Ginna
4Q/2015 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Perform 1-Hour Fire Tours as Required by the Technical Requirements Manual
The inspectors identified a Green non-cited violation of Ginna Operating License Condition 2.C.(3), “Fire Protection,” because Exelon Generation Company, LLC (Exelon) failed to perform 1-hour compensatory fire tours as required by Ginna's Technical Requirements Manual (TRM). Specifically, while a fire barrier component was physically removed, the TRM required a 1-hour fire watch inspection of the affected fire zone; Exelon was performing a 6-hour fire watch. Corrective actions included performing 1-hour fire tours, reinstalling the fire barrier when the work requiring its removal was cmpleted so that fire tours were no longer required, and entering the issue into the corrective action program.

This finding is more than minor because it adversely affected the protection against external factors (i.e., fire) attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. In accordance with Inspection Manual Chapter (IMC) 0609, Appendix F, “Fire Protection Significance Determination Process,” issued on September 20, 2013, the inspectors determined that the finding is of very low significance (Green), because for localized cable protection (task 1.4.4), an automatic suppression system protected the area where the cable protection was affected by the fire finding. Additionally, the finding has a cross-cutting aspect in the area of Human Performance, Resources, because Exelon did not ensure that procedures were adequate to support nuclear safety.

Inspection Report# : 2015002 *(pdf)*

Significance: G Jun 30, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Inadequate Procedure Implementation Results in Inadvertent Entry into 72-Hour Technical Specification Action Statement
A self-revealing Green non-cited violation of Technical Specification (TS) 5.4.1, “Procedures,” was identified for inadequate implementation of procedure M-71.4, “Removal and/or Installation of Modules within Defeated or Out-of-Service Instrument Loops.” Specifically, while performing maintenance procedures for the sodium hydroxide (NaOH) flow loop power supply replacement, Exelon Generation Company, LLC (Exelon) inadvertently caused a short in electrical circuitry that resulted in an automatic switch of instrument bus ‘C’ from inverter 'B' to its backup power supply; this caused an entry into a 72-hour TS action statement and actuation of the control room emergency air treatment system (CREATS). Corrective actions included entering this issue into the corrective action program.

This finding is more than minor because it was associated with the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with Inspection Manual Chapter (IMC) 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, the inspectors determined that the finding is of very low significance (Green), because the finding was not a deficiency affecting the design or qualification of a mitigating structure, system, and component; did not represent a loss of system and/or function; and did not represent an actual loss of function of at least a single train. Additionally, the finding has a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because Exelon did not recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes.
Inspection Report# : 2015002 *(pdf)*

Significance: G Jun 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Preferred Auxiliary Feedwater Protection from Potential Block Wall Failures
The inspectors identified a Green non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50, Appendix B, Criterion III, "Design Control," because Exelon Generation Company, LLC (Exelon) did not provide for verifying or checking the adequacy of design, such as by the performance of design reviews and calculations to ensure that masonry block wall failures in the intermediate building would not challenge preferred auxiliary feedwater (AFW) piping operability. Corrective actions included installation of a temporary modification wich corrected the condition and entering this issue into the corrective action program.

This finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, if nonsafety-related block wall 8-973-8I failed following a design basis seismic event, portions of the turbine-driven and 'B' motor-driven AFW systems could be impacted by falling blocks. In accordance with Inspection Manual Chapter (IMC) 0609.04, "Initial Characterization of Findings," and Exhibits 2 and 4 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At Power," the performance deficiency was a deficiency affecting external event mitigation systems (seismic/fire/flood/severe weather protection degraded). The performance deficiency did not involve the degradation of equipment or function specifically designed to mitigate a seismic, flooding, or severe weather initiating event (e.g., seismic snubbers, flooding barriers, tornado doors) only a reasonable doubt regarding the operability of the turbine-driven AFW system. Therefore, the inspectors determined that this finding is of very low safety significance (Green). Additionally, the finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Identification, because Ginna did not implement a corrective action program with a low threshold for identifying issues, and individuals did not identify issues completely, accurately, and in a timely manner in accordance with the program.
Inspection Report# : 2015002 *(pdf)*

Significance: G Mar 31, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Inadequate Corrective Actions Result in Failure of Bus 18 Undervoltage Solid State Switchboard Card
A self-revealing Green NCV of Title 10 of the Code of Federal Regulations (10 CFR), Appendix B, Criterion XVI, "Corrective Action," was identified for failure to establish measures to assure that a condition adverse to quality associated with the availability of the bus 18 solid state switchboard card (SS1) was promptly identified and corrected. Specifically, Ginna did not adequately complete previous corrective actions to ensure carbon resistors in risk significant components were identified and replaced in a timely manner which resulted in the failure of a safety-related bus undervoltage solid state switchboard card and indication of an undervoltage condition. Exelon technicians

replaced the failed card, completed an extent of condition review and entered the issue into the CAP

The inspectors determined the self-revealing performance deficiency was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors also determined the deficiency did not affect the design or qualification of a mitigating structure, system, and component; did not represent a loss of system and/or function; and did not represent an actual loss of function of at least a single train. Therefore, the inspectors determined this finding to be of very low safety significance (Green). In accordance with IMC 0612, the finding does not have a cross-cutting aspect, because the performance deficiency occurred more than 3 years ago, would not likely occur today under similar circumstances, and is not reflective of present plant performance. (Section 1R12)

Inspection Report# : 2015001 *(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: G Mar 31, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Inadequate Protective Action Recommendation Flowchart
A self-revealing Green NCV of 10 CFR 50.54(q)(2), 10 CFR 50.47(b)(10), and 10 CFR 50, Appendix E, "Emergency Planning and Preparedness for Production and Utilization Facilities," Section IV.B.1, was identified for Exelon inadequately maintaining the effectiveness of its Emergency Plan. Specifically, 10 CFR 50.54(q)(2) requires reactor licensees to follow and maintain the effectiveness of an emergency plan that meets the requirements in 10 CFR 50, Appendix E and the planning standards of 50.47(b), and Exelon did not adequately maintain the effectiveness of its Emergency Plan when Exelon implemented changes to the protective action recommendation (PAR) flowchart that would have resulted in Exelon inappropriately recommending evacuation of downwind areas and many more emergency response planning areas (ERPAs) than intended. Exelon corrective actions included issuing NERP Revision 04000 and CNG-EP-1.01-1013 Revision 00200, which corrected the PAR flowchart text, and ensuring all emergency directors were adequately trained and aware of the NERP and CNG-EP-1.01-1013 revisions.

The inspectors determined that the inadequate maintenance of the Emergency Plan was more than minor because it was associated with the procedure quality attribute of the Emergency Preparedness cornerstone and affected the cornerstone objective to ensure that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. An inadequate PAR resulting in evacuations of ERPAs when no evacuations are otherwise called for is less significant than an emergency action level overclassification resulting in an unnecessary PAR, because there is a potential dose avoidance benefit to the public at the General Emergency level. In this instance, a PAR is made, which is sufficient to ensure public health and safety, although some additional risk will be incurred. The (b)(10) risk-significant planning standard functions are still met, although Exelon did fail to comply with the planning standard. Therefore, the inspectors determined the finding was of very low safety significance (Green). The finding has a cross-cutting aspect in the area of Human Performance, Change Management, because Exelon did not use a systematic process for evaluating and implementing change so that nuclear safety remained the overriding priority. (Section 1EP4)

Inspection Report# : 2015001 *(pdf)*

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

Significance: N/A Feb 04, 2015
Identified By: Licensee
Item Type: VIO Violation
Incomplete/Inaccurate Medical Information Resulted in Issuance of an Initial Senior Operator License without a Required Medical Restriction and Failure to Report a Permanent Change in Medical Status
The U.S. Nuclear Regulator Commission (NRC) issued a Severity Level III Notice of Violation (NOV) to Exelon Generation Company, LLC (Exelon) for two related operator licensing issues. The first issue involved the submittal by Exelon of information to the NRC that was not complete and accurate in all material respects as required by Title 10 of the Code of Federal Regulations 50.9. Specifically, on October 8, 2008, Ginna submitted a senior reactor operation (SRO) application which did not specify that the applicant had a medical condition requiring medication for hypertension. Subsequently, the NRC issued an SRO license to the individual without a medical restriction. The second issue involved the failure to notify the NRC within 30 days of a permanent disability of an SRO as required by 10 CFR 50.74 (c). Specifically, Ginna staff was informed in July 2008 that the SRO was taking prescribed medication for hypertension. Ginna did not report this permanent medical condition to the NRC when they submitted NRC Form 396 as part of the SRO license application in October 2008, and during subsequent biennial requalification medical examinations in 2010 and 2012. Ginna also did not request an amended license with a condition to account for the medical issue until July 16, 2014. An IP 92702 follow-up inspection was completed on December 5, 2015, closing this NOV and is documented in the 4th quarter inspection report.

Inspection Report# : 2015004 *(pdf)*
Inspection Report# : 2015007 *(pdf)*

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