Ginna
4Q/2012 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2012
Identified By: Self-Revealing
Item Type: FIN Finding
Incorrect Oil Filter Gasket Installed in the 'B' Main Feedwater Pump Canister Cover
A self-revealing Green finding was identified for Ginna personnel not following Constellation procedure CNG-MN-4.01-GL004, "Work Package Writer's Guideline," Revision 00000, for planning a maintenance activity. Specifically, during the refueling outage, the work package for maintenance on the 'B' main feedwater pump did not identify the correct gasket for the lube oil filter canister; therefore, an incorrect gasket was installed. In addition, maintenance personnel missed an opportunity to prevent the installation of the incorrect gasket when they proceeded after recognizing that the work package was not specific on the gasket required. The gasket failed after being in service for approximately 10 days resulting in a significant oil leak and causing operators to rapidly reduce plant power to 47 percent to remove the pump from service and avoid a plant trip. Immediate corrective actions included replacing the gasket with the correct one and entering this issue into the corrective action program as CR-2012-8912.

This finding is more than minor because it is associated with the human performance attribute of the Initiating Events cornerstone and adversely impacted the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Additionally, the finding is similar to Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," Appendix E, "Examples of Minor Issues," example 4.b in that a personnel error caused a transient. Using IMC 0609, Appendix A, the inspectors determined this finding did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Human Performance, Work Practices, because Ginna personnel proceeded in the face of uncertainty or unexpected circumstances and installed a gasket without confirming it was the correct part [H.4.(a)].

Inspection Report# : 2012005 *(pdf)*

Mitigating Systems

Significance: G Dec 31, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Adequately Evaluate Changes to the Relay Room Halon Suppression System Inspection and Testing Frequency
The inspectors identified a Green non-cited violation of Ginna Operating License Condition 2.C.(3), "Fire Protection," for failure to adequately evaluate changes to the approved fire protection program that could adversely affect the ability to achieve and maintain safe shutdown in the event of a fire. Specifically, Ginna changed the relay room halon suppression system (S08) inspection and testing frequency from semiannually to biennially and did not appropriately evaluate the change nor properly monitor conditions between testing. As a result, one of the relay room halon system storage cylinders was found below the minimum acceptable pressure. Immediate corrective actions included entering this issue into the corrective action program as CR-2012-7267, declaring the S08 system non-functional, and establishing a continuous fire watch within
1 hour.

This finding is more than minor because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, the S08 system was last tested on October 13, 2011, and could have degraded to the point where it could not maintain minimum required halon concentration before it would have been retested and thoroughly inspected in October 2013. Using Inspection Manual Chapter 0609 Appendix F, a low degradation rating was assigned to this finding because the S08 system was determined to be functional and was expected to display nearly the same level of effectiveness and reliability as it would have had the degradation not been present. Therefore, the inspectors determined the finding to be of very low safety significance (Green). The finding does not have a cross-cutting aspect because the performance deficiency is not reflective of present plant performance.

Inspection Report# : 2012005 *(pdf)*

Significance: G Dec 31, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish Measures to Assure that Water in the 'B' Emergency Diesel Generator Underground Fuel Storage Tank was Promptly Identified and Corrected
The inspectors identified a Green non-cited violation of Title 10 of the Code of Federal Regulations (CFR) Part 50 Appendix B, Criterion XVI, "Corrective Action," for Ginna's failure to establish measures to assure that conditions adverse to quality are promptly identified and corrected. Specifically, Ginna did not establish measures to promptly identify and correct accumulated water in the 'B' emergency diesel generator (EDG) underground fuel oil storage tank. Subsequently, on November 8, 2012, Ginna identified 1.75 inches of water in the 'B' EDG underground fuel oil storage tank and declared the EDG inoperable. Immediate corrective actions included entering this issue into the corrective action program as CR-2012-7792 and CR-2012-8407, and immediately pumping out, collecting and assessing the amount of water identified in the 'B' EDG underground fuel storage tank.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely impacted the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, the finding is similar to Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," example 3.j., issued August 11, 2009, in that the water identified in the 'B' EDG underground fuel oil storage tank created a reasonable doubt of operability of the 'B' EDG, because the level of water exceeded the operability limit specified in the monitoring plan. Using IMC 0609, Appendix G, Attachment 1, Checklist 4, the inspectors determined this finding did not increase the likelihood of a loss of reactor coolant system (RCS) inventory, did not degrade Ginna's ability to terminate a leak path or add RCS inventory when needed, and did not degrade Ginna's ability to recover decay heat removal once it is lost. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of
Problem Identification and Resolution, Corrective Action Program, because Ginna personnel did not thoroughly evaluate problems such that the resolutions addressed causes and extent of conditions [P.1.(c)]

Inspection Report# : 2012005 *(pdf)*

Significance: G Apr 26, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Validate Plant Safe Shutdown Timeline for Design Basis Tornado.
The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion III, "Design Control," when it was determined that Ginna had not validated that the Safe Shutdown Analysis for a design basis tornado described in Updated Final Safety Analysis Report (UFSAR) Section 3.3.3.2.2 could be completed in a timely fashion. Specifically, although procedures existed and operators were trained on those procedures, Ginna had not validated that the safe shutdown methodology would establish standby auxiliary feedwater (SAFW) to the steam generator (S/G)

prior to the S/G boiling dry. As a result, time critical operator actions were not identified and operator training was not sufficient to ensure operators could perform this task in a timely manner. Ginna entered this concern into their CAP as condition report (CR) 2012-002825 and provided operators additional guidance on the new expectations for responding to this event.

The inspectors determined that the finding was more than minor because it was similar to examples 3K and 3L of IMC 0612, Appendix E, "Examples of Minor Issues." Using IMC 0609 Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding screened as potentially risk significant since normal core cooling could be adversely impacted during a severe weather initiating event. Therefore, the inspectors coordinated with the region Senior Reactor Analysts (SRAs) to conduct a Phase 3 analysis. The SRA Phase 3 determined this finding would screen to very low safety significance (Green) due to core damage frequency (CDF) being E-8 or approximately 1 core damage event in 10,000,000 years of reactor operation. This finding was determined not to be indicative of current licensee performance since the performance deficiency occurred in 1983, thus no cross-cutting aspect is assigned.

Inspection Report# : 2012008 *(pdf)*

Significance: G Mar 31, 2012
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Corrective Action on Human Performance Issues Results in Two Trains of Auxiliary Feedwater Inoperable
A self-revealing NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for Ginna's failure to implement adequate compensatory corrective actions associated with a series of human performance issues and valve mispositioning events. The corrective actions were inadequate in that Ginna failed to prevent an improperly tagged closed auxiliary feedwater (AFW) valve which resulted in two trains of AFW inoperable. Corrective actions included compensatory actions which required 100 percent peer checks on all tagout applications, a separate pre-job brief for the independent verification of tagouts, and for a senior reactor operator to observe the independent verification portion of the tagout process. This finding was entered into Ginna's corrective action program (CR-2012-0294).

This finding is more than minor because it is associated with the human performance attribute of the Mitigating Systems cornerstone, and it adversely affected 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). The inspectors determined this finding is of very low safety significance because it was not a design or qualification deficiency, did not involve an actual loss of safety function for greater than its technical specification allowed outage time, and did not screen as 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 because Ginna did not take appropriate corrective actions to address safety issues and adverse trends in a timely manner commensurate with their safety significance and complexity. Specifically, Ginna did not implement appropriate compensatory actions to address a weakness in procedure use and adherence by operations personnel [P.1(d)].
Inspection Report# : 2012002 *(pdf)*

Barrier Integrity

Significance: G Dec 31, 2012
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Meet a Conduct of Operations Standard Results in Loss of Spent Fuel Pool Cooling
A self-revealing Green finding was identified for Ginna personnel not following Constellation procedure CNG-OP-

1.01-1000, “Conduct of Operations,” Revision 00700, which requires operators to understand conditions prior to starting equipment. Specifically, Ginna operators inappropriately started the ‘B’ spent fuel pool (SFP) cooling pump with the SFP low level alarm lit, SFP level decreasing, and the level very close to the pump trip set point. Consequently, 3 hours after being started, the ‘B’ pump unexpectedly tripped on SFP low level resulting in a loss of SFP cooling. Immediate corrective actions included entering this issue into the corrective action program as CR-2012-7843, starting the 'A' SFP cooling pump to restore SFP cooling, and adding water to the SFP.

This finding is more than minor because it is associated with the human performance attribute of the Barrier Integrity cornerstone and adversely impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Using Inspection Manual Chapter 0609, Appendix G, Attachment 1, Checklist 4, the inspectors determined this finding did not increase the likelihood of a loss of reactor coolant system (RCS) inventory, did not degrade Ginna’s ability to terminate a leak path or add RCS inventory when needed, and did not degrade Ginna’s ability to recover decay heat removal once it is lost. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Human Performance, Resources, because Ginna did not ensure that resources were available to assure nuclear safety, specifically those necessary for adequate and available facilities and equipment including physical improvements [H.2.(d)].
Inspection Report# : 2012005 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

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