

U.S. NUCLEAR REGULATORY COMMISSION
REGION I

License No. DPR-18
Report No. 50-244/99-08
Docket No. 50-244
Licensee: Rochester Gas and Electric Corporation (RG&E)
Facility Name: R. E. Ginna Nuclear Power Plant
Location: 1503 Lake Road
Ontario, New York 14519
Inspection Period: August 9, 1999 through September 19, 1999
Inspectors: C. C. Osterholtz, (Acting) Senior Resident Inspector
F. L. Bower, Resident Inspector, Calvert Cliffs
Approved by: Michele G. Evans, Chief
Projects Branch 1
Division of Reactor Projects

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EXECUTIVE SUMMARY

R. E. Ginna Nuclear Power Plant NRC Inspection Report 50-244/99-08

This routine inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a 6-week period of resident inspection.

Operations

The licensee responded well to a Westinghouse technical bulletin indicating that DB-50 circuit breakers may fail to close, if required, during a seismic event. Placing this issue on the operator workaround list until modifications to the breakers were completed and expanding the review of potential breaker susceptibility to DB-25 and DB-75 breakers were good initiatives. (O2.1)

The licensee adequately implemented the tagout processes and has taken proper action to enter longstanding tagouts into their corrective action program for resolution. A sample of tagouts inspected in the plant were determined to have been hung in accordance with the tagging requirements. The inspectors identified some minor administrative discrepancies with tagging documentation that were appropriately entered into the licensee's corrective action program for resolution. (O2.2)

Maintenance

Observed maintenance activities were accomplished in accordance with procedural requirements. The licensee's post-maintenance testing was adequate to demonstrate the operability of equipment prior to its return to service. Test procedures contained adequate details for accomplishing test requirements. Testing was performed by knowledgeable personnel, and test instrumentation was properly calibrated. (M1.1)

The licensee effectively identified a deficiency in a flexible suction joint for the control room ventilation system air intake fan. The temporary modification performed on the system adequately corrected the deficiency and was completed in a timely manner. (M2.1)

The licensee's control of maintenance worker overtime authorization and use during the March 1999 refuel outage was poor, as demonstrated by the failure of a lead technician to obtain prior written approval, as required by station procedure. The licensee entered this issue into their corrective action program for resolution and committed to improve the effectiveness and implementation of existing overtime guidance. This failure to follow station procedures was treated as a non-cited violation. (M7.1)

Engineering

The licensee effectively identified and corrected a deficiency with the B-residual heat removal pump after discovering one baseplate floor bolt missing. The engineering analysis performed adequately verified pump operability. (E2.1)

Executive Summary (cont'd)

Plant Support

The licensee's plan to reduce contaminated square footage in the auxiliary building was a good initiative. The decontamination of the charging pump room enhanced the ability of operations personnel to routinely inspect the area. (R2.1)

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- Attachment 1 - Partial List of Persons Contacted
- Inspection Procedures Used
- Items Opened, Closed, and Discussed
- List of Acronyms Used

Report Details

I. Operations

O1 Conduct of Operations¹

01.1 General Comments (Inspection Procedure (IP) 71707)

The inspectors observed plant operations to verify that the facility was operated safely and in accordance with licensee procedures and regulatory requirements. This review included tours of the accessible areas of the facility. The inspectors conducted ongoing verifications of engineered safety feature (ESF) system operability, verifications of proper control room and shift staffing, verification that the plant was operated in conformance with the improved technical specifications (ITS) and appropriate action statements were implemented for out-of-service equipment, and verification that logs and records accurately identified equipment status or deficiencies.

01.2 Summary of Plant Status (71707)

The plant was at full power at the beginning of the inspection period. On August 23, 1999, the licensee discovered a tear in a flexible suction joint for the control room air intake fan that allowed excessive in-leakage of outside air into the control room and was reportable per 10 CFR 50.72 (see section M2.1). The tear was repaired with a temporary modification the same day. The plant remained at full power through the end of the inspection period.

O2 Operational Status of Facilities and Equipment

02.1 Westinghouse Circuit Breaker Operability During Seismic Events

a. Inspection Scope (71707)

The inspector reviewed the licensee's response to a Westinghouse technical bulletin on circuit breaker operability.

b. Observations and Findings

On August 23, 1999, Westinghouse issued a technical bulletin (W-TB-99-05) that indicated Westinghouse DB-50 style circuit breakers may not close if needed during a seismic event. During seismic testing of DB-50 circuit breakers, Westinghouse observed that the breakers would randomly fail to close due to two independent mechanisms. The breaker "X" relay would intermittently pick up without activating the breaker close coil, and the breaker inertia latch would intermittently prevent breaker mechanism movement when the close coil was energized. Both conditions would

¹ Topical headings such as O1, M8, etc., are used in accordance with the NRC standardized reactor inspection report outline. Individual reports are not expected to address all outline topics.

require manual operator action to mitigate. If a breaker attempted to close and failed, an operator would have to place the breaker control switch to the after trip position to reset the "X" relay. If the inertia latch condition occurred, it would cause the breaker control fuses to blow and an operator would have to replace the fuses. The licensee concluded that the Westinghouse DB-25 and DB-75 circuit breakers may also be susceptible to failure during a seismic event and expanded their review of this issue.

The licensee performed an operability analysis for safety related circuit breakers. The analysis concluded that sufficient time exists for operators to diagnose and correct potential breaker problems during a seismic event, because seismic events are not postulated to occur simultaneously with another event or accident. Therefore, the inventory in the steam generators can remove decay heat for the time period it would take operators to compensate for a potential circuit breaker failure. The analysis also indicated that the breakers would function if locally operated. However, since operator action would be required, the licensee designated the item as an operator workaround, and placed guidance in the operations plan for operations personnel to respond to a potential circuit breaker failure. The licensee indicated that a modification can be performed on the circuit breakers to alleviate the susceptibility of failure to close during a seismic event, and was pursuing the procurement and installation of new design components at the end of the inspection period. The licensee also indicated that the item would remain on the operator workaround list until the modifications are completed.

c. Conclusions

The licensee responded well to a Westinghouse technical bulletin indicating that DB-50 circuit breakers may fail to close, if required, during a seismic event. Placing this issue on the operator workaround list until modifications to the breakers were completed and expanding the review of potential breaker susceptibility to DB-25 and DB-75 breakers were good initiatives.

O2.2 Tagging and Work Control

a. Inspection Scope (71707)

The inspector reviewed the implementation of administrative procedure A-1401, "Station Holding Rules."

b. Observations and Findings

The inspectors reviewed the computer-based status record of the 42 active holds (equipment protective tagouts). The inspectors noted that the two oldest tagouts were initiated in 1995. The inspector questioned why these tagouts remained active. RG&E provided information that these tagouts had been entered into the corrective action program for resolution. The equipment effected was tagged in a safe condition while awaiting the development of plant changes to abandon the effected equipment in-place. The inspector also confirmed that RG&E had generated action reports to resolve the three additional tagouts that were greater than one year old.



The inspector selected a sample of tagouts for a detailed review. Of the 12 tagouts reviewed, five were found to have minor administrative errors including inconsistencies between the status maintained by the tagout release worksheet hard-copies and the computer-based status records and, tagouts remaining active for months after all tags were cleared in the field. The inspector also noted that the performance of surveillance procedure O-6.11, "Surveillance Requirement/Routine Operations Check Sheet," was deficient for the months of June and July 1999, in that, these procedural compliance errors were not identified during the monthly tagout review. The inspector determined that these discrepancies were administrative in nature and not safety significant. Accordingly, these minor procedural violations are not subject to formal enforcement action. RG&E initiated ACTION Report 99-1266 to enter these tagout documentation inconsistencies into the corrective action program for review and resolution. The ACTION Report concluded that the complexity of the tagout process may have contributed to these discrepancies.

The inspector selected seven tagouts to walkdown with an auxiliary operator. The inspector verified that the specified tags were properly installed and correctly labeled in accordance with the information on the tagout records. Based on a visual inspection, the inspector verified that the switches, breakers, and valves were in the positions specified by the tags. The inspector also accompanied an operator assigned to clear a tagout. The operator used appropriate self-checking techniques to ensure that the specified tags were properly removed from the isolation boundary equipment.

NRC Inspection Report 50-244/97-10 identified inspectors' concerns related to configuration control. These issues were documented and updated as inspector follow-up item IFI 97-10-01. RG&E initiated ACTION Report 98-0025 to review a series of identified configuration control issues for collective significance and generic implications. The resolution of the ACTION Report concluded that the majority of the configuration control issues were outage-related. Corrective actions included manning the work control center around-the-clock to improve consistency in the operation of the work control center.

The inspector conducted observations of the work control center. Currently, two senior reactor operators are assigned to the work control center "full-time" during day shift. This work control center staff was supplemented by available relief shift operators. The work control center, in part, was responsible for participating in the integrated maintenance planning process and verifying the adequacy of tagout boundaries submitted by maintenance planning. The work control center was delegated authority to establish and clear tagouts and to release work. The inspector noted that, when manned, the work control center aids in the reduction of traffic and potential distractions in the main control room. Based on observation and discussions with work control center personnel, the inspectors noted that one full-time work control center staff member was only in the work control center during the morning hours from August 16 through August 20, 1999. The other staff member was only available two mornings during that week. The remainder of their time was occupied with training, control room watchstanding, and other assigned duties. The inspectors noted that the work control center was generally manned by other available operations personnel while the "full-time" staff was not available. Based upon

the inspector's review, the inconsistent manning of the work control center may have contributed to the administrative deficiencies identified with active tagouts. The licensee acknowledged this inspector observation and was still evaluating work control center manning requirements at the end of the inspection period.

c. Conclusions

The licensee adequately implemented the tagout processes and has taken proper action to enter longstanding tagouts into their corrective action program for resolution. A sample of tagouts inspected in the plant were determined to have been hung in accordance with the tagging requirements. The inspectors identified some minor administrative discrepancies with tagging documentation that were appropriately entered into the licensee's corrective action program for resolution.

O8 Miscellaneous Operations Issues

O8.1 (Closed) Licensee Event Report (LER) 1999-06: Valve in Unexpected Position Results in Start of Turbine-Driven Auxiliary Feedwater Pump

LER 1999-06 was issued on May 21, 1999, after an inadvertent start of the turbine driven auxiliary feedwater pump (TDAFW) occurred on April 21, 1999, while the plant was in MODE 2 operations. Testing of the steam admission motor-operated valve (MOV-3505A) for the TDAFW had been completed and Reliability Test (RT) personnel had left the valve in the open position, as allowed by test procedure M-64.1.2, "MOVATS Testing of Motor Operated Valves." The RT lead technician indicated to the control room operators that the tagout associated with the testing could be cleared. DC power had been removed from MOV-3505A as part of the testing, and therefore the main control board position indication for MOV-3505A was not functioning. When the manual isolation valve for MOV-3505A (V-3505) was opened, steam was admitted to the TDAFW pump and the pump started. The AFW system engineer was in the vicinity of the TDAFW pump and notified the control room that the pump had started. Control room operators manually shut the TDAFW discharge flow control valves and V-3505 was shut. The inadvertent start caused a two degree Fahrenheit (°F) cooldown of the reactor coolant system (RCS). The licensee issued a four-hour notification to the NRC, in accordance with 10 CFR 50.72.

The inspector performed an on-site review of this LER. The licensee had performed an event investigation which attributed the root cause of the event to be an inadequate procedure combined with inadequate communication between RT and operations personnel, particularly with respect to pre-job briefs. Corrective actions included revising procedure M-64.1.2 to require a final valve position prior to completion of MOV testing, discussion on importance of attention to detail among operational shifts, and conducting "lessons learned" training on pre-job briefs with maintenance personnel. The inspector reviewed the changes made to M-64.1.2 and verified that the procedure required the operations staff to indicate the desired valve position, prior to removing the tagout used for valve testing. Both operations and maintenance personnel indicated that attention to

detail and thoroughness of pre-job briefs had been emphasized by their management. The inspectors concluded that the LER adequately described the root causes and corrective actions associated with the event. This LER is closed.

O8.2 (Closed) LER 1999-07, Revision 1: Personnel Error Causes Two Channels to be in Tripped Condition, Resulting in Reactor Trip

LER 1999-07 was issued on May 24, 1999, after an April 23, 1999 event in which an automatic reactor trip signal was generated when an instrumentation and control (I&C) technician inadvertently pulled the fuses for power range channel N43 instead of power range channel N42, which had already been defeated (see IR 50-244/99-03). Revision 1 to the LER was issued on July 23, 1999, after the licensee performed an event investigation which focused on human performance issues associated with the event.

The inspector performed an on-site review of the LER. The LER indicated that the root cause for pulling the wrong fuses was a failure to self check and peer check during the maintenance. Corrective actions included counseling the technicians, generating a training work request to conduct STAR training for I&C technicians, relabeling the nuclear instrument cabinets to use color codes to differentiate among the different channels, and to conduct toolbox training for I&C technicians to reinforce management expectations on work practices. The inspectors reviewed the enhancements made to the nuclear instrumentation cabinets and discussed the event with operations and maintenance personnel. The inspectors observed that the use of excessive overtime during outage activities could have contributed to these human performance events. As discussed in Section M7.1 of this report, the licensee has committed to improve the effectiveness of their overtime authorization program. The inspectors concluded that the LER adequately described the root causes and corrective actions associated with the event. This LER is closed.

O8.3 (Closed) LER 1999-08: Faulted Bistable During Calibration of Redundant Channel Results in Overtemperature Delta T Reactor Trip

The inspectors performed an on-site review of this LER. LER 1999-08 was issued on May 27, 1999, after an April 27, 1999 event in which an automatic reactor trip occurred from approximately 90% power on overtemperature delta T (OTΔT). Instrumentation and control (I&C) technicians were performing calibration checks on channel 2 when a spike on the channel 3 OTΔT module occurred, satisfying the two-out-of-four logic and causing the automatic trip signal. Troubleshooting revealed a faulted bistable in channel 3 had caused the spike. Erratic bistable output was observed by I&C technicians during bench testing. The bistable was replaced and the plant returned to power operations April 29, 1999. The inspectors had observed portions of the troubleshooting activities and discussed the fault with the system engineer. Additionally, the inspectors reviewed and agreed with the post-trip evaluation report presented to the plant operations review committee. The faulted bistable was sent to the vendor for further analysis. The inspectors concluded that the LER adequately described the root causes and corrective actions associated with the event. This LER is closed.

O8.4 (Closed) LER 1999-10: Radiation Monitor Alarm, Due to Higher than Normal Radioactive Gas Concentration, Results in Auxiliary Building Ventilation Isolation

The inspector performed an in-office review of LER 1999-10. The LER was issued on July 15, 1999, after a June 15, 1999 event in which the auxiliary building ventilation automatically isolated during a drain down of the A-chemical and volume control system (CVCS) holdup tank. RCS activity was higher than normal due to a suspected leaking fuel assembly. Control room operators noted auxiliary building particulate and gas monitors increasing during the maintenance activity, and the ventilation isolation occurred on high auxiliary building gas. The licensee later determined that the high alarm setpoints for auxiliary building particulate and gas were excessively conservative, approximately one per cent of the release limits as defined by the Offsite Dose Calculation Manual. The licensee implemented new alarm setpoints for containment particulate and gas to prevent further unnecessary automatic auxiliary building ventilation isolations. The licensee also indicated that a comprehensive plan to address operation with suspected leaking fuel assemblies would be developed. The inspectors concluded that the LER adequately described the root causes and corrective actions associated with the event. This LER is closed.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Maintenance and Surveillance Activities

a. Inspection Scope and Findings (62707 and 61726)

The inspectors observed portions of plant maintenance activities to verify that the correct parts and tools were utilized; the applicable industry codes and technical specification requirements were satisfied; adequate measures were in place to ensure personnel safety and prevent damage to plant structures, systems, and components; and to ensure that equipment operability was verified upon completion of post maintenance testing.

The following maintenance and surveillance activities were observed:

- a. A-steam generator level instrument calibration
- b. A-containment recirculation fan cooler breaker inspection and maintenance
- c. PT-12.1, "Emergency Diesel Generator A"
- d. PT-12.2, "Emergency Diesel Generator B"
- e. PT-16Q-B, "Auxiliary Feedwater Pump B - Quarterly"
- f. PT-2.8-Q, "Component Cooling Water Pump Quarterly Test"

b. Conclusions

Observed maintenance activities were accomplished in accordance with procedural requirements. The licensee's post-maintenance testing was adequate to demonstrate the operability of equipment prior to its return to service. Test procedures contained

adequate details for accomplishing test requirements. Testing was performed by knowledgeable personnel, and test instrumentation was properly calibrated.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Control Room Air Intake Fan Temporary Modification and 10 CFR 50.72 Report

a. Inspection Scope (62707)

The inspector reviewed the licensee's response to a self identified deficiency in a suction joint for the control room return air fan.

b. Observations and Findings

On August 23, 1999, the licensee discovered a six inch tear in a flexible suction joint for the control room air intake fan, located in the air handling room in the turbine building. This allowed unisolable outside air to be drawn into the control room air handling unit. The licensee performed an analysis and determined that the tear had allowed in-leakage of 178 cubic feet per minute (CFM). This exceeded the allowable rate as designated in the Updated Final Safety Analysis Report (UFSAR) of 45 CFM. The licensee issued a one hour notification to the NRC in accordance with 10 CFR 50.72, and entered ITS 3.0.3.

The licensee generated an ACTION report (99-1271) to address the issue and maintenance personnel installed a temporary modification to the expansion joint to eliminate the in-leakage. The deficiency was identified at 10:15 a.m., and the modification was completed at 11:03 a.m. ITS 3.0.3 was then exited, and the system was leak checked satisfactorily. The licensee indicated that the tear may have been a design defect, and planned to perform a root cause analysis as part of the ACTION Report. The inspector noted that the system had been worked on and satisfactorily leak tested during the previous refueling outage in March, 1999.

c. Conclusions

The licensee effectively identified a deficiency in a flexible suction joint for the control room ventilation system air intake fan. The temporary modification performed on the system adequately corrected the deficiency and was completed in a timely manner.

M7 Quality Assurance in Maintenance Activities

M7.1 (Closed) Unresolved Item (URI) 99-05-02: Breach of Overtime Requirements for On-site Personnel

a. Inspection Scope (45000)

The inspector reviewed the use of overtime for the March, 1999 refueling outage.

b. Observations and Findings

Unresolved Item 99-05-02 was opened on August 6, 1999, during the corrective action team inspection when the team observed a presentation on the sequence of events and causes of a reactor trip that occurred on April 23, 1999. The lead technician who was involved in causing the trip had worked 11 consecutive days, 10 of which were 12-hour shifts and one that was an 8-hour shift. Plant Operations Review Committee (PORC) members discussed and challenged some of the potential root causes, but notably did not pursue the potential excessive overtime use by the lead technician.

Since information on the use of overtime was not developed in the PORC meeting, the team followed up on the issue. The official work record for the lead technician, who had been involved in causing the trip, showed that he had substantially exceeded the limit of 72 hours in a seven-day period. The team determined that the licensee had no written authorization for the lead technician to exceed the limits on maximum hours worked. Station procedure A-52.10, "Overtime Policy for Key Maintenance Personnel," revision 9, requires that written authorization be obtained from the Plant Manager, Maintenance Superintendent, or Production Superintendent, if a worker is going to exceed prescribed overtime requirements. This severity level IV violation is being treated as a Non-Cited Violation (NCV 50-244/99-08-01), consistent with Appendix C of the NRC Enforcement Policy.

The licensee generated an ACTION Report (99-0975) to address this violation and performed their own analysis on the use of overtime for maintenance personnel during the refueling outage. The licensee discovered additional instances where maintenance workers had exceeded program requirements without written authorization. The licensee committed to improving the effectiveness of the program and also to reduce the potential for an individual to work excessive overtime by the next refueling outage.

c. Conclusions

The licensee's control of maintenance worker overtime authorization and use during the March 1999 refuel outage was poor, as demonstrated by the failure of a lead technician to obtain prior written approval, as required by station procedure. The licensee entered this issue into their corrective action program for resolution and committed to improve the effectiveness and implementation of existing overtime guidance. This failure to follow station procedures was treated as a non-cited violation.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Baseplate Floor Bolt Missing for the B-Residual Heat Removal Pump

a. Inspection Scope (37551)

The inspectors reviewed the licensee's response to the discovery of a missing baseplate floor bolt for the B-residual heat removal (RHR) pump.

b. Observations and Findings

On August 11, 1999, during a routine individual plant examination of external events (IPEEE) walkdown of the B-RHR pump, a licensee system engineer identified that one of the six baseplate floor bolts for the B-RHR pump was missing. The licensee's preliminary analysis could not justify that the pump was seismically qualified. The licensee declared the B-RHR pump inoperable and issued a one-hour notification to the NRC, in accordance with 10 CFR 50.72. The licensee generated an ACTION Report (99-1237) and performed a walkdown of all other ESF equipment to ensure no other baseplate floor bolts were missing. The licensee immediately assigned a maintenance crew to install a new baseplate floor bolt. The bolt was replaced and the B-RHR pump was declared operable on August 12, 1999.

The licensee performed a detailed analysis of the B-RHR pump related to concrete, reinforcing bar, and uplift loads and determined that the pump was seismically qualified with the one baseplate floor bolt missing. The preliminary analysis had not accounted for the reinforcing bar present in the concrete. The inspector reviewed the analysis and concurred that the B-RHR pump had been seismically qualified. The licensee subsequently retracted the 10 CFR 50.72 notification on August 26, 1999.

c. Conclusions

The licensee effectively identified and corrected a deficiency in the B-residual heat removal pump after discovering one baseplate floor bolt missing. The engineering analysis performed adequately verified pump operability.

E8 Miscellaneous Engineering Issues

E8.1 (Closed) IFI 99-03-01: Reactor Protection Module Modifications for Primary System Temperature, and Primary Resistance Temperature Detector (RTD) Replacements

IFI 99-03-01 was opened on June 15, 1999, after multiple problems surfaced following a modification to the over power delta temperature (OPΔT) and over temperature delta temperature (OTΔT) instruments. The modification provided for the resistance temperature detector (RTD) processing modules to be replaced in channels 1, 3, and 4 to allow for continuous signal processing. The modification had been successfully

performed on channel 2 during the previous refueling outage. After installation, the licensee unexpectedly encountered problems with setpoint drift (see section E8.2), and the appearance of an additional AC ripple current on top of the normal DC output for channels 1, 3 and 4. The setpoint drift caused channels 1, 3, and 4 to be declared inoperable on May 3, 1999, prompting the licensee to enter ITS 3.0.3 and begin reducing power at 10% per minute. The licensee subsequently contacted the module vendor, NUS Instruments, and replaced the existing Foxboro bistables in channels 1, 3, and 4 with NUS bistables. The NUS bistables included an AC filter and were considered to be more compatible with the NUS modules. The licensee exited ITS 3.0.3 on May 4, 1999, after the bistable replacements and recalibration of channels 1, 3, and 4. However, some AC noise was still present on the bistables and power was administratively restricted to 98.5%.

Further investigation by the licensee revealed that the modules installed in channels 1, 3, and 4 were not exactly the same as the module installed in channel 2 during the previous refueling outage. Part substitutions in the surge suppression portion of the circuit had apparently caused the AC ripple. The licensee was subsequently able to eliminate the AC ripple after sub-component replacement and recalibration. Full power operation resumed on May 26, 1999. The inspector discussed the modification with the electrical systems manager, who indicated that further diagnostic testing of the modules in cooperation with NUS Instruments was scheduled for the next refueling outage in September, 2000. This item is closed.

E8.2 (Closed) LER 1999-09 : Instrumentation Declared Inoperable in Multiple Channels Results in Condition Prohibited by Technical Specifications

LER 1999-09 was issued on June 2, 1999, after a May 3, 1999 event in which setpoint drift of the newly installed modules for OPΔT and OTΔT in channels 1, 3, and 4 caused three out of four channels to be declared inoperable, causing a condition prohibited by the ITS (see IR 50-244/99-03). The inspector performed an on-site review of this LER and the licensee's root cause analysis and corrective actions for this event are described in section E8.1 of this report. This LER is closed.

IV. Plant Support

R2 Status of RP&C Facilities and Equipment

R2.1 Contaminated Area Reduction Plan Review

a. Inspection Scope (71750)

The inspectors reviewed the licensee's plan to reduce contaminated areas in the auxiliary building.

b. Observations and Findings

On September 2, 1999, the licensee issued a plan to reduce contaminated square footage in the auxiliary building. The plan identified and evaluated all contaminated areas, focusing on the extent of the contamination and the radiation exposure that would be induced to maintain the areas clean. The contaminated areas were also prioritized placing emphasis on areas that were routinely entered by operations personnel while performing their daily rounds. The charging pump room in the auxiliary building basement was placed on the high priority list because the area is routinely entered by operations personnel and maintenance is frequently performed in the area. The inspectors noted that the charging pump room had been properly decontaminated by the end of the inspection period.

c. Conclusions

The licensee's plan to reduce contaminated square footage in the auxiliary building was a good initiative. The decontamination of the charging pump room enhanced the ability of operations personnel to routinely inspect the area.

S8 Miscellaneous Security and Safeguards Issues

S8.1 (Closed) LER 1999-S01: Safeguards Event

LER 1999-S01 was issued on July 19, 1999, after the licensee had determined that a safeguards event had occurred. The inspector performed an in-office review of the licensee's response to the event and the subsequent corrective actions taken as documented in the LER, and found them to be adequate. This LER is closed.

V. Management Meetings

X1 Exit Meeting Summary

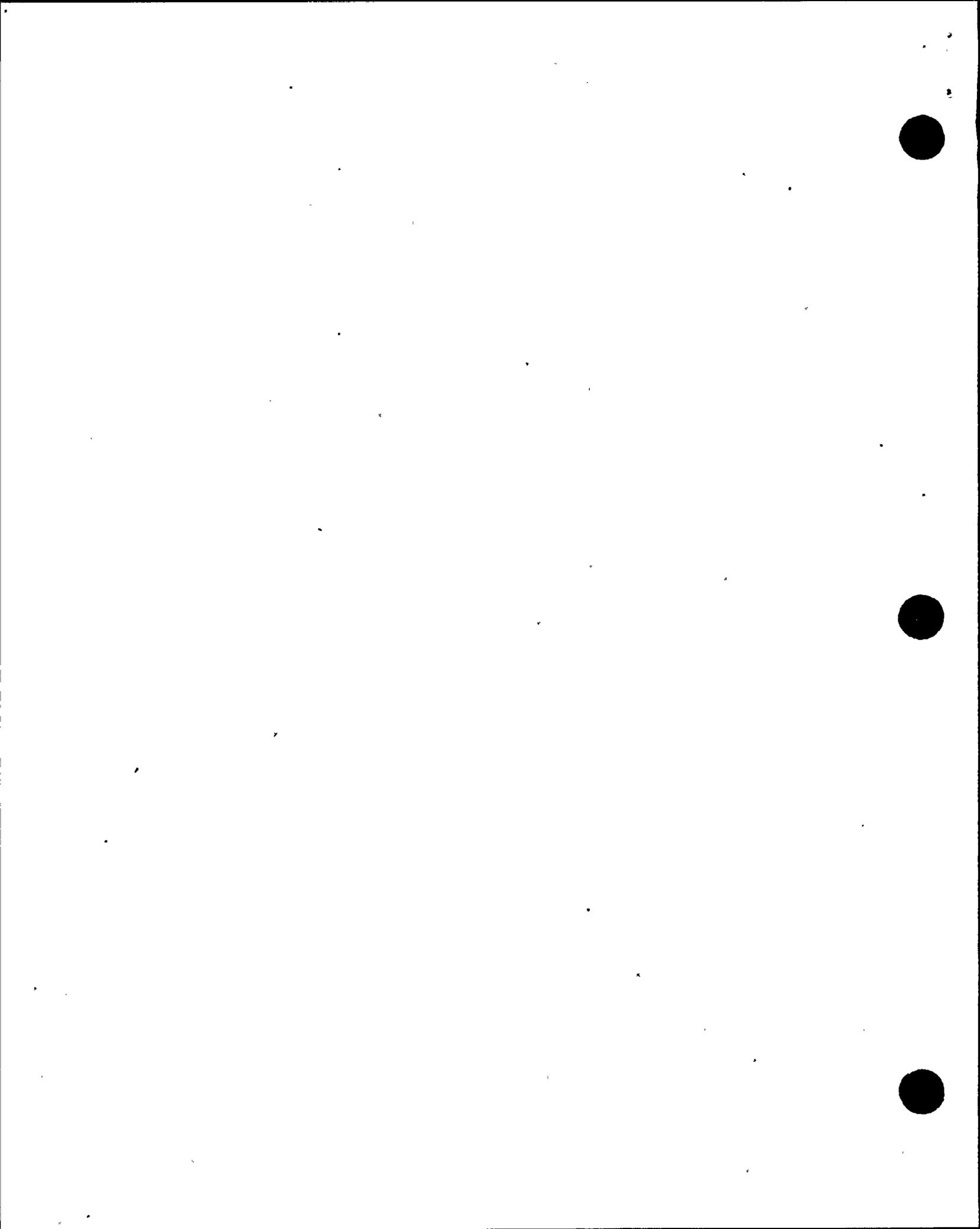
After the inspection was concluded, the inspectors presented the results to members of licensee management on September 28, 1999. The licensee acknowledged the findings presented.

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

X3 Management Meeting Summary

X3.1 RG&E Management Drop-in Visit to the Region I Office

On September 3, 1999, Mr. Paul Wilkens, Senior Vice President, Generation, and members of his staff met with Mr. Hubert Miller, Regional Administrator, Region I, and members of his staff at the Region I office in King of Prussia, Pennsylvania. Mr. Wilkens and Mr. Miller discussed a variety of topics.



ATTACHMENT I

PARTIAL LIST OF PERSONS CONTACTED

Licensee

J. Widay	VP, Plant Manager
T. Alexander	Operational Review Manager
P. Bamford	Reactor Engineering Manager
G. Graus	I&C/Electrical Maintenance Manager
G. Hermes	Acting Primary Systems Engineering Manager
J. Hotchkiss	Mechanical Maintenance Manager
G. Joss	Results and Test Supervisor
M. Lilley	Quality Assurance Manager
R. Marchianda	Nuclear Assessment Manager
T. Marlow	Nuclear Engineering Services Manager
J. Pascher	Electrical Systems Engineering Manager
T. Plantz	Maintenance Systems Manager
R. Ploof	Secondary Systems Engineering Manager
P. Polfleit	Emergency Preparedness Manager
R. Popp	Production Superintendent
J. Smith	Maintenance Superintendent
W. Thomson	Radiological Protection & Chemistry Manager
J. Wayland	Scheduling Manager
T. White	Operations Manager
G. Wrobel	Nuclear Safety & Licensing Manager

INSPECTION PROCEDURES USED

IP 37551:	Onsite Engineering
IP 40500:	Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
IP 61726:	Surveillance Observation
IP 62707:	Maintenance Observation
IP 71707:	Plant Operations
IP 71750:	Plant Support
IP 92700:	Onsite Follow-up of Written Reports of Nonroutine Events at Power Reactor Facilities
IP 92901:	Follow-up - Operations
IP 92902:	Follow-up - Maintenance
IP 92903:	Follow-up - Engineering



ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

NCV 99-08-01 Breach of Overtime Requirements for On-Site Personnel

Closed

NCV 99-08-01 Breach of Overtime Requirements for On-Site Personnel

URI 99-05-02 Breach of Overtime Requirements for On-site Personnel

IFI 99-03-01 Reactor Protection Module Modifications for Primary System Temperature, and Primary Resistance Temperature Detector (RTD) Replacements

LER 1999-06 Valve in Unexpected Position Results in Start of Turbine-Driven Auxiliary Feedwater Pump

LER 1999-07 Personnel Error Causes Two Channels to be in Tripped Condition, Resulting in Reactor Trip

LER 1999-08 Faulted Bistable During Calibration of Redundant Channel Results in Overtemperature Delta T Reactor Trip

LER 1999-09 Instrumentation Declared Inoperable in Multiple Channels Results in Condition Prohibited by Technical Specifications

LER 1999-10 Radiation Monitor Alarm, Due to Higher than Normal Radioactive Gas Concentration, Results in Auxiliary Building Ventilation Isolation

LER 1999-S01 Safeguards Event

Discussed

IFI 97-10-01 Weak Configuration Control



LIST OF ACRONYMS USED

CFM	cubic feet per minute
CFR	Code of Federal Regulations
CVCS	Chemical and Volume Control System
ESF	Engineered Safety Feature
I&C	Instrumentation and Control
IFI	Inspector Follow-up Item
IPEEE	Individual Plant Examination of External Events
IR	Inspection Report
ITS	Improved Technical Specification
LER	Licensee Event Report
MOV	Motor-Operated Valve
NCV	Non-cited Violation
NRC	Nuclear Regulatory Commission
OPΔT	Over Power Delta Temperature
OTΔT	Over Temperature Delta Temperature
PORC	Plant Operations Review Committee
RCS	Reactor Coolant System
RG&E	Rochester Gas and Electric Corporation
RHR	Residual Heat Removal
RTD	Resistance Temperature Detector
TDAFW	Turbine-Driven Auxiliary Feedwater
UFSAR	Updated Final Safety Analysis Report
URI	Unresolved Item