

# Ginna

## 3Q/2006 Plant Inspection Findings

---

### Initiating Events

**Significance:**  Aug 31, 2006

Identified By: NRC

Item Type: FIN Finding

#### **Failure to Correct an NRC-Identified Finding in a Timely Manner**

The NRC identified a Finding for the failure to take prompt corrective action for a 2004 NRC-Identified Finding. Specifically, Ginna did not install an alarm in the control room for the RCS leakage detection function of the containment radioactive airborne particulate detector, as identified in the Updated Final Analysis Safety Report (UFSAR). The alarm was installed in August 2006, after the team questioned the status of the corrective actions.

The performance deficiency is a failure to promptly correct a condition adverse to quality. In 2004, the NRC identified that a control room alarm for the RCS leakage detection function was not present, as listed in the UFSAR. Ginna did not take corrective actions until August 2006, as a result of the PI&R Team's questions. The finding is more than minor because the deficiency is associated with the design control attribute of the Initiating Events Cornerstone, and adversely affects the cornerstone objective of limiting the likelihood of those events that upset plant stability during power operations. Specifically, the failure to have the alarm, which would alert the operators to take actions in accordance with approved procedures, eliminates one of the first indications of a leak, which could precede a loss of primary coolant event. The finding was determined to be of very low safety significance because the finding would neither result in exceeding the TS limit for identified RCS leakage nor would the finding have affected mitigation systems resulting in a total loss of their safety function. The finding has a cross-cutting aspect in the area of problem identification and resolution because Ginna failed to take prompt corrective action for a 2004 NRC-identified condition adverse to quality.

Inspection Report# : [2006006\(pdf\)](#)

---

### Mitigating Systems

**Significance:** SL-IV Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to make a 10-CFR 50.72(b)(3)(v)(A) Notification**

The inspectors identified that on two occasions Ginna failed to notify the NRC that offsite power was inoperable. Specifically, on July 17 and August 1, 2006, Ginna did not report to the NRC that offsite power was inoperable. This finding was determined to be a non-cited violation of 10 CFR 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors." This deficiency was evaluated using the traditional enforcement process since the failure to make a required report could adversely impact the NRC's ability to carry out its regulatory mission. Because this finding was of very low safety significance and has been entered into the corrective action program it is being treated as a NCV.

Inspection Report# : [2006004\(pdf\)](#)

---

**Significance:**  Sep 30, 2006

Identified By: NRC

Item Type: FIN Finding

#### **Did not conduct a thorough operability assessment and identify that the "C" SAFW was degraded**

The inspectors identified that Ginna personnel did not initially adequately assess the effects of a service water leak that occurred in the room cooler for the "C" Standby Auxiliary Feedwater (SAFW) pump. Water which had accumulated in the electrical control panel for the pump was not detected. The water was subsequently found by Ginna personnel during performance of a routine surveillance test of the "C" SAFW pump and the pump was declared inoperable until the water

was removed, which resulted in approximately 19 additional hours of out-of-service time.

This finding is more than minor because it is associated with the Mitigating Systems Cornerstone and affects the cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. The finding screened to Green since it was not a design or qualification deficiency and did not result in a loss of safety function. This finding is related to the cross-cutting aspects of problem identification and resolution in that Ginna did not fully evaluate the operability of the "C" SAFW pump following the leak, which sprayed water on electrical components.

Inspection Report# : [2006004\(pdf\)](#)

**Significance:** SL-IV Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

**Ginna Did Not Notify the NRC of a Licensed Operator's Medical Condition**

The inspectors identified that Ginna did not notify the NRC within 30 days of the identification of a medical condition that caused a reactor operator to fail to meet the requirements of 10 CFR 55.21. Ginna did not provide a Form 396 (medical condition certification) to the NRC in a timely manner. The finding was determined to be a non-cited violation of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status."

This deficiency was evaluated using the traditional enforcement process since the failure to make a required report could adversely impact the NRC's ability to carry out its regulatory mission. Because this finding was of very low safety significance and has been entered into the corrective action program it is being treated as an NCV.

Inspection Report# : [2006004\(pdf\)](#)



**Significance:** G Aug 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

**Reactor Startup and Power Operation with the SAFW System Inoperable**

The NRC identified a NCV for operating in an unanalyzed condition that was in violation of the Ginna Technical Specifications. Specifically, with the SAFW system inoperable, a reactor mode change was made and the plant was operated at power for approximately ten days, a period in excess of the TS allowed outage time.

The performance deficiency is the failure to properly evaluate the interaction of the flow transmitters to the operation of the SAFW system, which caused the Ginna staff to not recognize that the system had been in an unanalyzed condition from April 8 until April 18, 2005. This resulted in the failure to identify that they had violated multiple conditions prohibited by TS. The finding is more than minor because it is associated with the Mitigating Systems Cornerstone objective to ensure the operability, availability, and reliability of both trains of the SAFW system. The specific attribute is human performance, which affected equipment operability. The Region I Senior Risk Analyst (SRA) determined that this issue was of very low safety significance. This finding has a cross-cutting aspect in the area of problem identification and resolution because the licensee did not properly evaluate the effect of the isolation of the flow transmitters on the operability of the SAFW system.

Inspection Report# : [2006006\(pdf\)](#)



**Significance:** G Aug 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Use OE to Identify that the TS Basis for the AFW and SAFW Systems Was Invalid**

The team identified a NCV of 10CFR50, Appendix B, Criterion XVI, "Corrective Action," for a failure to identify that the TS basis for the AFW and SAFW systems was incorrect. Specifically, the TS Basis for the AFW and SAFW systems stated that the recirculation function was not required for operability of the pumps. This change was originally made in the mid-1990's. However, Ginna missed several opportunities during the review of industry OE, to identify and correct the problem, most recently during a 10CFR50.59 screening for a TS Basis change in 2004.

The performance deficiency is the failure to identify, using industry Operating Experience (OE), that the basis for the operability of a safety-related system was inaccurate. Specifically, the TS Basis for the AFW and SAFW systems stated that the recirculation line was not required for system operability. This finding is more than minor because if left

uncorrected, it could become a more significant safety concern. It affects the design control attribute of the Mitigating Systems Cornerstone and the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). This finding was determined to be of very low safety significance because it did not result in the loss of a safety function, it did not result in outage time for one or more trains of a structure, system or component (SSC) to exceed its allowed TS outage times, and it is not potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a cross-cutting aspect in the area of problem identification and resolution for operating experience because Ginna did not effectively incorporate operating experience to identify an invalid TS basis for the AFW and SAFW systems.

Inspection Report# : [2006006\(pdf\)](#)

**Significance:**  Jun 23, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **Missed Fire Brigade Training**

The team identified a NCV of license condition 2.C.3 for the failure to implement and maintain in effect all fire protection features. Specifically, Ginna failed to provide the required quarterly training to five fire brigade members in the fourth quarter of 2005 and subsequently failed to remove those personnel from fire brigade duty during the period from January 1, 2006, to the time when those brigade members received their remedial training. Site procedures require that fire brigade members attend quarterly classroom training and be removed from duties until remediated should the training be missed.

The finding is more than minor because the finding is associated with the Mitigating System cornerstone attribute of protection against external factors and affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The assumptions and limitations of the Fire Protection Significance Determination Process, IMC 0609, Appendix F, specifically excludes fire brigade issues and as such this finding required NRC management review to determine it was of very low safety significance.

Inspection Report# : [2006007\(pdf\)](#)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **INADEQUATE CONTROL OF TRANSIENT COMBUSTIBLE MATERIAL**

The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 5.4.1.d, which requires, in part, that written procedures be established, implemented, and maintained for the fire protection program. Contrary to TS 5.4.1.d, during a fire walkdown of the auxiliary building operating floor the inspectors identified four drums of charcoal which were not identified as a transient combustible load and did not have a transient combustible permit in violation of Ginna fire protection procedure FPS-16. Ginna entered this performance deficiency into their corrective action program for resolution.

The inspectors determined that the failure to properly implement procedure FPS-16 was more than minor because it affected the objectives of availability and reliability for systems which respond to mitigate events under the protection against external hazards attribute of the Mitigating Systems cornerstone and because the amount of charcoal exceeded the transient combustible limit of the Fire Hazards Analysis for that area of the plant. The inspectors assessed the finding using Appendix F of the Significance Determination Process (SDP) and determined the finding to be of very low safety significance. The finding is of very low safety significance because the charcoal in question has a fairly high ignition point (350°C) and they were stored in approved containers resulting in a Degradation Rating of Low, which screens to Green in the fire protection SDP. A contributing cause of this finding is related to the cross-cutting element of human performance. (Section 1R05)

Inspection Report# : [2006002\(pdf\)](#)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

**SIMULATOR INCORRECTLY REPLICATED PLANT DESIGN**

The inspectors identified a non-cited violation (NCV) of 10 CFR 55.46 (c)(1) which requires a plant-referenced simulator used for the administration of an operating test or to meet experience requirements must demonstrate the expected plant response to operator input and to normal, transient, and accident conditions to which the simulator has been designed to respond. Contrary to the above, on January 25, 2006, the inspectors identified that Ginna failed to ensure that the simulator correctly replicated the expected plant response to accident conditions as a result of an improperly implemented modification to add PPCS to the simulator in 2001. This error was entered into the Ginna corrective action program.

The inspectors determined that this simulator fidelity issue was more than minor because it affected the capability objective of the human performance attribute under the Mitigating Systems cornerstone. The finding was evaluated using the Operator Requalification Human Performance SDP (MC 0609 Appendix I). In the SDP, Appendix I, Block 12, the inspectors is required to determine if deviations between the plant control room and the plant reference simulator negatively impact operator actions or result in the potential for negative training. The inspectors determined that negative training was the result of this condition which screens to a finding of very low safety significance. (Section 1R11)

Inspection Report# : [2006002\(pdf\)](#)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

**MISSED FIRE BRIGADE DRILLS**

The inspectors identified a non-cited violation (NCV) of 10 CFR 50, App. R III.I.3.b which requires that drills shall be performed at regular intervals not to exceed 3 months for each shift fire brigade. Contrary to the requirement, four of five shift fire brigades were not drilled during the fourth quarter of 2005. This finding was entered into Ginna's corrective action program.

The inspectors determined that the failure to meet the fire brigade drill requirement was more than minor because it affected the reliability and capability objectives of the protection against external factors attribute under the Mitigating Systems cornerstone. The finding was evaluated using Fire Protection Significance Determination Process (Manual Chapter 0609, App F). The finding category is Fire Prevention and Administrative Controls with an assigned degradation factor of low which screens to Green in Step 1.3.1. A contributing cause of this finding is related to the cross-cutting element of human performance. (Section 4OA2)

Inspection Report# : [2006002\(pdf\)](#)

**Significance:**  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Maintain Fire Protection Procedures as Required by Technical Specification 5.4.1**

The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 5.4.1, which requires, in part, that fire protection procedures be established, implemented, and maintained. Contrary to TS 5.4.1, during a walkdown of fire protection procedure SC-3.16.1, the inspector noted that the procedure contained incorrect operating instructions for the diesel-driven and motor-driven fire pumps.

The inspectors determined that the procedure errors in SC-3.16.1, were more than minor because they were associated with the procedure quality attribute of the Mitigating System Cornerstone and affected the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. The inspectors assessed the finding using the fire protection Significance Determination Process (SDP) and determined the finding to be of very low safety significance. The finding was of very low safety significance because the procedure errors did not result in a loss of safety function. Specifically, the fire pumps were not rendered inoperable by the procedure errors. As a result, the procedure issues were assigned a degradation rating of low, which screens to Green in the fire protection SDP. The cause of this finding is related to the cross-cutting area of problem identification and resolution.

Inspection Report# : [2005005\(pdf\)](#)

**Significance:**  Oct 07, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Battery Test Procedure Resulted in Use of Inaccurate Test Instrumentation**

The inspectors identified a nont-cited violation of 10 CFR 50, Appendix B, Criterion XI, "Test Control," for failure to assure that the station battery test procedure incorporated acceptance limits and that test results were evaluated to assure that the test requirements had been satisfied. During the period 2000-2005, the licensee performed three Technical Specification surveillances on each safety-related station battery to verify the Operability of the safety-related components. The inspection team found that the results from the battery test procedure were not adequately assessed. Test results from this period indicated erratic readings on several battery cells; however, the licensee failed to evaluate the impact these readings had on the Operability of the batteries. In response to the team's questions, the licensee entered the issue into their corrective action program (CAP) and was able to show via subsequent test results that the batteries were Operable.

Inspection Report# : [2005006\(pdf\)](#)

---

## **Barrier Integrity**

---

## **Emergency Preparedness**

---

## **Occupational Radiation Safety**

---

## **Public Radiation Safety**

---

## **Physical Protection**

[Physical Protection](#) information not publicly available.

---

## **Miscellaneous**

Last modified : December 21, 2006