure. The original equipment manufacturer concluded that the lack of free movement of the operating mechanism trip shaft was the cause of the breaker not resetting and closing. The trip shaft did not move freely due to lack of end-to-end play.

Exelon's apparent cause evaluation associated with this issue and AR 02178745 noted that these circuit breakers undergo full PM every 4 years, and all PMs on both EDG output breakers have been done in accordance with the PM frequency. The last performance of the PM for the bus 14 breaker was on November 14, 2011. The procedure for the PM has the technicians check for free movement of the trip of the trip shaft, but not end-to-end play movement or clearances to allow end-to-end play. Additionally, the vendor manual does not direct measuring clearances or verifying end-to-end play; this is called out as a vendor task. Therefore, the inspectors concluded that no performance deficiency existed since it was not reasonable for Exelon to foresee and prevent this issue.

The inspectors reviewed LER 2014-003-00 and determined that traditional enforcement applies in accordance with IMC 0612, Sections 0612-09 and 0612-13, and NRC Enforcement Policy, Section 2.2.4.d, because a violation of NRC requirements existed without an associated Reactor Oversight Process performance deficiency. The inspectors determined that the maintenance completed on the bus 14 breaker was in accordance with vendor recommendations. This issue was considered to be a Severity Level IV violation of TS 3.8.1 in accordance with Enforcement Policy Section 6.1.d. In addition, IMC 0612, Appendix B, Figures 1 and 2, "Issue Screening," were referenced in documenting this Severity Level IV self-revealing violation. This issue was entered into Exelon's CAP as AR 02178745.

Because it was not reasonable for Exelon to have been able to foresee and prevent the breaker failure, the NRC determined no performance deficiency existed. Thus, the NRC has decided to exercise enforcement discretion in accordance with Section 3.5 of the NRC Enforcement Policy and refrain from issuing enforcement action for the violation (EA-15-004). Further, because Exelon's action and/or inaction did not contribute to this violation, it will not be considered in the assessment process or the NRC's action matrix. This LER is closed.

4OA6 Meetings, Including Exit

On January 14, 2015, the inspectors presented the inspection results to Mr. Joseph Pacher, Site Vice President, and other members of the Ginna staff. The inspectors verified that no propriety information was retained by the inspectors or documented in this report.

4OA7 Licensee-Identified Violations

The following Severity Level IV violations were identified by Exelon and are violations of NRC requirements which meet the criteria of the NRC Enforcement Policy for being dispositioned as NCVs:

- According to 10 CFR 55.21 and 33, licensed operators are required to have a physical examination every 2 years to ensure that their medical condition and general health will not adversely affect the performance of assigned operator job duties or cause operational errors endangering public health and safety. As a part of licensed operator medical evaluations, olfactory testing is required as specified in ANSI/ANS 3.4 1983. Olfactory testing in the standard states, "Nose. Ability to detect odor of products of combustion and of tracer and marker gases." Contrary to this requirement, in CR-2014-003860, Exelon identified that Ginna medical staff had not been testing operators for the mercaptan marker used in natural gas. This violation is subject to traditional enforcement because of the potential impact upon the regulatory process since the operators' medical conditions are reviewed by the NRC when issuing or renewing operator licenses. This issue meets the criteria for a Severity Level IV violation, because upon subsequent olfactory testing, all operators were found to meet the health requirements for licensing.

- According to 10 CFR 50.74, each licensee shall notify the NRC within 30 days of a change in an operator's or senior operator's status including termination of any operator or senior operator. Contrary to this requirement, in AR 02120732, Exelon identified that Ginna staff did not notify the NRC of termination of two senior operators. The facility terminated the affected operators August 9, 2013, but did not notify the NRC of the change in status until September 10, 2014. This issue meets the criteria for a Severity Level IV violation because the September 10, 2014, notification did not result in increased inspection activities or cause the NRC to reconsider a regulatory position.

ATTACHMENT: SUPPLEMENTARY INFORMATION

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

J. Pacher, Site Vice President
W. Carsky, Plant Manager
S. Doty, Director, Site Maintenance
K. Garnish, Sr. Manager, Operations Support & Services
M. Geckle, Manager, Site Transition
T. Harding, Manager, Site Regulatory Assurance
D. Markowski, Sr. Engineering Manager
T. Mogren, Director, Site Engineering
T. Paglia, Director, Site Operations
J. Scalzo, Manager, Site Security
J. Sperr, Manager, System Engineering
S. Wihlen, Director, Work Management

LIST OF ITEMS OPENED, CLOSED, DISCUSSED, AND UPDATED

Open

05000244/2014005-01	AV	Incomplete and Inaccurate Medical Information Provided by Exelon Which Resulted in Issuance of an Initial Senior Operator License without a Required Medical Restriction (Section 1R11)
05000244/2014005-02	AV	Failure to Report a Permanent Change in a Licensed Operator's Medical Status and Request a Condition be Placed on the Operator's License (Section 1R11)

Closed

05000244/2014-003-00	LER	'A' Emergency Diesel Generator Output Breaker Fails to Close during Routine Surveillance Testing Resulting in a Condition Prohibited by Technical Specifications and a Potential Inability to Fulfill a Safety Function (Section 4OA3)

LIST OF DOCUMENTS REVIEWED

Section 1R01: Adverse Weather Protection

Procedures
ER-SC.1, Adverse Weather Plan, Revision 01903
O-22, Cold Weather Walkdown Procedure, Revision 01100

Action Requests

AR 02405105	AR 02407003	AR 02412570
AR 02405106	AR 02407007	AR 02412571
AR 02405115	AR 02407010	AR 02414162
AR 02405117	AR 02412539	AR 02418948
AR 02405119	AR 02412553	AR 02423330
AR 02405120	AR 02412564	AR 02425211
AR 02405121	AR 02412566	AR 02428425
AR 02405123	AR 02412567	AR 02429729

Section 1R04: Equipment Alignment

Procedures
STP-O-30.4, Auxiliary Feedwater System Valve and Breaker Position Verification, Revision 00401
STP-O-30.9, Component Cooling Water Flow Path Verification, Revision 00002
STP-O-30.10, Emergency Diesel Generator 'A' Pre-Startup Alignment, Revision 00501

Drawings
33013-1237, Auxiliary Feedwater Piping and Instrumentation Drawing (P&ID), Revision 68
33013-1239, Diesel Generator – 'A' P&ID, Revision 27, Sheet 1
33013-1245, Auxiliary Coolant Component Cooling Water P&ID, Revision 34
33013-1246, Auxiliary Coolant Component Cooling Water P&ID, Revision 17, Sheet 1
33013-1246, Auxiliary Coolant Component Cooling Water P&ID, Revision 13, Sheet 2
33013-1250, Station Service Cooling Water Safety-Related P&ID, Revision 49, Sheet 2

Action Requests
AR 02388106
AR 02388128
AR 02388177

Section 1R05: Fire Protection

Procedures
FRP-13.0, Intermediate Building Clean Side Fan Floor, Revision 00902
FRP-25.0, Diesel Generator Room 'B' and Vault, Revision 00900
FRP-35.0, Standby Auxiliary Feedwater Building, Revision 00602

Drawings
21488-100, Fire, Smoke, and Pressure Barriers Plan View Elevation 289 feet 6 inches, 293 feet 0 inches, 298 feet 4 inches, 315 feet 4 inches, and Screen House Elevation 239 feet 6 inches, 243 feet 6 inches, and 253 feet 6 inches, Revision 6, Sheet 6

21488-120, Intermediate Building – Clean Side Stair Tower and North Wall Penetration Locations Floor Elevation 298 feet 4 inches and 315 feet 4 inches, Revision 5, Sheet 9
21488-0111, Diesel Generator Room 'B' Vault North Wall Penetration locations Floor Elevation 244 feet 0 inches, Revision 4, Sheet 3
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Product Meeting Report dated December 23, 2014
Quarterly Assessment of the Aggregate Impact of Off-Normal Conditions, 2nd and 3rd Quarters 2014
Shift Turnover Report dated December 23, 2014
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VTD-W0120-4192, Instructions for Types DB-75, DB-100 and DBF-40 Air Circuit Breakers, Revision 002
VTD-W0120-6965, Maintenance Program Manual for Safety-Related Type DB Low-Voltage Metal Enclosed Switchgear, Revision 005

Section 4OA7: Licensee-Identified Violations

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LIST OF ACRONYMS

10 CFR	Title 10 of the *Code of Federal Regulations*
AFW	auxiliary feedwater
ANS	American Nuclear Society
ANSI	American National Standards Institute
AR	action request
AV	apparent violation
CAP	corrective action program
CCW	component cooling water
CENG	Constellation Energy Nuclear Group, LLC
CR	condition report
ECP	engineering change package
EDG	emergency diesel generator
Exelon	Exelon Generation Company, LLC
Ginna	R.E. Ginna Nuclear Power Plant
IMC	Inspection Manual Chapter
LER	licensee event report
MR	maintenance rule
NCV	non-cited violation
NRC	Nuclear Regulatory Commission, U.S.
OOS	out of service
P&ID	piping and instrumentation drawing
PM	preventive maintenance
RCA	root cause analysis
RCS	reactor coolant system
SDP	significance determination process
SSC	structure, system, and component
TS	technical specification
UFSAR	Updated Final Safety Analysis Report
WO	work order