

U.S. NUCLEAR REGULATORY COMMISSION
REGION
SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE
INSPECTION REPORT 50-244/84-99
ROCHESTER GAS AND ELECTRIC CORPORATION
R.E. GINNA NUCLEAR POWER PLANT
ASSESSMENT PERIOD: JULY 1, 1983 - DECEMBER 31, 1984
BOARD MEETING: FEBRUARY 25, 1985

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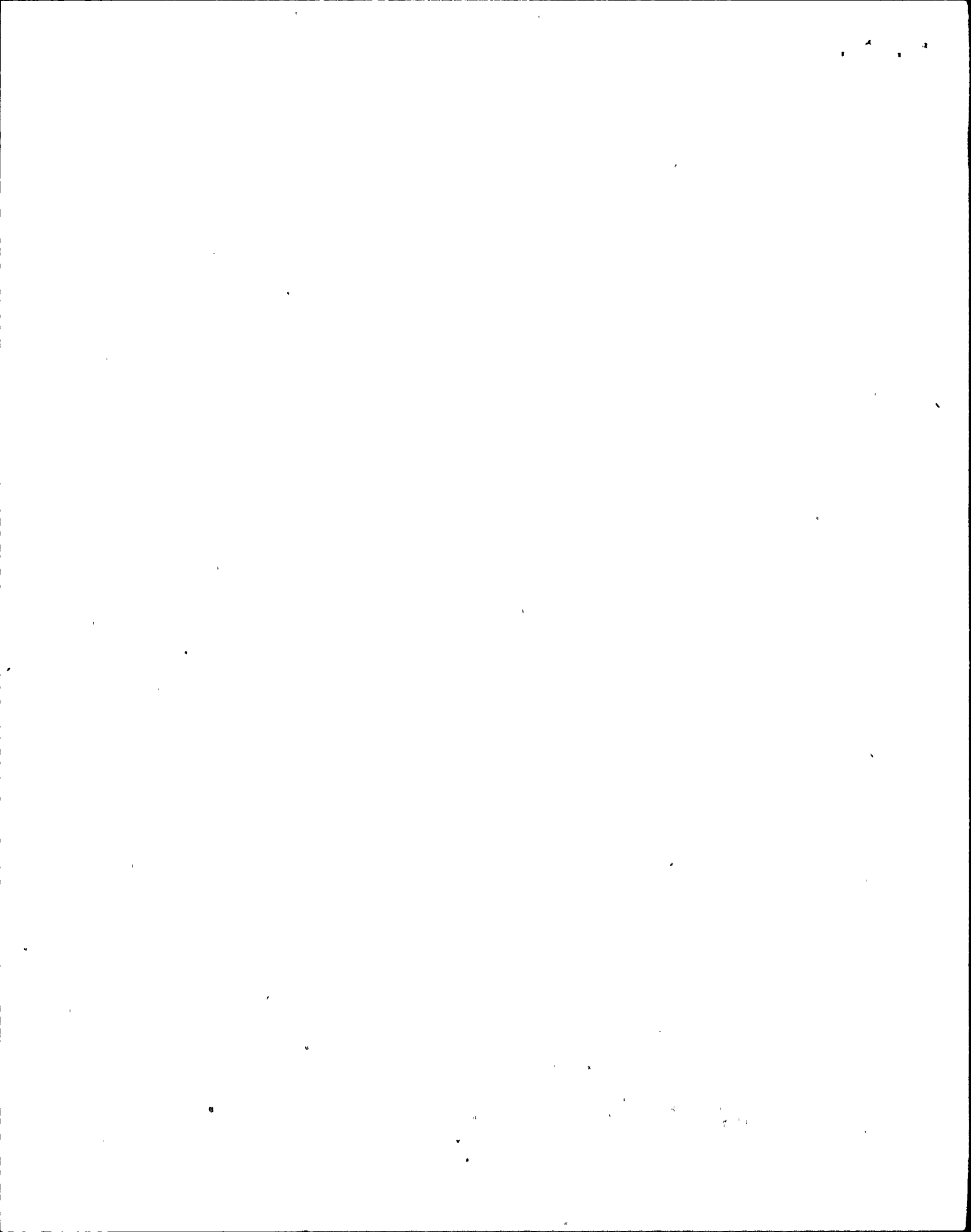
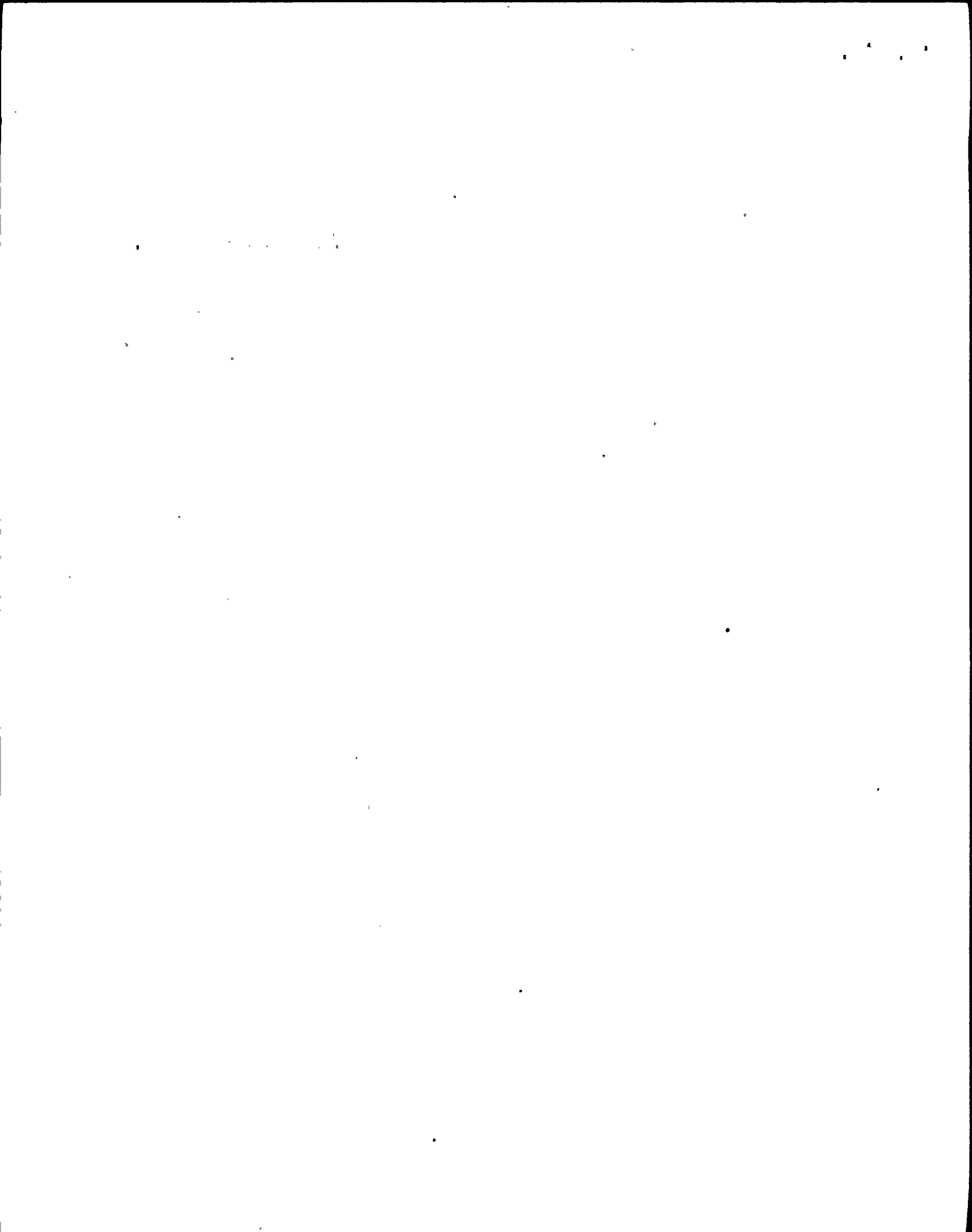


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I. INTRODUCTION

A. Purpose and Overview

The Systematic Assessment of Licensee Performance (SALP) is an integrated NRC staff effort to collect the available observations and data on a periodic basis and to evaluate licensee performance based upon this information. SALP is supplemental to normal regulatory processes used to ensure compliance to NRC rules and regulations. SALP is intended to be sufficiently diagnostic to provide a rational basis for allocating NRC resources and to provide meaningful guidance to the licensee's management to promote quality and safety of plant construction and operation.

A NRC SALP Board, composed of the staff members listed below, met on February 25, 1985 to review the collection of performance observations and data to assess the licensee performance in accordance with the guidance in NRC Manual Chapter 0516, "Systematic Assessment of Licensee Performance". A summary of the guidance and evaluation criteria is provided in Section II of this report.

This report is the SALP Board's assessment of the licensee's safety performance at R. E. Ginna Nuclear Power Station for the period July 1, 1983 through December 31, 1984. It is noted that summary findings and totals reflect the current eighteen month assessment period.

B. SALP Board Members

R. W. Starostecki, Director, Division of Reactor Projects (DRP)
S. D. Ebner, Director, Division of Reactor Safety (DRS)
T. T. Martin, Director, Division of Radiation Safety and Safeguards (DRSS)
S. J. Collins, Chief, Projects Branch No. 2, DRP
W. J. Lazarus, Project Engineer, DRP 2C
W. A. Cook, Resident Inspector, Ginna
C. L. Miller, Project Manager, NRR

Other Attendees

W. Kane, Deputy Director, Division of Reactor Projects
J. Knight, Acting Director, Division of Engineering, NRR
J. Joyner, Chief, Nuclear Materials and Safeguards Branch, DRSS
R. Bellamy, Chief, Radiation Protection Branch, DRSS
J. Linville, Acting Chief, Projects Section No. 2C, DRP

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The facility operated at full power from July 1, 1983 to March 3, 1984 with the exception of an inadvertent reactor trip on September 16, 1983 and five forced load reductions. The

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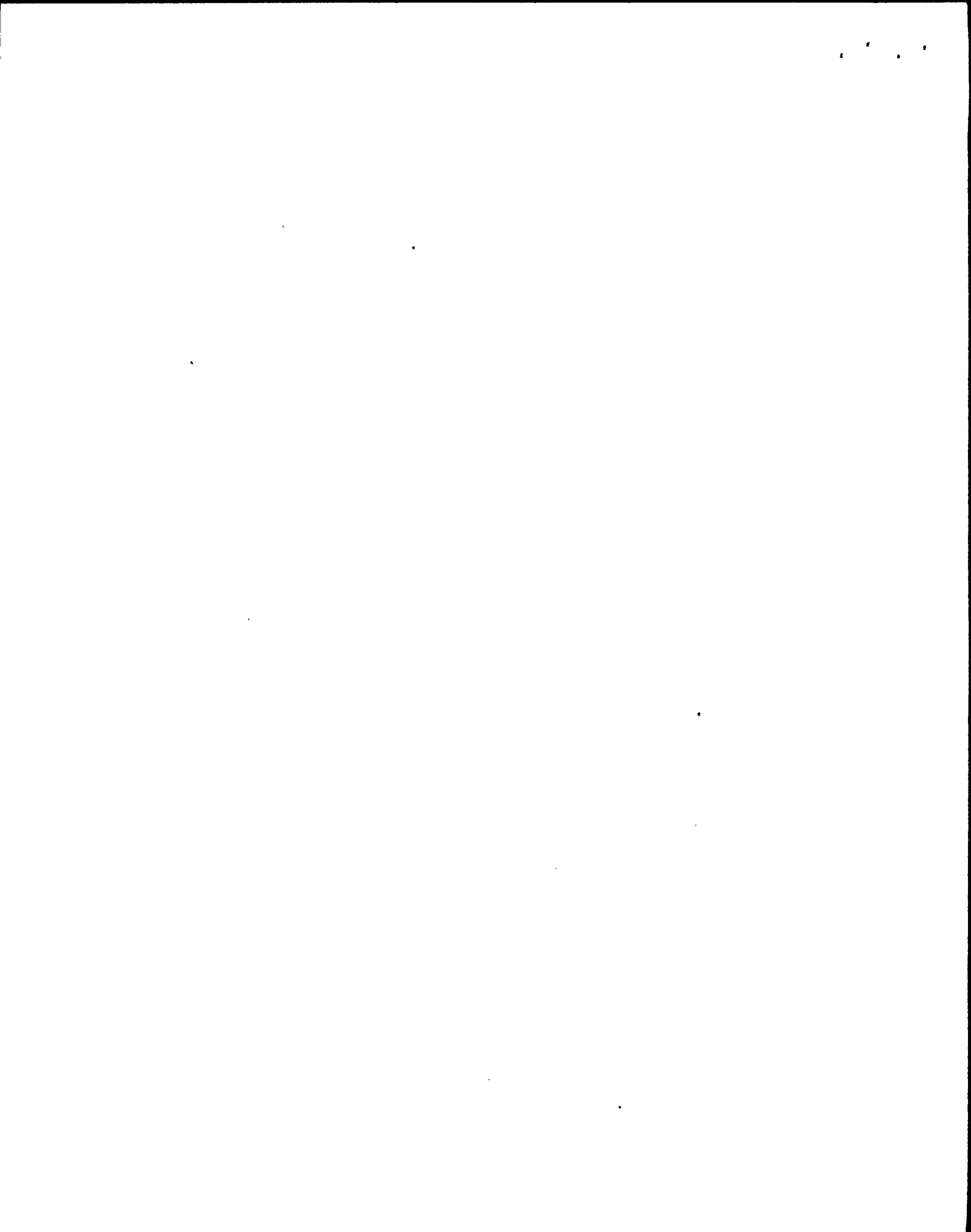


September 16 reactor trip occurred during a load reduction in preparation for a forced shutdown required by boric acid storage tank concentrations being below Technical Specification requirements. The reactor tripped at 21 percent power as a result of a turbine trip which occurred when an operator inadvertently deenergized Bus 11A which carried the only operating main feedwater pump. The plant was restored to full power on September 17, 1983. The short duration forced load reductions were necessary to: perform a weld repair on the test plug of the 2B reheater test line on November 13, 1983; maintain lake intake/discharge differential temperature less than the New York State commitment of 28 degrees on December 24, 1983 (due to electrical problems with the recirculating gate drive motor); repair the 1B main feed pump lube oil cooler on January 9, 1984; comply with a Technical Specification requirement to shutdown because both Safety Injection Accumulators were experiencing low pressure caused by a leaking vent valve on February 18, 1984 (repairs were completed during the load reduction and the plant returned to power); and to repair a steam leak on the 2B reheater steam line instrument tap on February 22, 1984.

Between March 3 and May 14, 1984 the plant was involved in the scheduled annual refueling and inspection outage. Routine steam generator eddy current testing was performed and as a result nine tubes were sleeved in the B steam generator and one tube plugged in each of the A and B steam generators. Other major work items accomplished during the 1984 outage include the replacement of the B reactor coolant pump shaft and impeller, and replacement of the moisture separator reheater internals. During this cycle the licensee commenced the loading of Westinghouse optimized fuel assemblies. Twenty of the twenty-eight new assemblies loaded were of the Westinghouse design.

Following the refueling outage, the facility commenced power ascension on May 14, 1984 but shutdown before exceeding 25 percent power due to a condenser tube leak which necessitated additional secondary chemistry cleanup. Power operations were recommenced on May 23 and continued through the end of this assessment period with the exception of one unscheduled outage and one major load reduction. On May 30, 1984 an exciter failure resulted in a plant trip. The unscheduled outage lasted three days as repairs were affected by plant maintenance personnel. The load reduction of August 7, 1984 was imposed by the repair of a steam leak on the suction relief valve to the 1B main feed pump.

The facility is currently experiencing the longest continuous power run in its operating history, surpassing 213 days on January 1, 1985.



2. Inspection Activities

A resident inspector was continually assigned during the assessment period with an approximate one month overlap in March 1984 during site turnover from R. Zimmerman to W. Cook. The total NRC inspection hours for the assessment period were 3598 (resident and region-based) distributed in the appraisal functional areas as shown in Table 2.

A special inspection conducted during the period between January 3 and May 11, 1984 by five Region I inspectors examined the licensed operator requalification program. A brief summary of this inspection is incorporated in functional area A.

A team of NRC inspectors and contract personnel observed the station emergency exercise on September 12, 1984.

Tabulations of Violations and Inspection Activities conducted during the assessment period are attached as Tables 3 and 4, respectively.

II. CRITERIA

Licensee performance is assessed in selected functional areas, depending on whether the facility is in a construction, preoperational, or operating phase. Each functional area normally represents areas significant to nuclear safety and the environment, and are normal programmatic areas. Special areas may be added to highlight significant observations.

One or more of the following evaluation criteria were used to assess each functional area.

1. Management involvement and control in assuring quality
2. Approach to resolution of technical issues from a safety standpoint
3. Responsiveness to NRC initiatives
4. Enforcement history
5. Reporting and analysis of reportable events
6. Staffing (including management)
7. Training and qualification effectiveness

Based upon the SALP Board assessment each functional area evaluated is classified into one of three performance categories. The definitions of these performance categories are:

Category 1. Reduced NRC attention may be appropriate. Licensee management attention and involvement are aggressive and oriented toward nuclear safety; licensee resources are ample and effectively used so that a high level of performance with respect to operational safety or construction is being achieved.

Category 2. NRC attention should be maintained at normal levels. Licensee management attention and involvement are evident and are concerned with nuclear safety; licensee resources are adequate and reasonably effective so that satisfactory performance with respect to operational safety or construction is being achieved.

Category 3. Both NRC and licensee attention should be increased. Licensee management attention or involvement is acceptable and considers nuclear safety, but weaknesses are evident; licensee resources appear to be strained or not effectively used so that minimally satisfactory performance with respect to operational safety or construction is being achieved.

The SALP Board has also categorized the performance trend over the course of the SALP assessment period. The categorization describes the general or prevailing tendency (the performance gradient) by comparing the trend late in the assessment period to that evident during the beginning of the SALP period. The performance trends are defined as follows:

Improving: Licensee performance has generally exhibited improvement over the course of the SALP assessment period.

Consistent: Licensee performance has remained essentially constant over the course of the SALP assessment period.

Declining: Licensee performance has generally declined over the course of the SALP assessment period.

III. SUMMARY OF RESULTS

A. Overall Facility Evaluation

This is the fourth assessment of licensee performance by the NRC Staff under the Systematic Assessment of Licensee Performance program. The composition of this assessment differs from previous reports in that Quality Assurance/Quality Control is addressed as a separate functional area to summarize the NRC findings and perceptions of the lack of licensee management support for the QA/QC organization. Licensee management does not seem to use QA/QC as a viable feedback mechanism to measure and review station performance. Dependence on an experienced plant staff and their consistently high level of performance has apparently precluded testing the QA/QC organization effectiveness. Thus, the station workers and staff do not support the QA/QC organization. This prevailing attitude of the lack of relevance of QA/QC to safety warrants prompt licensee management

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attention to assure the ability of the QA/QC organization to effectively perform its feedback role should problems develop in the future.

Licensee performance in six functional areas including Maintenance, Surveillance, Fire Protection and Housekeeping, Security and Safeguards, Refueling and Outage Management, and Licensing Activities exemplifies a strong commitment to safe efficient plant operation. In the remaining three functional areas further licensee effort is required to achieve this level of performance. The Plant Operations area improved. Management involvement to increase the formality and effectiveness of Morning Priority Required (MOPAR) meeting and better supervisory oversight to reduce personnel errors have contributed to the longest power run in the facility's operating history during the assessment period. Management efforts to promptly address weaknesses identified in the licensed operator requalification program were commendable. Competent supervisory control and an efficient staff have contributed to a general improvement in the Radiological Controls area, in spite of limited corporate staff involvement. A lack of aggressiveness in pursuing the timely resolution of previously identified NRC concerns detracted from the overall Emergency Preparedness rating this assessment period although performance during the 1984 Emergency Exercise was acceptable.

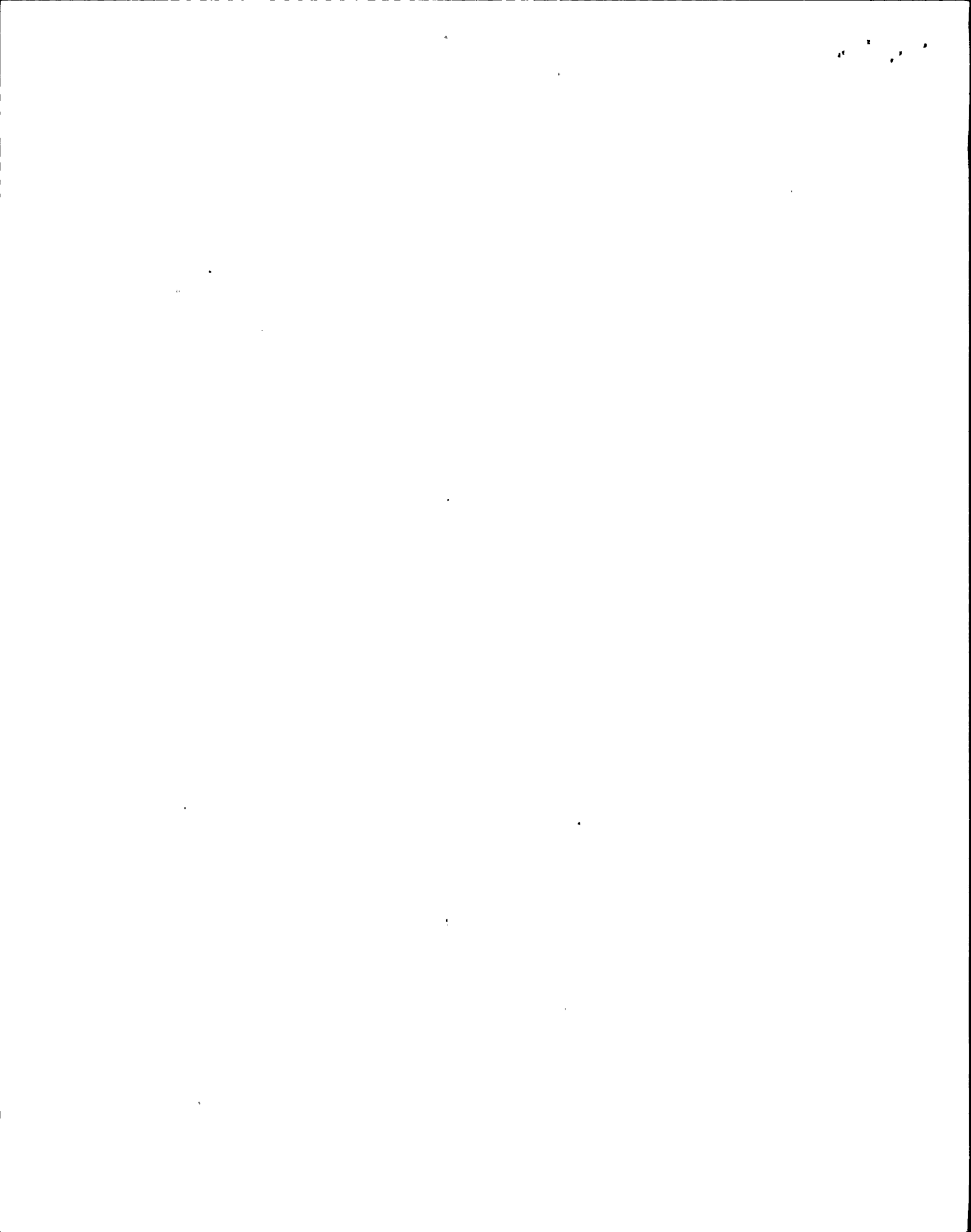
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B. Facility Performance

	FUNCTIONAL AREA	CATEGORY LAST PERIOD	CATEGORY THIS PERIOD	RECENT TREND
1.	Plant Operations o Operator Licensing and Training	2	2	IMPROVING
2.	Radiological Controls o Radiation Protection o Radioactive Waste Management o Transportation o Effluent Control and Monitoring	2	2	IMPROVING
3.	Maintenance	2	1	CONSISTENT
4.	Surveillance (Including Preoperational Testing)	2	1	CONSISTENT
5.	Fire Protection and Housekeeping	1	1	CONSISTENT
6.	Emergency Preparedness	2	2	CONSISTENT
7.	Security & Safeguards	1	1	CONSISTENT
8.	Refueling/Outage Activities (Including Inservice Inspection)	1	1	CONSISTENT
9.	Licensing Activities	1	1	CONSISTENT
10.	Quality Assurance/ Quality Control	*	3	NONE

*Not previously addressed as a separate category



IV. PERFORMANCE ANALYSIS

A. PLANT OPERATIONS (51%)

1. Analysis

The functional area of plant operations includes operator training and licensing, design changes and station modifications, committee activities and reporting systems reviewed by the resident inspector and region-based inspectors.

During the previous assessment period, problems were identified in the areas of: routine review of daily operations; communications between plant staff and project personnel with respect to modification turnover; and the submission of Technical Specification required reports.

During this assessment period Plant operators have demonstrated a uniformly professional dedication to their daily responsibilities and responded quickly and efficiently to abnormal events. Operations supervision was actively involved in the routine review of daily events and normally pursued problem areas to satisfactory resolution in a timely manner. Management has demonstrated a continued sound commitment to safety in its day to day control of plant activities and generally demonstrated a conservative approach when making decisions affecting safety. In addition, plant staff technical and engineering reviews provided through the PORC have continued to strengthen and enhance overall plant operations.

Early in the assessment period there were NRC findings of inadequate overview and control of plant modifications. In particular, the installation of the Post Accident Sampling System was identified as having been placed in service and accepted by PORC without proper assurance that all testing was complete and satisfactory and all quality control concerns properly resolved. This item was indicative of problems identified in the previous assessment period. Commitments to revise the modification control and turnover process were implemented prior to the end of this assessment period, but an inspection to evaluate the effect of the changes has not been completed. This item will be reviewed in the next assessment period.

On two separate occasions during this assessment period, fire protection systems were partially disabled or improperly administratively controlled by operations department personnel without proper compensatory measures taken. Similar occurrences were observed in the previous assessment period. Although considered to be isolated events, control of the frequent disabling and reactivation of fire protection/detection systems must be given the proper level of emphasis as important to safety. Continued management attention in this area is warranted.

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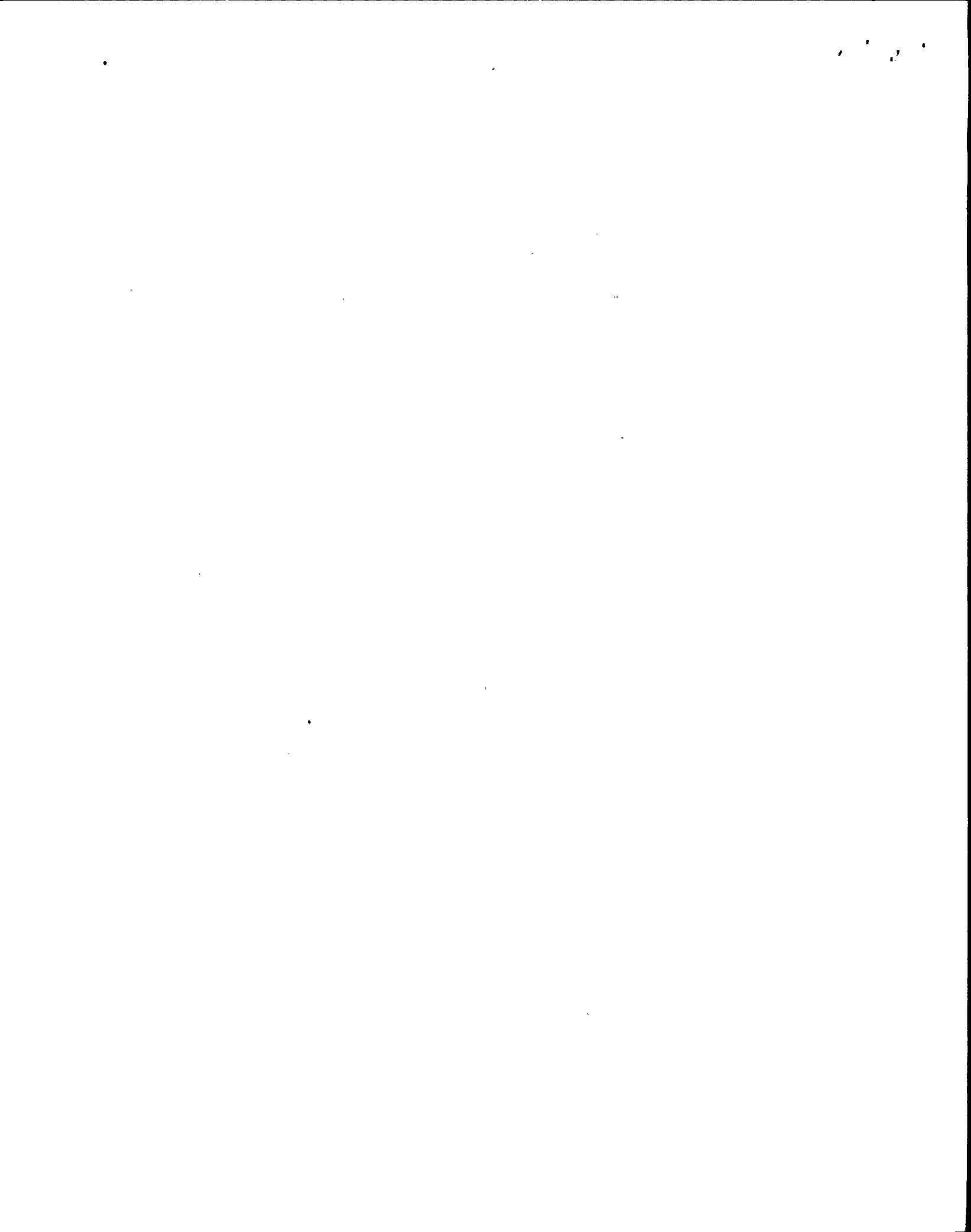
Activities pertaining to current Spent Fuel Pool Storage Rack modifications resulted in the violation of Technical Specifications prerequisites for the handling of irradiated fuel in the Auxiliary Building. Of particular concern to the NRC was that indications of an abnormal ventilation condition had been identified, but not properly evaluated or resolved prior to the authorized movement of fuel. An Enforcement Conference was held for this item on November 5, 1984. Licensee response was prompt and corrective actions comprehensive. Not only have fuel handling prerequisites been substantially upgraded, but plant Morning Priority Action Required (MOPAR) meetings, (composed primarily of PORC members), have become much more structured and formal in addressing and pursuing daily concerns and potential safety issues.

Two inspections by region-based inspectors to review selected IE Bulletin responses and periodic review by the resident inspector of technical specifications required reports and routine reports have been performed this assessment period. In general, the licensee's responses and reports have been timely and adequate. Plant personnel were knowledgeable of the actions taken, records were complete, readily retrievable and adequately documented the tasks performed and licensee findings.

Operator Licensing and Training (316 hours)

Toward the middle of the assessment period a team of NRC operator licensing examiners concluded that significant weaknesses existed in the implementation of the station's approved licensed operator requalification program. In particular, the program review indicated a lack of depth in the annual requalification examinations, inconsistency in the implementation of staff licensed operator training requirements and an overemphasis on the annual requalification examination as the sole measure of the requalification training program effectiveness. Based on that assessment, a comprehensive and ambitious revision to the licensed operator requalification program was undertaken by the licensee. It is recognized that further revisions to this program may be warranted because of the significant impact the changes are having on plant staff workload, however, the licensee is to be credited with the responsiveness and timeliness in addressing this issue. Corporate management involvement and commitment to the resolution of this issue is evident.

With regard to Operator Licenses, 13 SRO and 7 RO licensing examinations were administered during this assessment period, with 10 of the SRO and 6 of the RO candidates receiving a license. This trend is indicative of a strong initial license and upgrade training programs.



A review of non-licensed training by a region-based inspector concluded that the training department is adequately staffed and that management involvement was evidenced by the fact that they contracted for an independent review of maintenance training to identify areas of needed improvement. With the exception of QC personnel, involvement of maintenance personnel, I&C technicians and R&T personnel in general plant systems training has not been observed. Training records for both licensed and non-licensed personnel were both complete and easily retrievable.

2. Conclusion

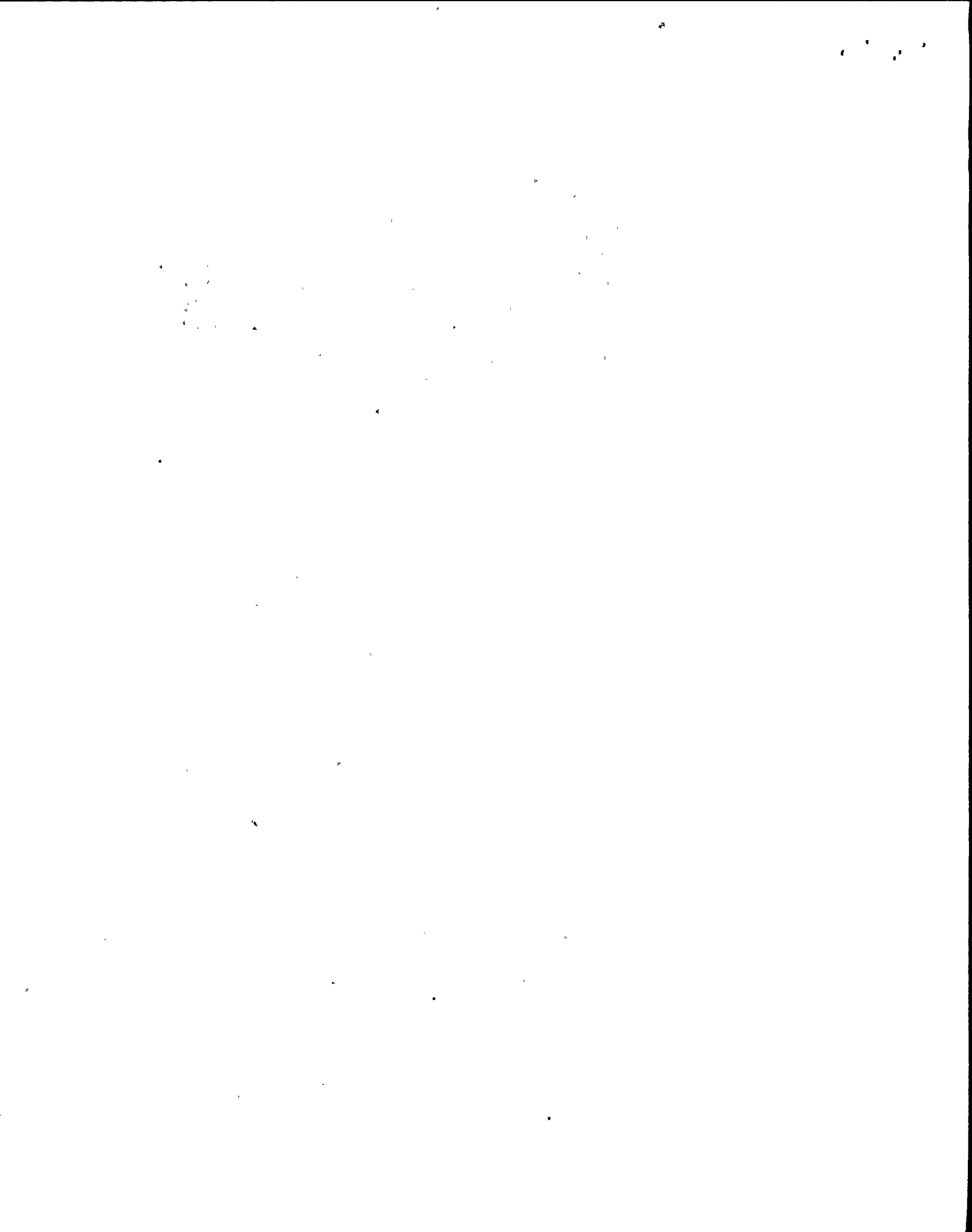
Rating: Category 2

Trend: Improving

3. Board Recommendations

Licensee: Continue licensed operator training upgrade initiatives.

NRC: Review implementation of modification program corrective actions resulting from Inspection Report 50-244/83-23.



B. RADIOLOGICAL CONTROLS (11%)

1. Analysis

During the previous assessment period problems with dosimetry control were identified. In addition, although improvements in site ALARA and external exposure control efforts were identified, documentation in these areas was considered to need improvement.

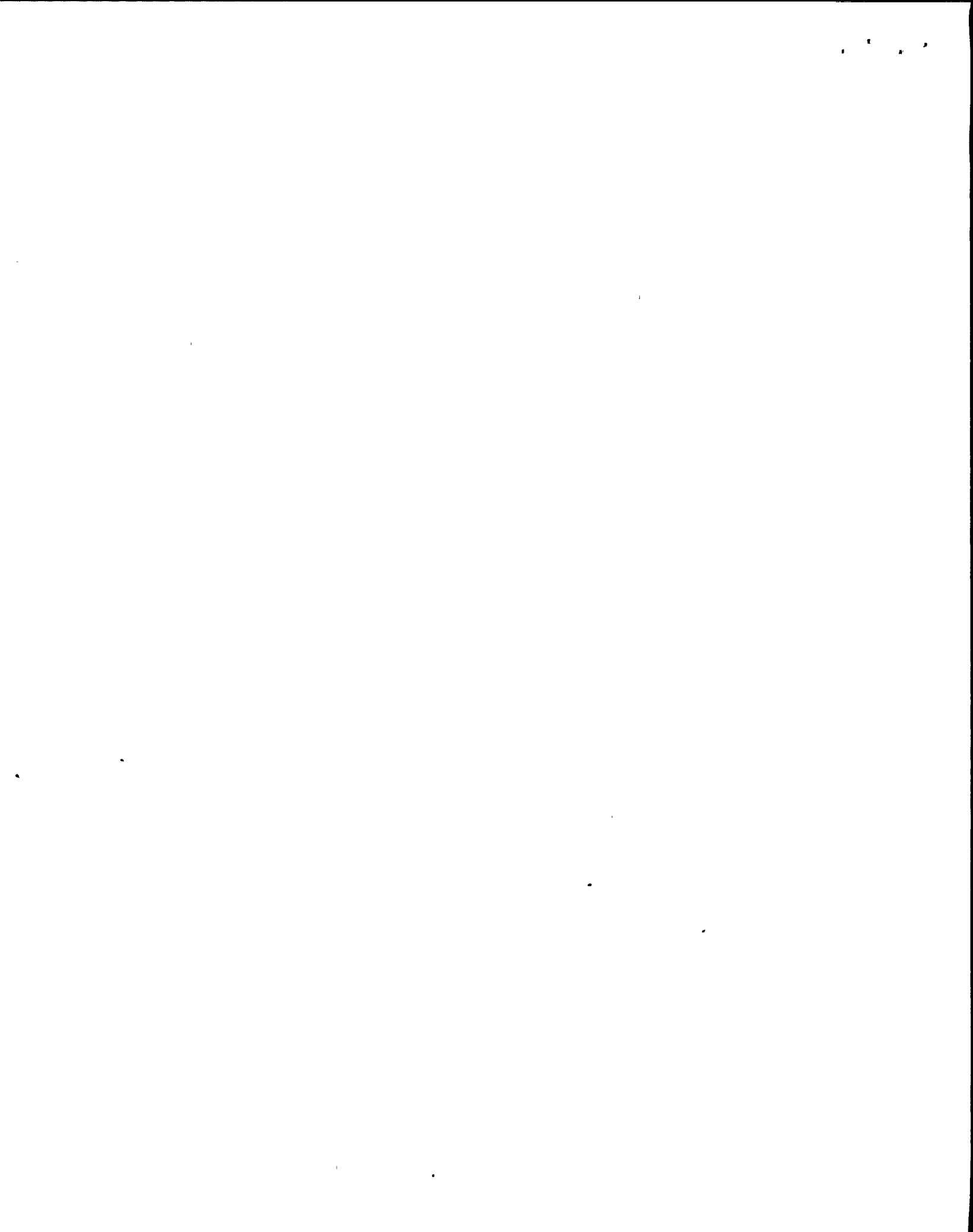
During the assessment period there were five minor violations. There were no escalated enforcement actions, civil penalties or confirmatory action letters. One radiologically significant event occurred and was resolved by the licensee. There were five routine inspections by region based radiation specialists. In-Plant Radiation Safety was inspected twice, Waste Management and Transportation also twice, while Effluent Control was reviewed once.

The radiological controls organization is small and team oriented with competent and experienced personnel. Most are cross-qualified in both health physics and chemistry areas. The site organization is generally self-sufficient without significant technical support from contractors or the corporate staff. This approach has allowed for a high degree of direct site management involvement and control in most activities. However, refinement and improvement in certain areas such as laboratory analysis, training, and procedure development is necessary. Staffing is ample as indicated by control of overtime and minimal use of contractors. Both routine and outage tasks are completed on a timely basis.

Corporate oversight has been minimal. An increasing trend of man-rem exposure may be attributed to certain equipment failures, however, the lack of formal ALARA review of outage work planned and directed from the corporate level may be a contributing factor to the exposure trend. The recent formalization of a corporate ALARA program has not been reviewed by the NRC staff.

Radiation Protection

Within the radiation protection organization the decision making consistently occurs at a level that ensures adequate management review. All radiation work permits are initiated by one of the HP first line supervisors. Prior to work involving significant personnel exposure, a thorough and documented ALARA review is completed by a management committee. Audits of routine and special activities are complete, timely and thorough. Weekly tours of 17 known or potential in-plant problem areas are conducted by HP supervisors and a formal check-off is completed and reviewed by the PORC committee. Site Quality Control personnel also conduct frequent compliance inspections with effective follow-up on findings.



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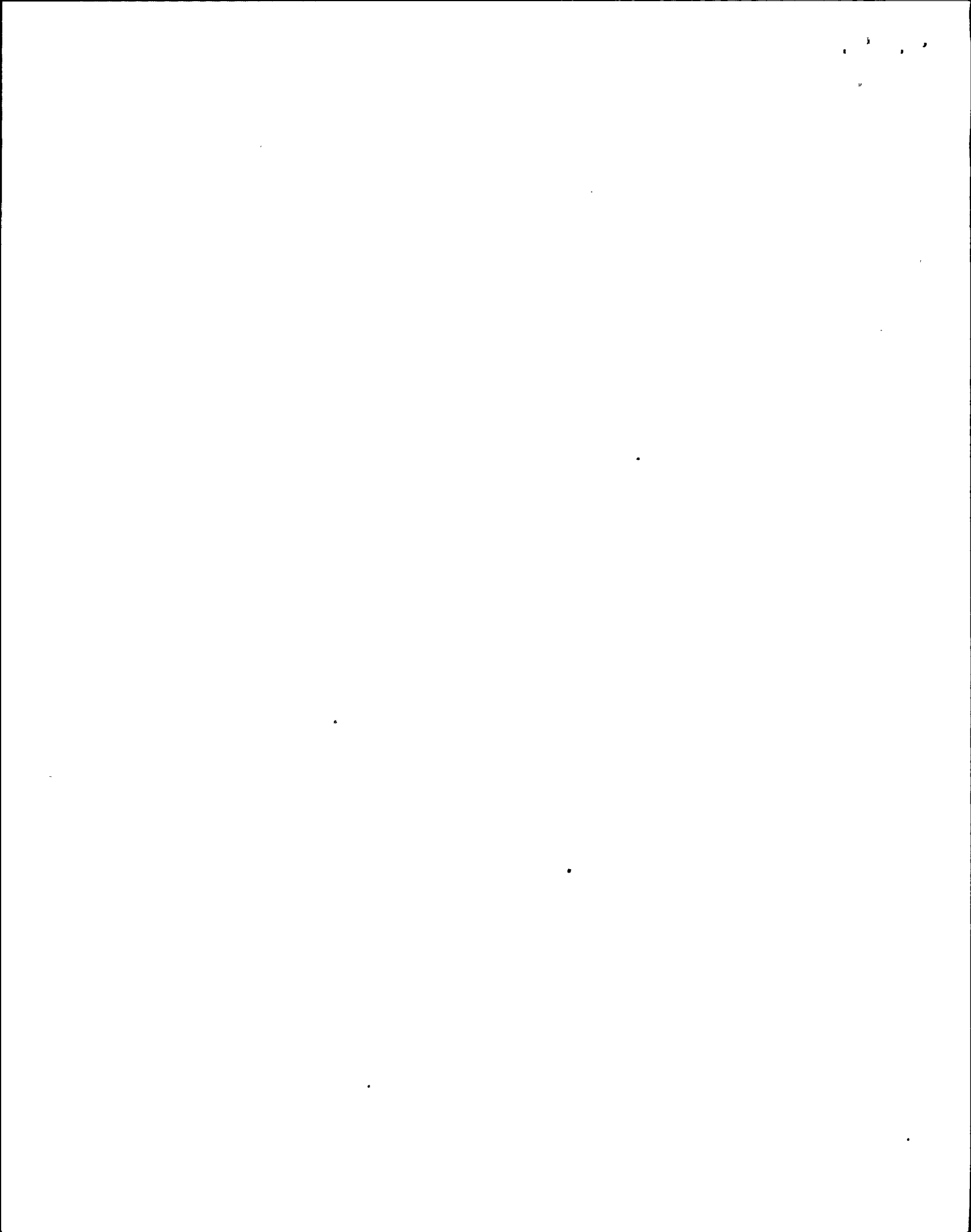
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Corporate oversight has been minimal. Man rem exposure continues to decrease as a result of site staff efforts. While a written corporate program effecting ALARA implementation had not been developed until recently, this has not impacted site efforts to implement dose reduction. The recent formalization of a corporate ALARA program has not yet been reviewed by the NRC staff.

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Records are complete, well maintained and available. The records of personnel exposures and radioactive waste shipments were readily available for inspector review.

Procedures and policies are rarely violated, however, minor problems have occurred in the procedures area. The procedure for waste solidification was not reviewed by PORC or approved by the Station Superintendent. The procedure for monitoring airborne particulate activity does not provide clear and unambiguous instruction for the HP technician.

The licensee's responsiveness to NRC initiatives is generally viable, sound and thorough. Although the Post Accident Sampling System installation was completed within the established commitment dates, system operability verifications and proper testing documentation, as controlled by the administrative modification processes, were found to be inadequate.

Corrective action relative to enforcement initiatives was prompt and effective. Improved control of access to high radiation areas was commendable.

The training and qualification program makes a positive contribution to the HP staff's understanding of the work. Interviews with the staff, permanent and contractor technicians indicate a knowledge of the required procedures and policies which reduces the number of personnel errors.

Radioactive Waste Management and Transportation

The administration of the Quality Assurance Program for transportation activities occurs at the corporate level. However, corporate management is usually not involved in site activities and the annual audits of transportation were somewhat lacking in depth. In contrast, the inspections of shipments by the on-site QC personnel have been complete and thorough.

Records related to the transportation and burial of waste were complete and well maintained. Documents relating to the shipping containers, pertinent burial site regulations and shipping manifest were readily available for review.

The licensee demonstrated a clear understanding of the issues related to the implementation of 10 CFR 61 regulations for waste classification and characterization. This resulted in timely and thorough implementation of the regulations. Similar performance was noted in response to the IE Bulletins, Circulars and Branch technical positions that were issued in conjunction with the transportation regulations.

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A training and qualification program is well defined and implemented for the personnel associated with transportation activities. However, the qualification of QC inspectors was not clearly defined. This problem was subsequently resolved.

Effluent Control and Monitoring (EF)

The policies for the Radiological Environmental Monitoring Program (REMP) program are generally well stated and understandable. As a result, the data required by the Technical Specifications is readily available.

Within the REMP organization there is only one dedicated Environmental Technician. The licensee had not clearly defined the responsibility and qualifications for this position. However, all HP and chemistry technicians are trained in REMP techniques and provide back-up capability for the environmental technician. This reserve of qualified personnel ensures that the REMP monitoring results are complete, well maintained and available.

The licensee review of monitoring results is technically sound and thorough in most cases. Some discrepancies with EPA results were resolved but lacked adequate documentation. Also, test data to qualify the TLD system for environmental monitoring was not available on site.

2. Conclusion

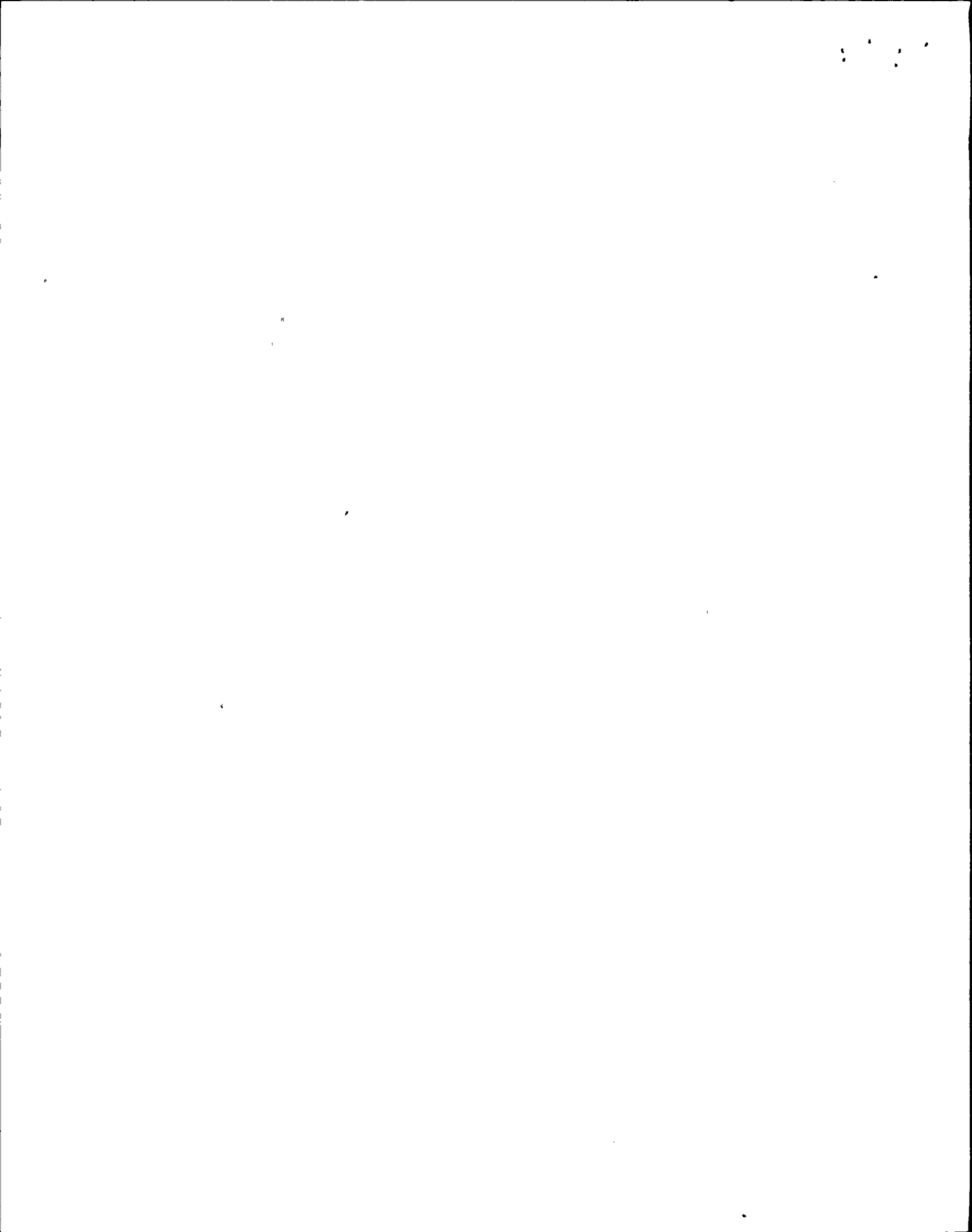
Rating: Category 2

Trend: Improving

3. Board Recommendations

Licensee: Consider role of corporate staff ALARA program in support of site staff.

NRC: Determine involvement of corporate staff in achieving ALARA during next scheduled plant outage.



C. MAINTENANCE (6%)

1. Analysis

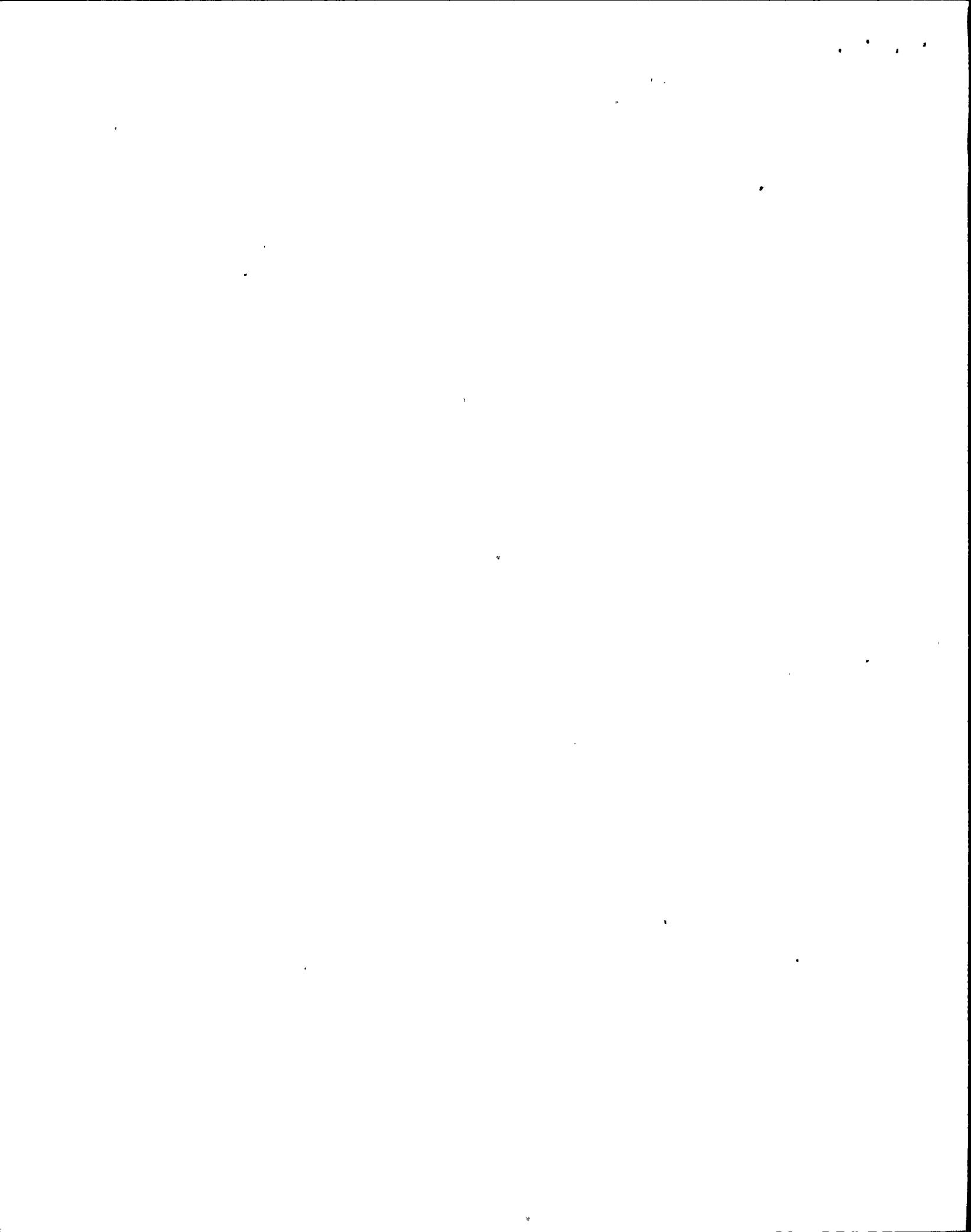
During the previous assessment period poor communications between the Maintenance and Testing Departments was identified as a weakness. In addition, improper maintenance control on the containment personnel hatch resulted in the performance of inappropriate post maintenance testing which could have led to a violation of containment integrity.

During the current period this functional area was under frequent review by the resident inspector and periodic review by a region-based inspector. In general, maintenance practices have been carried out with good regard for plant and personnel safety and in accordance with prescribed administrative and procedural requirements. The station benefits from having strong Instrumentation & Control, Electrical and Mechanical Maintenance Departments which have experienced personnel in key roles and low turnover rates.

Improvements in communications between Maintenance and Testing Departments have been observed and may be attributed to both improved procedures and more formal plant staff meetings. As a result of an NRC finding in the previous assessment period regarding the failure to perform proper post-maintenance testing on the containment personnel hatch, a thorough review of safety-related equipment maintenance procedures was performed to ensure post-maintenance testing requirements were properly identified. Coordination of plant evolutions has been enhanced by more structured MOPAR meetings.

The station preventive maintenance program continues to be a strong asset, contributing to the longest generating run of the facility in its operating history. Day 213 was surpassed on January 1, 1985. A special review of station maintenance practices and equipment history records by the resident inspector, concluded that periodic preventive and emergency maintenance has maintained or improved plant equipment performance and not contributed to subsequent failures.

On September 20, 1984, a non-safeguards breaker (Westinghouse DB-25) failed and resulted in a minor fire. Investigation by electrical maintenance personnel to determine the failure mode identified the cause. The licensee promptly inspected identical safeguards breakers for similar problems. On May 30, 1984, an unscheduled outage resulted from an electrical fault in the main generator exciter. Repairs were affected by station maintenance personnel and the generator restored to service in three days.



The resident inspector observed portions of emergency maintenance to repair a steam leak on valve 431A, pressurizer spray valve. Procedure adherence was adequate and ALARA practices were satisfactory. Team work and cooperation between the different departments involved in the evolution was excellent.

As demonstrated by the above examples, the station maintenance activities are conducted in a competent, professional manner and supervised by experienced, well-organized managers.

2. Conclusion

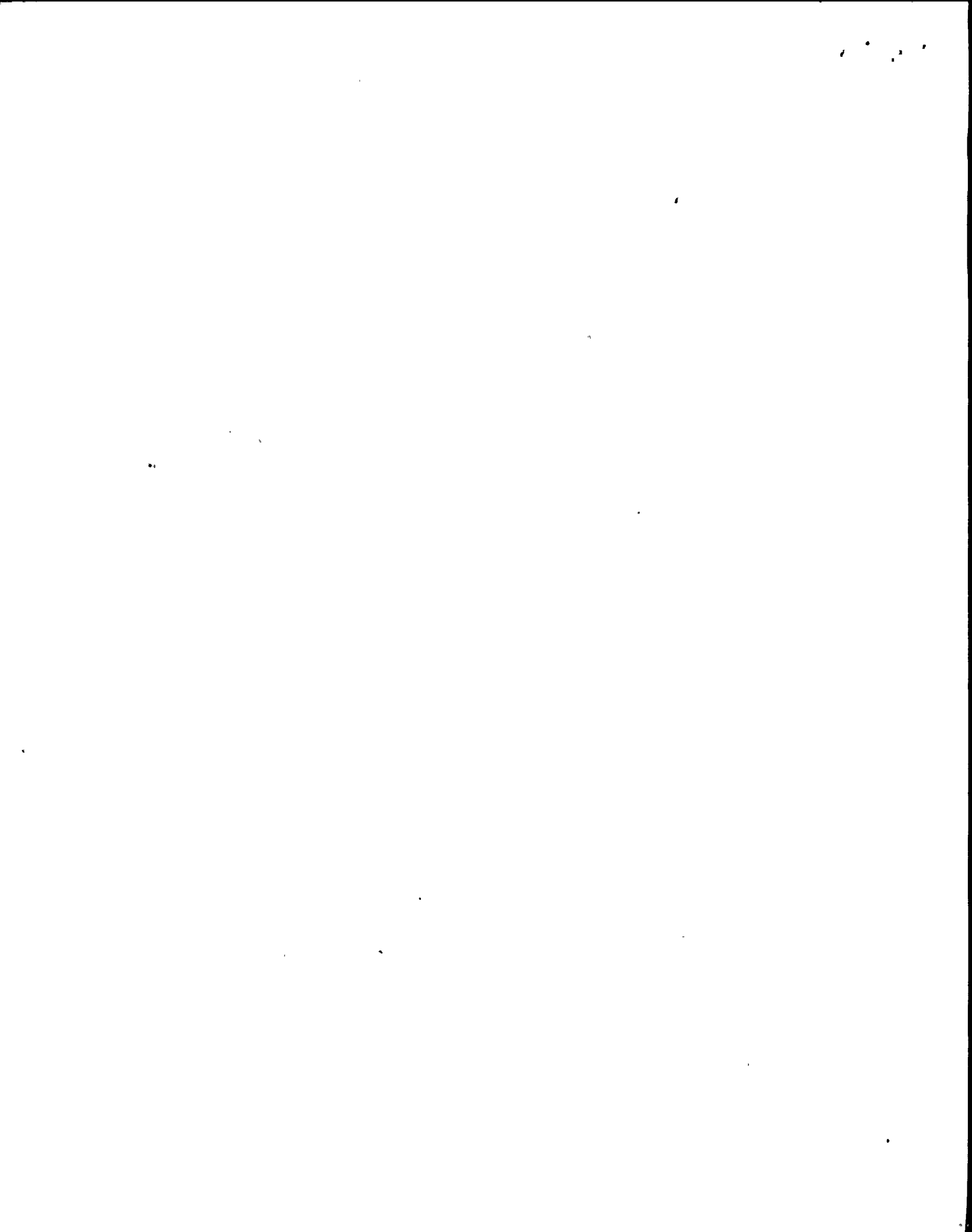
Rating: Category 1

Trend: Consistent

3. Board Recommendations

Licensee: None

NRC: None



D. SURVEILLANCE (7%)

1. Analysis

During the previous assessment period weaknesses were identified in this functional area with respect to poor communications between the Testing and Maintenance Departments and occasional inattentiveness in the performance of surveillance testing. General improvement in both areas has been observed this SALP period.

The bulk of surveillance activities is performed by Results and Test, Instrumentation & Control and Operations Departments. Surveillance scheduling continues to be followed and planned manually by all departments concerned. Computerized scheduling is planned but not implemented to date. Duplication of surveillance tracking has ensured no tests have been missed this assessment period.

Each department generally, adheres to a strict guidance for dual verification and thorough post-testing reviews. On one occasion this period, final review of a periodic test identified an error missed by previous reviewers. On October 11, 1984, operations personnel performed Periodic Test, (PT)-1, "Rod Controls System", and incorrectly logged test data which was outside the acceptance criteria. Immediate supervisory review missed the error, but final review by the Results & Test Supervisor identified the error. Proper reverification of the test results was performed. Subsequent review of the same periodic test identified a procedural ambiguity which resulted in operators failing to properly test the Rod Control System. Results and Test staff are to be credited for their identification and correction of this deficiency.

While performing the calibration of Power Range Neutron Monitor N-43, on June 27, 1984, the Instrumentation and Control technician conducting the test inadvertently pulled the control power fuses instead of the instrument power fuses. The technician immediately recognized his error and reinstalled the fuses, however, a short duration turbine runback resulted. Response of control room operators was commendable in handling the run back. This incident of momentary inattentiveness appears to an isolated event and does not indicate a trend. Management attention in this functional area appears to be adequate.

Two inspections were conducted of the restart testing program by two region-based inspectors. The inspections focused on startup physics testing for cycle XIV. Management involvement and control in assuring quality was evidenced by a well defined startup test program. The test program described the sequence of tests, plant conditions under which the tests were to be performed, precautions and prerequisites, and administrative controls before power was increased between test phases. Tests were performed with approved procedures by qualified individuals. Review of test results performed by the engineering staff and the safety committee were technically sound and timely.

The licensee exhibited a conservative approach to nuclear safety. For example, upon identification of a 0.2% error in the calculation for core thermal power, the licensee decided to operate at slightly less than rated power with conservative reactor power trip settings, resulting in not exceeding licensed core thermal power limits.

Key positions and responsibilities for the restart physics test program are well defined. Adequate technical support was provided for the test program. However, QA/QC surveillance and followup only covered the refueling program and did not extend to the startup physics testing program. No inadequacies were identified in the startup test program as a result of this lack of QA/QC coverage. The licensee has committed to provided QA/QC coverage during future startup physics testing.

2. Conclusion

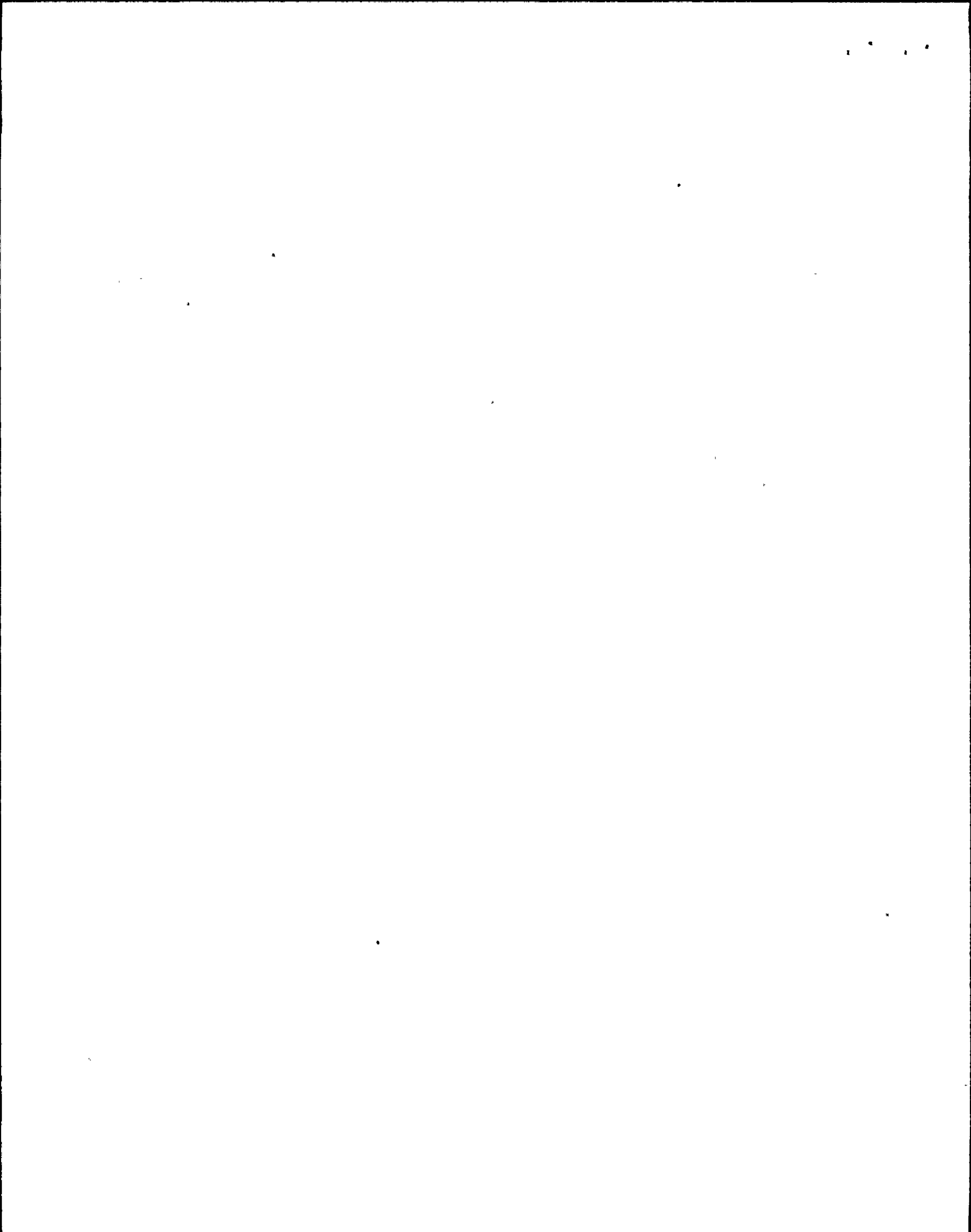
Rating: Category 2

Trend: Consistent

3. Board Recommendations

Licensee: Monitor implementation of non-licensed training.

NRC: None



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2. Conclusion

Rating: Category 1

Trend: Consistent

3. Board Recommendations

Licensee: Monitor implementation of non-licensed training.

NRC: None



E. FIRE PROTECTION/HOUSEKEEPING (3%)

1. Analysis

During the previous assessment period poor communications between the Fire Protection Staff and Operations Department resulted in inappropriate compensatory measures being taken for fire protection systems being disabled, however, improvement towards the end of the previous assessment period was observed.

During this assessment period one inspection of the fire protection program was conducted by a region-based inspector. The resident inspector observed fire protection and housekeeping practices throughout the assessment period.

Staffing levels are satisfactory with a full time Fire Protection and Safety Coordinator, knowledgeable in fire protection and nuclear safety, in charge of the program.

Fire brigades were adequately trained in accordance with requirements. The fire brigade consists of personnel from the Operations and Security departments. Due to different shift rotations of the two departments, members of the fire brigade continually change. Although not considered to be a significant weakness, the effectiveness of the fire brigade as emergency firefighting teams may be reduced due to continually changing members and the inability to drill as a regular team.

Inspector review of the Project Quality Assurance storage areas early in the assessment period identified problems with cleanliness, inventory control and access control. Prompt management attention corrected these deficiencies and subsequent inspections of these areas have indicated satisfactory compliance with requirements.

Fire protection equipment was well maintained and in good working condition, except as noted in section IV.A.2. Plant cleanliness and housekeeping are considered a strength and management attention continues to be effective in the prevention of fires in the plant.

Following completion of the 1984 refueling outage, plant housekeeping in the nonradiologically controlled areas was identified as not being consistent with normal licensee standards. Prompt management attention resulted in a rapid improvement and continued emphasis on plant cleanliness.

2. Conclusion

Rating: Category 1

Trend: Consistent

3. Board Recommendations

Licensee: None

NRC: None

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F. EMERGENCY PREPAREDNESS (10%)

1. Analysis

During the previous assessment period, a problem was identified regarding the excessive time taken to address the deficiencies identified as part of the the November 1981 Emergency Preparedness Implementation Appraisal (EPIA). Corrective actions had not been taken on four of the deficiencies as of November 1983. The four items were: a program for high level waste management; a study of the uncertainties of the plume trajectory due to the lake breeze; Emergency Plan and procedure revisions to describe a complete and functional emergency organization; and, to provide guidance to the Emergency Coordinator.

These items were finally resolved late in this assessment period. The excessive time to resolve these deficiencies is apparently due to marginal staffing in the emergency preparedness area. One person, located in the corporate office, is assigned to this area. It should be noted that the approaches to resolution of these problems were technically sound. A violation was issued during this assessment period for the failure to conduct the required annual emergency preparedness training. Three persons designated as qualified Emergency Coordinators had not received the required annual refresher training.

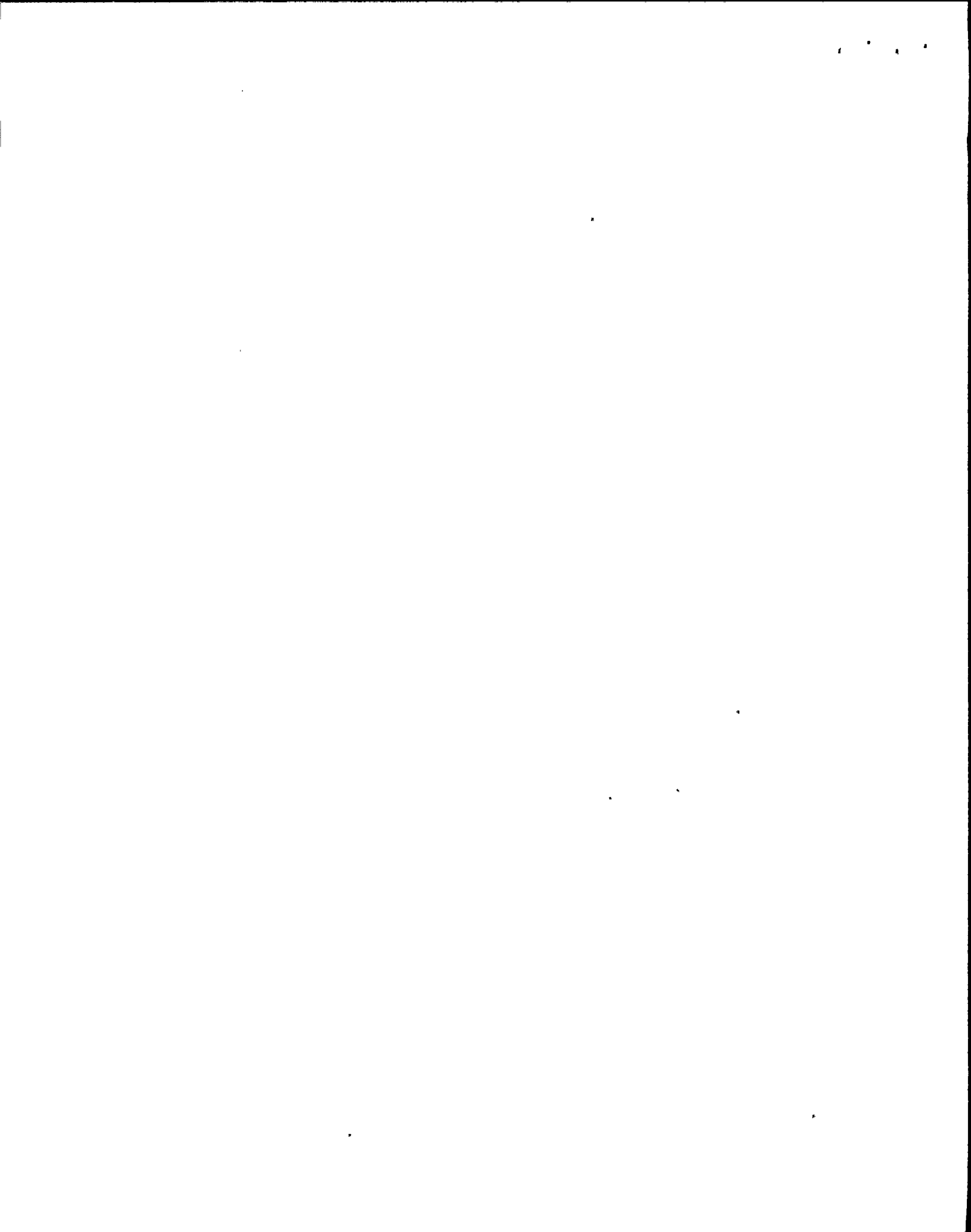
During this assessment period, three region-based inspections were conducted, inclusive of the observation of the annual Emergency Exercise conducted on September 12, 1984. The inspections included routine review of the licensee's Emergency Plan and the effectiveness of its implementation, as well as, follow-up of previously identified inspection items.

Licensee execution and participation in the full-scale Emergency Exercise held on September 12, 1984 was considered to be satisfactory as evaluated by the NRC inspection team. No major discrepancies were noted and few recommendations for improvement were identified. It is noted that the corporate coordinator for Emergency Preparedness retired near the end of this assessment period. The NRC will monitor the licensee's actions to ensure continuity and effectiveness during the personnel transition in this functional area.

2. Conclusion

Rating: Category 2

Trend: Consistent



3. Board Recommendations

Licensee: The licensee should be sensitive to the maintenance of continuity in the corporate coordinator for emergency preparedness position.

NRC: Monitor corporate support of the emergency preparedness program staffing.

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G. SECURITY AND SAFEGUARDS (4%)

1. Analysis

During the previous assessment period no significant weaknesses were observed in this functional area. Corporate management involvement on site was noted as being commendable and the security force attrition rates had shown continued improvement since 1979.

This assessment period corporate management involvement in the Physical Security Program was demonstrated by: adequate funding for program improvements including vehicle barriers in response to an NRC Information Notice; new X-ray equipment with improved imagery for package searches; a recording and monitoring system for the security radio network; and the establishment and implementation of a goals program which focused on compliance with regulatory requirements. Additionally, significant effort was expended during this assessment period to provide better liaison with local, county, and state law enforcement organizations by holding formal meetings. The meetings focused on improving emergency response capabilities. One such meeting, outside the assessment period, was attended by a region-based physical security inspector who found that the meeting was well attended and covered pertinent topics of mutual interest to the licensee and law enforcement organizations. State police officials have expressed an interest in attending a radiological emergency response course.

Site security management has undertaken a review of security procedures in an effort to provide better distribution of workloads, and a general updating. About 60% of the procedures have been revised and reissued. A review by a physical security inspector found the procedure review process was comprehensive, with good attention to detail evident, and responsive to program needs. Records were found to be complete, well maintained and accessible. The licensee submitted two 10 CFR 73.71 security event reports during this period. The reports were accurate and timely and compensatory actions were initiated in accordance with the Safeguards Contingency Plan. The licensee's security staffs, both corporate and site, were found to be adequate and effective in carrying out the program. Position responsibilities are well defined to meet program needs and all duties are carried out in a professional and dedicated manner.

The effectiveness of the contract security management staff was demonstrated by the improved reliability and operating performance of security equipment, the professional attitude and appearance of personnel, knowledge of task assignments and general overall performance. Contract supervision, as well as licensee management representatives conducted frequent, un-

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announced, audits and surveillances of program activities during all shifts. The contractor's staff has been augmented by establishing and filling the position of Operations Officer to provide better oversight of shift operations. The incumbent is well qualified, experienced and appears to be effective.

The licensee's security organization continues to demonstrate professional and effective implementation of the Security Plan.

2. Conclusion

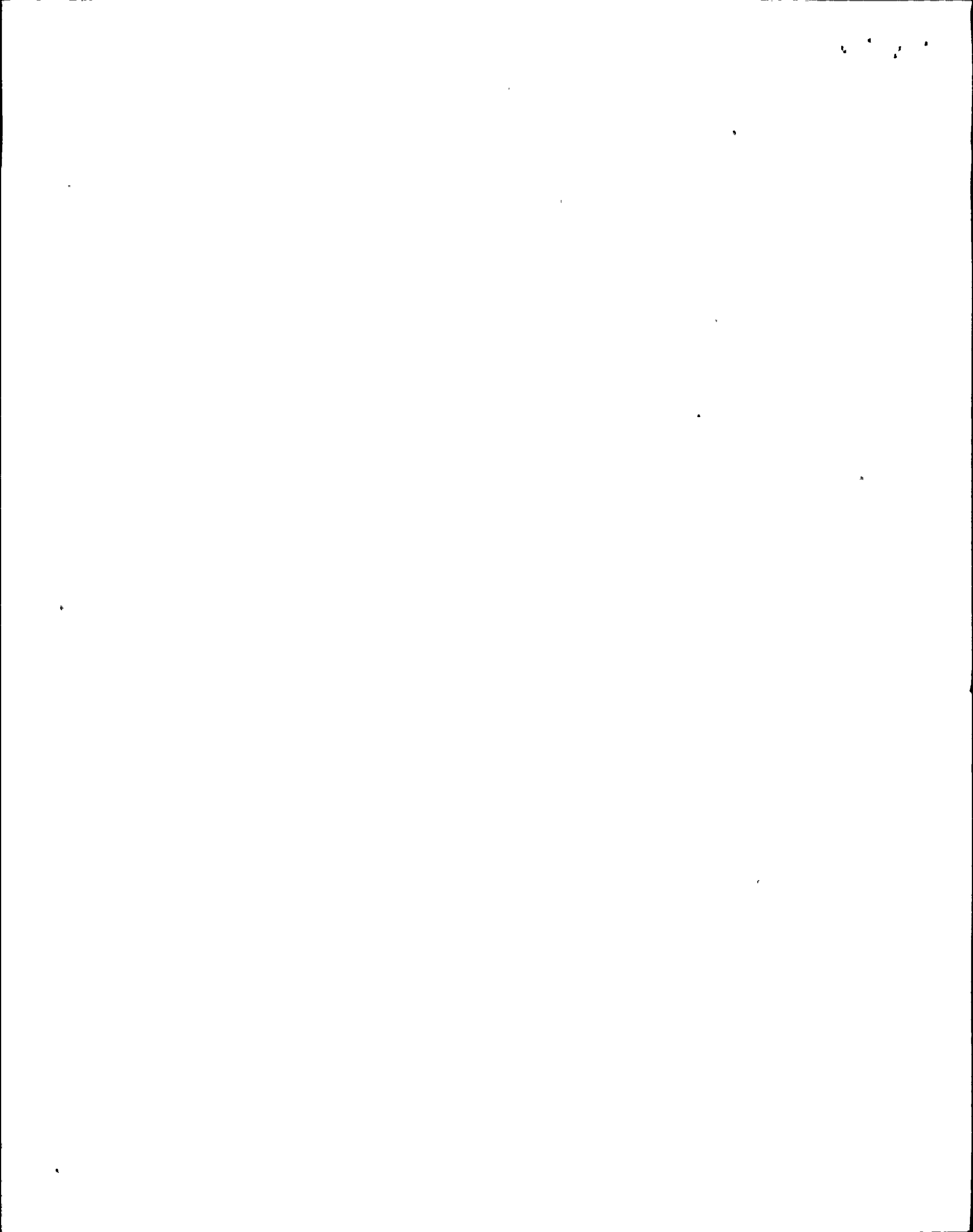
Rating: Category 1

Trend: Consistent

3. Board Recommendations

Licensee: None

NRC: Continue implementation of minimum inspection program.



H. REFUELING AND OUTAGE MANAGEMENT (3%)

1. Analysis

During this assessment period the annual 1984 refueling outage was accomplished between March and May. The resident inspector and region-based inspectors reviewed outage activities. This functional area includes review of the Inservice Testing Program.

As in previous assessment periods, planning and control of outage activities continues to be a noteworthy strength. Computer tracked planning coupled with aggressive supervisory control of plant activities, contributed to a smoothly organized outage in spite of earlier encountered problems. During fuel transfer system pre-refueling checkout, the 'dummy' fuel assembly was inadvertently dropped, damaging the fuel transfer car and a portion of the drive system. Damage to the fuel transfer car resulted in a major rescheduling of critical path primary system work items which the licensee effectively implemented.

Maintenance and surveillance activities conducted during the refueling outage were pursued with the same high level of integrity and expertise observed throughout the assessment period.

In response to NRC inspection findings identified early in the assessment period, the licensee embarked on an extensive revision to the Inservice Testing Program for Quality Group A, B, and C components and systems. Although one of the inspector's immediate concerns for the timeliness of the required inspections has been resolved, the licensee is still working on the final revision to the Inservice Testing Program, and incorporation of up-to-date isometric drawings for leakage examination has not yet been completed and reviewed. This NRC finding was preceded by a similar 1980 corporate Quality Assurance Audit finding which was not addressed in a timely manner.

2. Conclusion

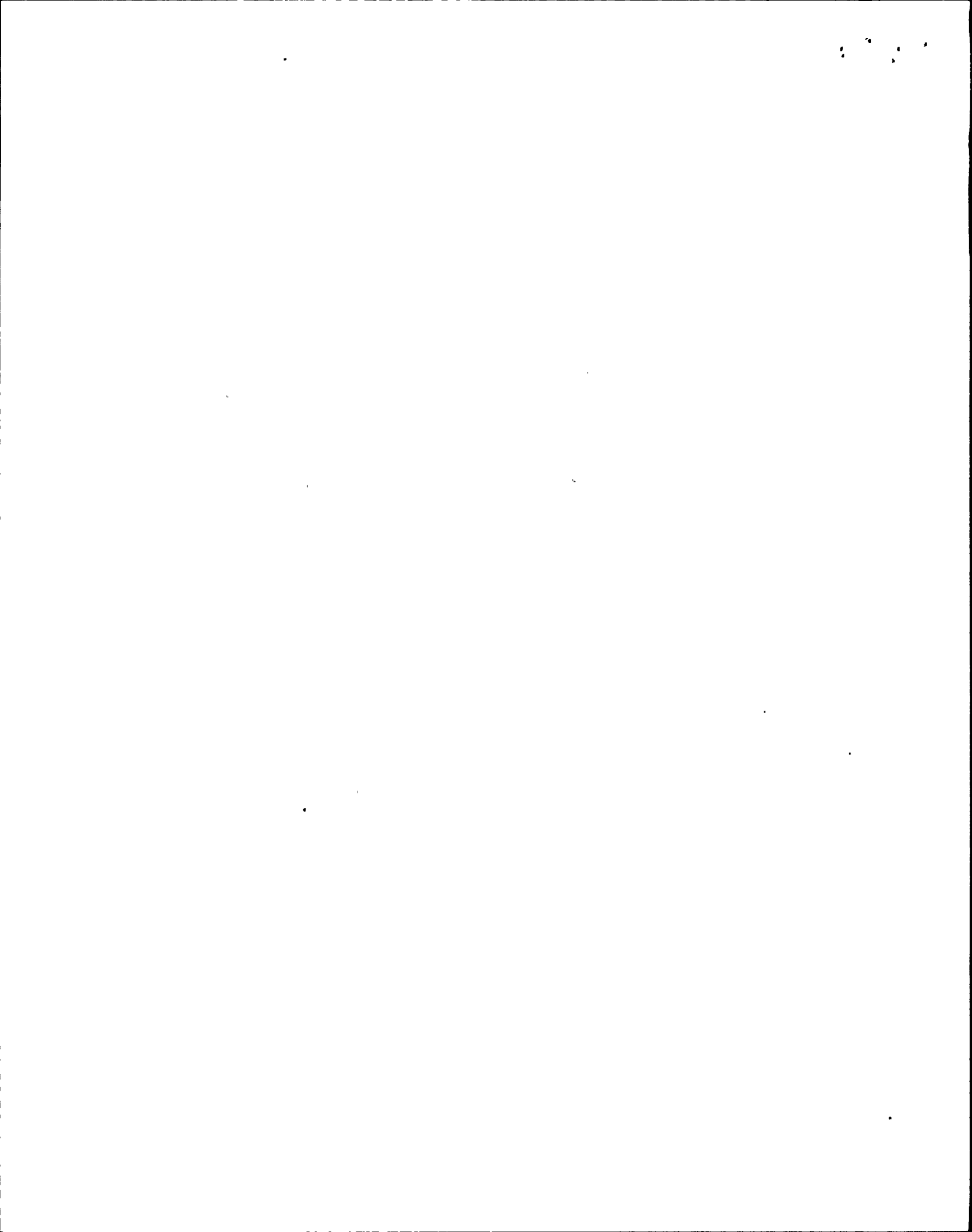
Rating: Category 1

Trend: Consistent

3. Board Recommendations

Licensee: None

NRC: None



I. LICENSING ACTIVITIES

1. Analysis

In general, the RG&E performance in the area of licensing shows evidence of high level management involvement, clear understanding of the technical issues and a responsiveness to NRC initiatives. During this SALP period a total of 61 licensing actions were completed. Included were some complex actions such as the conversion of the Preliminary Operating License to an Full-Term Operating License, spent fuel pool rerack, and the introduction of a new fuel design for use in the reactor. The successful completion of the actions is indicative of good management and control.

The licensee has exhibited a clear understanding of the issues in the resolution of technical problems. A conservative approach is routinely employed when a potential for safety significance exists. Technically sound and thorough approaches are presented in almost all cases.

With respect to responsiveness to NRC initiatives, deadlines are met. Responses are technically sound and thorough in most cases. Staff questions regarding the licensee submittals are usually resolved quickly by telephone followed by written documentation when requested. Acceptable resolutions are proposed initially in most cases.

Reportable events are usually identified and reported in a timely manner.

2. Conclusion

Rating: Category 1

Trend: Consistent

3. Board Recommendations

Licensee: None

NRC: None

J. QUALITY ASSURANCE/QUALITY CONTROL (5%)

1. Analysis

Quality Assurance (QA) and Quality Control (QC) are addressed as a separate functional area this assessment period in order to highlight indications of significant shortcoming in this area. Region I staff has evidence to conclude that QA and QC do not receive aggressive management support. This lack of support has manifested itself in the development of a station attitude that QA and QC are not considered to be important to safety by plant management.

One inspection was conducted by two region based inspectors in the QA area. This inspection involved 95 inspection hours. The two severity Level IV violations identified during this inspection were: (1) failure to include Nonconformance Reports in the Technical Specification (TS) required semiannual audits of corrective actions conducted during 1983 and 1984 and (2) failure to maintain controlled access to four Level D storage areas.

Corrective actions by the licensee for the violations were: (1) to include Nonconformance Reports as part of their semiannual audits and (2) the clarification of Level D storage area access control requirements as described in their Quality Assurance Manual and A-1303 Guide Procedure and the installation of storage area perimeter fencing. These corrective actions are acceptable and responsive to the concerns identified in the notice of violation.

An analysis of inspection results indicates a general lack of understanding of the QA requirements among the Corporate and Site personnel and Supervision. For example, a QA auditor's failure to recognize the importance of Nonconformance Reports (NCRs) as a means to achieve prompt corrective actions for significant deficiencies resulted in the failure to include these reports in the TS required semiannual audits. This lack of coverage of NCRs also went unnoticed by corporate auditors, the offsite review committee and several levels of management. Similarly, QA personnel and several levels of management failed to recognize and implement the QA program requirements for level D storage areas even though these areas were easily observable on a day to day basis.

This inspection also identified lax attitudes of QA, plant supervision and management personnel toward maintaining a written and disciplined administrative control program. For example, it required well over one year to revise and reissue procedures affected by a licensee reorganization. Management attention is required in this area to assure that QA program requirements are known and met by personnel and all levels of management at both site and corporate office.

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An analysis of inspection results indicates lack of understanding of these QA requirements among the corporate and site personnel and supervision. For example, a QA auditor, who did not recognize the importance of Nonconformance Reports (NCRs) as a means to achieve prompt corrective actions for deficiencies, did not include these reports in the TS required semiannual audits. This lack of coverage of NCRs also went unnoticed by other QA auditors. Similarly, QA/QC personnel failed to recognize and implement the QA program requirements for level D storage area access control even though these areas were observable on a day to day basis.

This inspection also identified lax attitudes of QA, plant supervision and management personnel toward maintaining a written and disciplined administrative control program. For example, it required well over one year to revise and reissue procedures affected by a licensee reorganization. Management attention is required in this area to assure that QA program requirements are known and met by personnel and all levels of management at both site and corporate office.

to

In addition to the above findings, an extensive investigation was conducted into statements made by a QA auditor who alleged that he had been pressured to delete valid audit findings from his audit reports and that he had been discriminated against in pay and performance evaluations because he identified too many deficiencies during his audits and resisted the pressure to suppress his findings. A special inspection was performed to determine whether, in fact, specific audit findings had been deleted from the audit report. The audit findings in question involved deficiencies in administrative controls. Although in two cases, deletion of audit findings was substantiated, they were of minor safety significance, and differences of opinion existed as to validity or whether they should have been handled outside the scope of the audit.

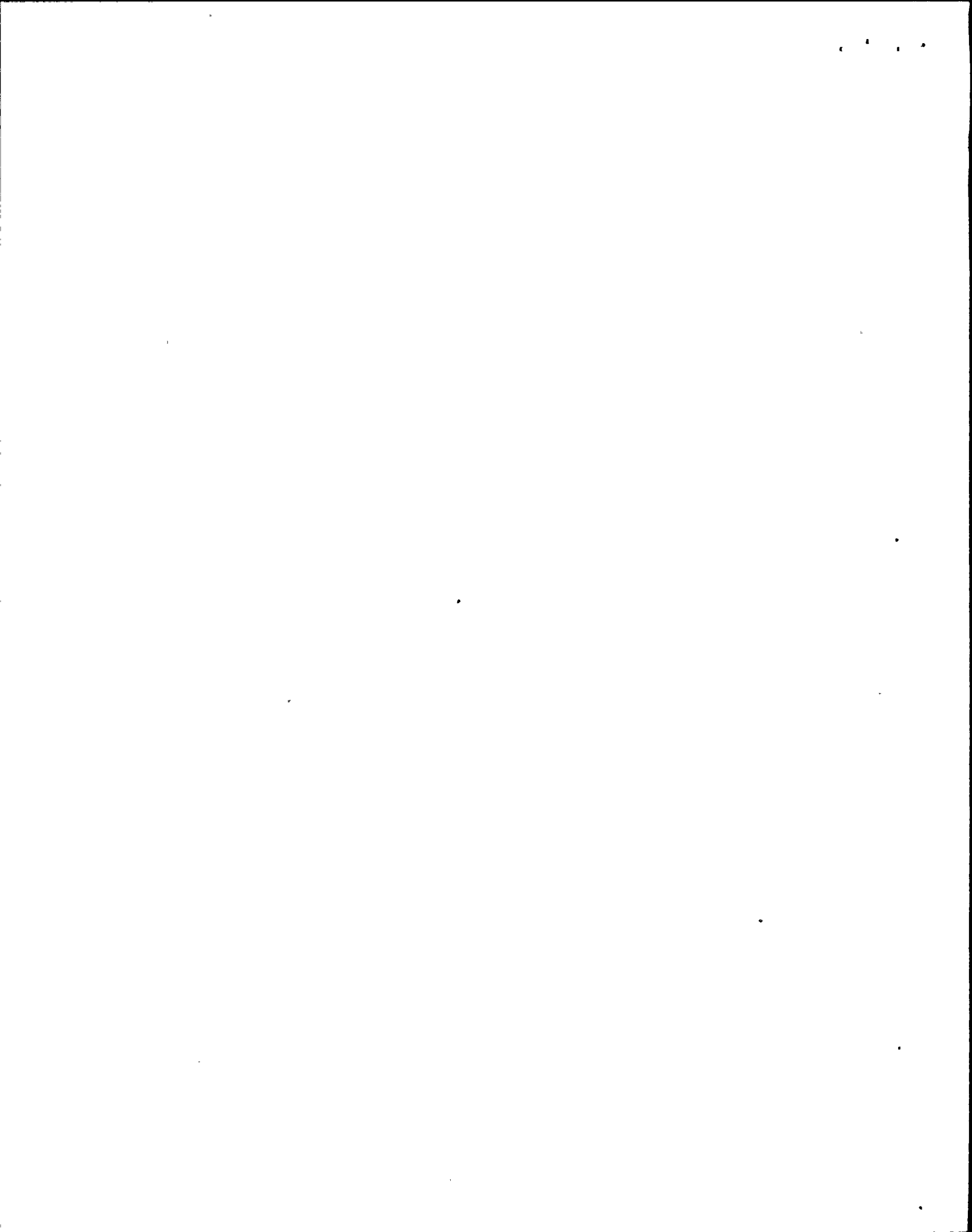
The investigation into the allegations of discrimination and harassment failed to identify sufficient evidence to substantiate the claims. The investigators interviewed personnel at all levels of management and the QA/QC organization, revealing a pattern of indicators of a pervasive site and corporate management attitude that QA/QC are unimportant to safety of operation. These indicators include: lack of support for QC inspectors, placement of inexperienced personnel in key positions in the QC organization, and the appearance of a lack of thoroughness and aggressiveness of corporate QA in the performance of audits. These attitudes are reflected by the crafts and technicians who appear to barely tolerate the efforts of QC personnel to oversee their activities. In spite of the apparent lack of management support, QC inspectors have continued to perform their duties in a professional and competent manner. The bulk of the QC inspector force, providing coverage of routine plant activities and station modification activities, is comprised of contractor personnel. During this assessment period one contractor inspector was hired as an RG&E employee. As the result of the personnel initiatives of the QC Supervisor, a significant increase in QC inspector training has been realized, improving QC inspector performance, plant operating knowledge and credibility with plant personnel.

Although significant safety problems have not been identified as a result of these deficiencies, prompt management intervention is necessary to provide the appropriate support for the QA/QC programs at all levels in order to make the programs more meaningful and effective.

2. Conclusion

Rating: Category 3

Trend: None



3. Board Recommendations

Licensee: Review management objectives with respect to QA/QC organization and implement program to improve station program and its status.

NRC: Perform program review to determine effectiveness of QA/QC program implementation and management involvement.

V. SUPPORTING DATA AND SUMMARIES

A. Investigations and Allegations Review

In October 1983, several allegations were made to the NRC in regard to work performed by Bell-Schneider Corporation pertaining to the installation of the Post Accident Sampling System and modifications made in the Seismic Upgrade Program. As a result of a special inspection, significant weaknesses were identified in administrative practices relating to modification processes and subsequent plant turnover and acceptance. Final review of the licensee's revised modification program will be conducted in the next assessment period.

In February 1984 a special safety inspection was concluded which reviewed allegations presented to the NRC with regard to apparent Quality Assurance audit improprieties. The allegations were partially substantiated and an Enforcement Conference was convened on April 6, 1984 to discuss the inspector's findings with licensee management. In addition, an investigation was conducted by the Office of Investigation into allegations of intimidation, harassment and discrimination of a QA auditor. There was insufficient evidence to substantiate these claims. Further details of these items may be found in section IV.J. of this report.

During June 1984, a former employee of Bell-Schneider Corporation made allegations to the NRC concerning quality assurance improprieties in the modification documentation turnover. Although inspector review of these allegations did not substantiate any wrongdoing, a concern for the proper handling of modification processes and turnover paperwork was identified and will be followed-up in the review of the revised program as discussed above.

B. Escalated Enforcement Action

None.

C. Management Conferences Held During the Assessment Period

Enforcement Conference held at NRC Region I office on April 6, 1984, regarding follow-up of Quality Assurance Allegation.

Enforcement conference held at NRC Region I office on November 5, 1984, regarding violation of Technical Specifications for handling of irradiated fuel in the Auxiliary Building.

Management meetings on February 3, 1984, March 1, 1984 and March 15, 1984 were held at the NRC Region I office to discuss the licensed operator requalification program.

D. Licensee Event Reports (LERs)

<u>Tabular Listing</u>	<u>Number</u>
A. Personnel Error	6
B. Design/Man./Constr./Install	2
C. External Cause	0
D. Inadequate Procedure	3
E. Component Failure	9
X. Other	2
	Total (22)

Licensee Event Reports Reviewed:

Reports Nos. 83-22 to 84-13

Causal Analysis

Only three sets of common mode events were identified:

- a. LERs 84-02 and 84-05 reported problems with MOV-700 (RCS loop A RHR suction valve) failing to stroke to the open position.
- b. LERs 83-30 and 84-13 reported the identification of Technical Specification changes improperly reflected in station procedures.
- c. LERs 83-27 and 84-06 reported personnel errors resulting in inadvertant automatic actuation of ESF or Reactor Protection Systems.

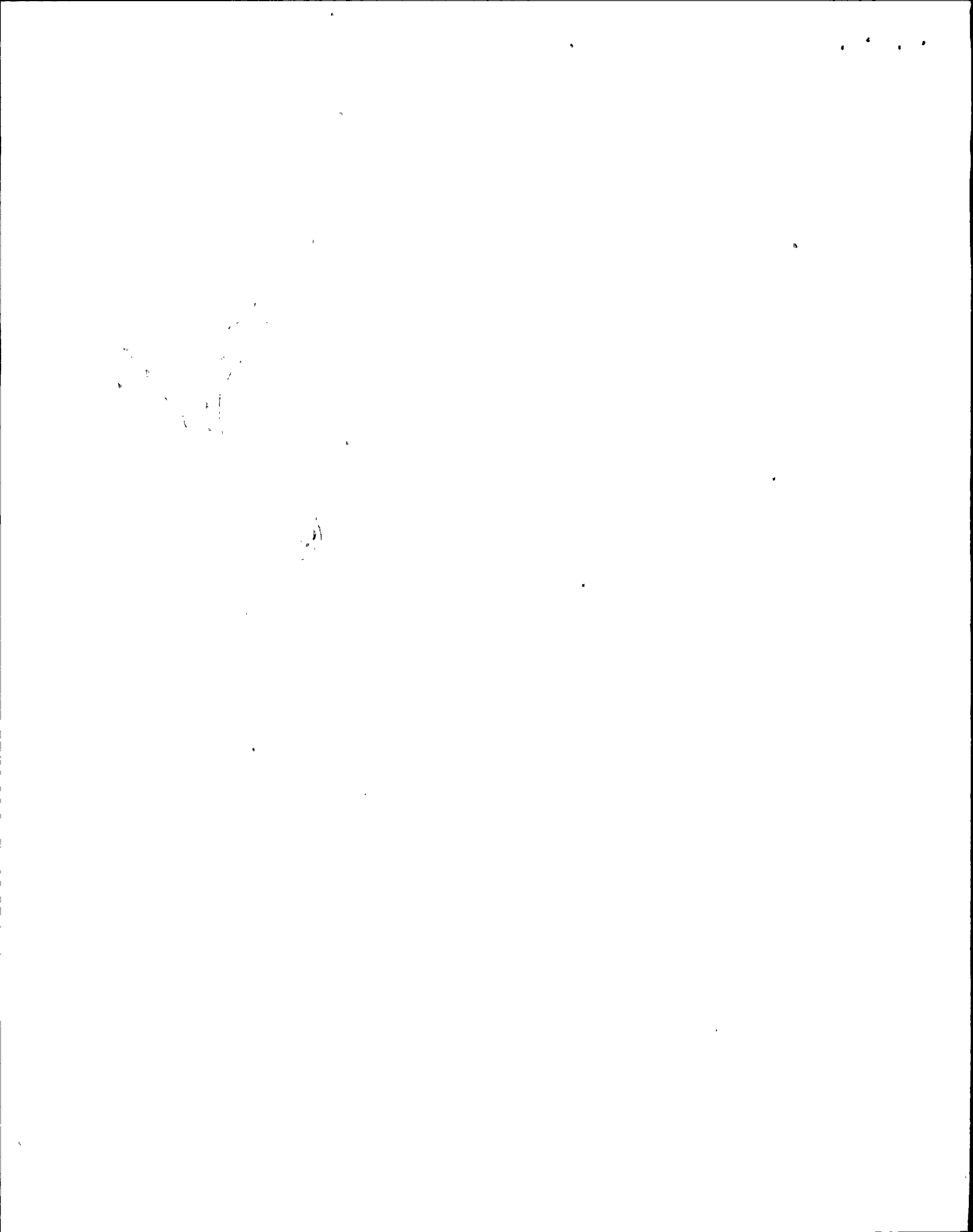


TABLE 1

TABULAR LISTINGS OF LERS BY FUNCTIONAL AREA

R. E. GINNA NUCLEAR POWER PLANT

<u>Area</u>	<u>Number/Cause</u>	<u>Total</u>
A. Plant Operations	6/A, 1/B, 1/D, 4/E, 2/X	14
B. Radiological Controls	NONE	0
C. Maintenance	1/E, 1/B	2
D. Surveillance	2/D, 4/E	6
E. Fire Protection	NONE	0
F. Emergency Preparedness	NONE	0
G. Security and Safeguards	NONE	0
H. Refueling	NONE	0
I. Licensing Activities	NONE	0
J. Quality Assurance/ Quality Control	NONE	0
	Total	22

Cause Codes: A - Personnel Error
B - Design, Manufacturing, Construction, or
Installation Error
C - External Cause
D - Defective Procedures
E - Component Failure
X - Other

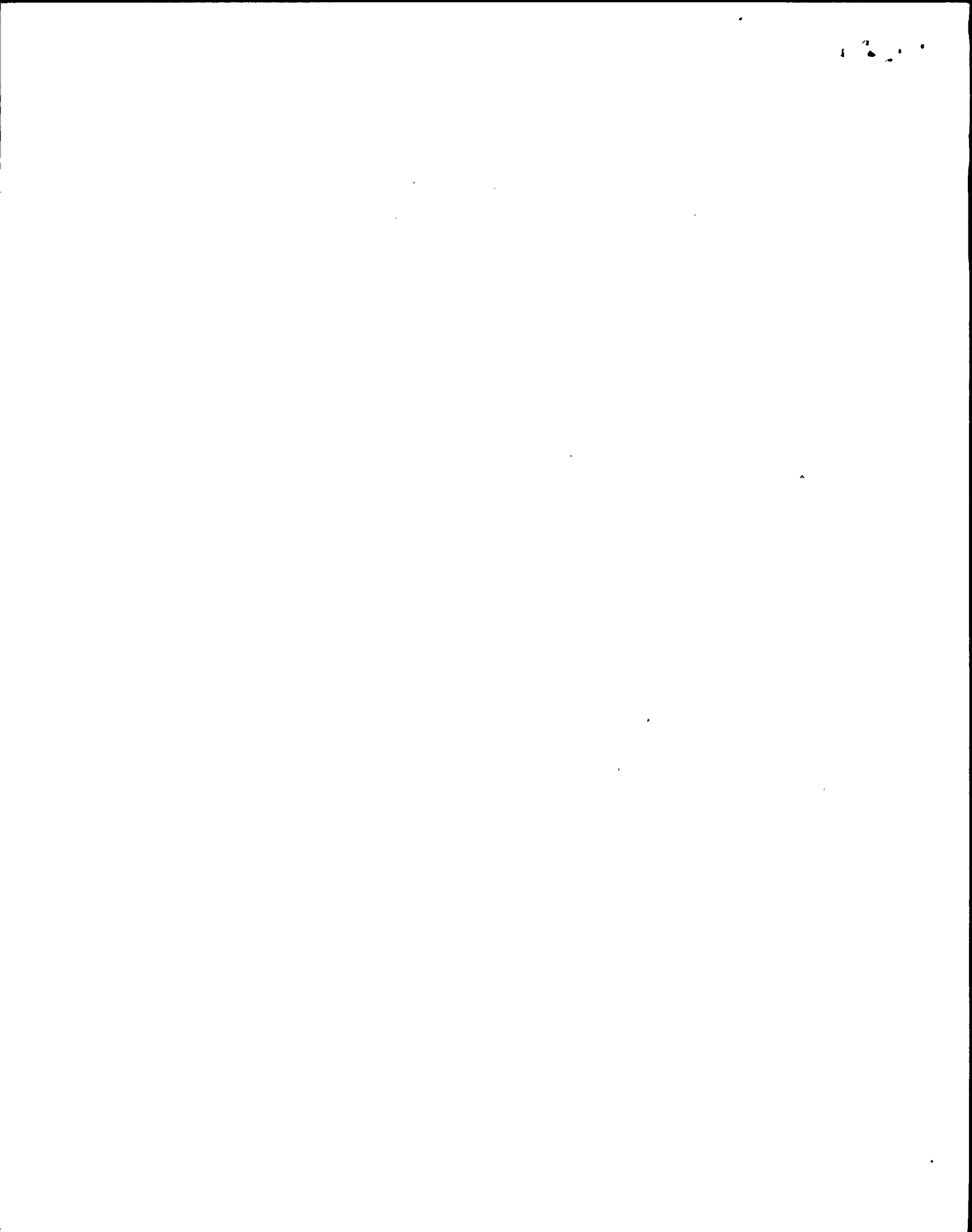


TABLE 2
INSPECTION HOURS SUMMARY (7/1/83 - 12/31/84)
R. E. GINNA NUCLEAR POWER PLANT

	<u>Hours</u>	<u>% of Time</u>
A. Plant Operations	1841	51
B. Radiological Controls	388	11
C. Maintenance	220	6
D. Surveillance	255	7
E. Fire Protection/Housekeeping	119	3
F. Emergency Preparedness	346	10
G. Security and Safeguards	141	4
H. Refueling & Outage Management	112	3
I. Licensing Activities	--*	--*
J. Quality Assurance/Quality Control	<u>176</u>	<u>5</u>
Total	3598	100

* Hours expended in facility license activities and operator license activities are not included with direct inspection effort statistics.

TABLE 3
Violation Summary (7/1/83 - 12/31/84)

R. E. GINNA NUCLEAR POWER PLANT

A. Number and Severity Level of Violations

Severity Level I	0
Severity Level II	0
Severity Level III	0
Severity Level IV	14
Severity Level V	<u>6</u>
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B. Violation Vs. Functional Area

FUNCTIONAL AREAS	Severity Levels					DEV
	I	II	III	IV	V	
A. Plant Operations				3	4	
B. Radiological Controls				4	1	
C. Maintenance						
D. Surveillance				1		
E. Fire Protection & Housekeeping					1	
F. Emergency Preparedness				1		
G. Security Safeguards						
H. Refueling & Outage Management						
I. Licensing Activities						
J. Quality Assurance/Quality Control					<u>5</u>	
				Totals	14	6

(TABLE 3 Continued)

C. Summary

Inspection Report No.	Inspection Date	Subject	Severity Level	Functional Area
83-19	8/8-9/11	Failure to perform prompt corrective action	IV	J
83-22	9/12-10/31	Failure to address need for corrective action	IV	A
83-23	10/18-11/18	Failure to review SM procedure	IV	A
83-23	10/18-11/18	Failure to maintain good housekeeping practices	V	E
83-23	10/18-11/18	Failure to adhere administrative procedures	V	A
83-24	11/1-1/15	Failure to perform surveillance test	IV	D
84-02	3/6-3/9	Failure to measure airborne radioactive concentrations	IV	B
84-02	3/6-3/9	Failure to review procedure	IV	B
84-02	3/6-3/9	Failure to establish Qualification program	IV	B
84-02	3/6-3/9	Failure to adhere to established procedure	IV	B
84-05	3/27-3/30	Failure to adhere to Inservice Inspection program	IV	J

84-07	2/13-3/1	Inadaquate number at PORC quorum	V	A
84-07	2/13-3/1	Failure to use approved procedure	V	A
84-07	2/13-3/1	Failure to document adverse conditions	IV	J
84-08	4/23-4/27	Failure to insure Radiation Emergency training	IV	F
84-12	5/7-5/11	Failure to provide suitable measurements of airborne radioactive concentrations	V	B
84-13	5/14-5/18	Failure to include Nonconformance Reports	IV	J
84-13	5/14-5/18	Failure to control access to storage areas	IV	J
84-16	6/9-7/31	Failure to identify inoperable system	V	A
84-23	10/5- 10-19	Failure to establish required prerequisites for irradiated fuel handling	IV	A

TABLE 4INSPECTION REPORT ACTIVITIESR. E. GINNA NUCLEAR POWER PLANT

REPORT	INSPECTOR	HOURS	AREAS INSPECTED
83-17	Resident	138	Routine inspection of plant operations; surveillance testing; maintenance; followup on Integrated Plant Safety Assessment Items; followup on Bulletins & Circulars; Inservice Inspection Program Review; annual emergency exercise review and Licensee Event Reports
83-18	Specialist	34	Pipe Support Base Plate Designs Using Expansion Anchor Bolts; Seismic Analyses for As-Built Safety-Related Piping Systems and Masonry Wall Design
83-19	Resident	124	Routine
83-20	Specialist	24	Transport and receipt of radioactive materials
83-21	Specialist	33	Security Procedures, Organization, Audit, Records & Reports, Training/Qualification and Safeguards Contingency Plans
83-22	Resident	130	Routine, followup on NUREG 0737, Item II.B.1
83-23	Resident; Specialist	159	Special, Allegations-inadequate contractor QC of modifications
83-24	Resident	155	Routine
83-25	Specialist	26	Emergency Preparedness
83-26	Specialist	33	Training and requalification
84-01	Resident	125	Routine, TMI Lessons Learned

84-02	Specialist	40	Transportation activities
84-03	Specialist	35	Allegations-QA audit findings
84-04	Specialist	40	Post Accident Sampling System
84-05	Specialist	96	Inservice Inspection Program
84-06	Resident; Specialist	218	Routine
84-07	Region I Management	24*	Operator Licensing Examinations effectiveness QA program
84-08	Specialist	68	Emergency Preparedness
84-09	Specialist	26	Nonradiological chemistry program
84-10	Resident; Specialist	282	Routine, Reactor Coolant System Vent modification
84-11	Region I		Operator Licensing Examinations
84-12	Specialist	38	Radiation protection program
84-13	Specialist	98	QA program-onsite, offsite review committees, program changes
84-14	Region I	280	Licensed Operator Requalification Assessment
84-15	Specialist	38	Startup testing
84-16	Resident; Specialist	241	Routine, Allegation followup
84-17	Specialist	64	Radioactive waste program
84-18	Specialist	48	Fire Protection/Prevention Program
84-19	Resident	209	Routine, TMI Action Plan Items
84-20	Specialist	60	Radiological environmental monitoring program
84-21	Specialist	161	Emergency Preparedness
84-22	Resident	137	Routine, TMI Action Plan Items, Simulator construction, calorimetric calculation and DB-25 breaker

84-23	Resident; Specialist	52	Fuel handling in Auxiliary Building
84-24	Resident	278	Routine
84-25	Deleted		
84-26	Specialist	30	Reactor Physics testing
84-27	Examiner	12*	Licensing Examination
84-28	Specialist	81	Emergency Preparedness

*Not included in director inspection effort

TABLE 5LER SYNOPSIS (7/1/83 -12/31/84)R. E. GINNA NUCLEAR POWER PLANT

LER Number	Type	Summary Description
83-022	30 day	CV Isolation Valve, AOV-846 Inoperable
83-023	30 day	Block Valve MOV 516 Closed Due to Indicated Leakage through PORV-430
83-024	30 day	Steam Generator Flow Transmitter found out of tolerance
83-025	30 day	Leak on Upstream Side of V-056E, Pressurizer Liquid Sample Manual Isolation Valve
83-026	14 day	Boric Acid Storage Tanks Out of Specification
83-027	30 day	A Unit Trip due to Personnel Error Resulting in a Loss of Reactor Coolant Loops with the Reactor Coolant System Temperature greater than 350 degrees F
83-028	30 day	CVCS Boric Acid System Leakage
83-029	30 day	Calibration of Nuclear Power Range
83-030	30 day	Permissive Circuit, P-10 Less Conservative than Technical Specifications
84-001	30 day	Inoperable Safety Injection Accumulators
84-002	30 day	Inoperable Residual Heat Removal (RHR) System
84-003	30 day	Potential Loss of Residual Heat Removal (RHR) Capability
84-004	30 day	Inoperable Waste Gas Oxygen Analyzer

84-005	30 day	Inoperable Residual Heat Removal (RHR) System
84-006	30 day	Automatic Actuation of the Engineered Safety Feature (ESF)
84-007	30 day	Automatic Actuation of the Reactor Protection System (RPS)
84-008	30 day	Inoperable Fire Suppression System
84-009	30 day	Automatic Actuation of any Engineered Safety Feature
84-010	30 day	Inoperable Fire Suppression System
84-011	30 day	Inoperable Rod Position Indicating System
84-012	30 day	Damper on 1C Auxiliary Building Exhaust Fan Closed During Fuel Movement
84-013	30 day	Failure to Exercise Control Rods in Bank D during monthly Surveillance Test



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
631 PARK AVENUE
KING OF PRUSSIA, PENNSYLVANIA 19406

MAR 08 1985

Docket No 50-244

Rochester Gas and Electric Corporation
ATTN: Mr. Roger W. Kober
Vice President
Electric and Steam Production
49 East Avenue
Rochester, New York 14649

Gentlemen:

Subject: Systematic Assessment of Licensee Performance (SALP)

The NRC Region I SALP Board conducted a review on February 25, 1985 and evaluated the performance of activities associated with the R. E. Ginna Nuclear Power Plant. The results of this assessment are documented in the enclosed SALP Board report. A meeting has been scheduled for March 18, 1985 at your offices to discuss this assessment. This meeting is intended to provide a forum for candid discussions relating to this performance.

At the meeting, you should be prepared to discuss our assessment and your plans to improve performance. Any comments you may have regarding our report may be discussed at the meeting. Additionally, you may provide written comments within 20 days after the meeting.

Following our meeting and receipt of your response, the enclosed report, your response, and a summary of our findings and planned actions will be placed in the NRC Public Document Room.

Your cooperation is appreciated.

Sincerely,

A handwritten signature in dark ink, appearing to read "Thomas E. Murley".

Thomas E. Murley
Regional Administrator

Enclosure: As stated

cc w/encl:
Harry H. Voigt, Esquire
Central Records (4 copies)
Director, Power Division
Public Document Room (PDR)
Local Public Document Room (LPDR)
Nuclear Safety Information Center (NSIC)
NRC Resident Inspector
State of New York

850502040T

