EA 99-161

Dr. Robert C. Mecredy Vice President, Ginna Nuclear Operations Rochester Gas and Electric Corporation 89 East Avenue Rochester, New York 14649

### SUBJECT: NRC's R. E. GINNA INSPECTION REPORT 05000244/2000-008

Dear Dr. Mecredy:

On November 11, 2000, the NRC completed an inspection of your R. E. Ginna facility. The enclosed report presents the results of that inspection. Preliminary findings were presented to RG&E management led by Mr. J. Widay in an exit meeting on November 16.

NRC inspectors examined numerous activities that related to reactor safety and compliance with the Commission's rules and regulations, and with the conditions of your operating license. The inspection consisted of selected examinations of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of this inspection, no findings of significance were identified. However, a previously identified item involving an inadequate safety evaluation for changes made to the main steam non-return check valves was determined to be a violation of 10 CFR 50.59. This violation is being treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the Enforcement Policy. The NCV is described in the subject inspection report. If you contest this violation, you should provide a response within 30 days of the date of this inspection report, with basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001, with copies to: the Regional Administrator, Region I; the Director, Office of Enforcement; and the NRC resident Inspector at the Ginna facility.

Dr. Robert C. Mecredy

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Sincerely,

/RA/

Michele G. Evans, Chief Projects Branch 1 Division of Reactor Projects

Docket No. 05000244 License No. DPR-18

Enclosure: Inspection Report 05000244/2000-008

cc w/encl:

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# U.S. NUCLEAR REGULATORY COMMISSION

# **REGION I**

Docket No: License No:	05000244 DPR-18
Report No:	05000244/2000-008
Licensee:	Rochester Gas and Electric Corporation (RG&E)
Facility:	R. E. Ginna Nuclear Power Plant
Location:	1503 Lake Road Ontario, New York 14519
Dates:	October 1 through November 11, 2000
Inspectors:	<ul><li>H. K. Nieh, Senior Resident Inspector</li><li>C. R. Welch, Resident Inspector</li><li>T. A. Moslak, Health Physicist</li><li>T. F. Burns, Reactor Inspector</li></ul>
Approved by:	Michele G. Evans, Chief Projects Branch 1 Division of Reactor Projects

### SUMMARY OF FINDINGS

IR 05000244-00-08, 10/01-11/11/2000; Rochester Gas & Electric; R. E. Ginna Nuclear Power Plant. Integrated Resident Report.

The inspection was conducted by resident inspectors and regional radiation protection and inservice inspection specialists.

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# ATTACHMENT

Attachment 1 - NRC's REVISED REACTOR OVERSIGHT PROCESS

### **Report Details**

### SUMMARY OF PLANT STATUS

Ginna began the period in the refueling mode of a scheduled outage. Plant startup activities commenced on October 18. During plant power ascension on October 21, control room operators manually tripped the reactor, from approximately 70% power, due to the loss of a circulating water pump (section 1R14). Full power operation was established on October 25 and continued through the end of the inspection period.

### 1. REACTOR SAFETY (Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity)

- 1R04 Equipment Alignment
- a. Inspection Scope

The inspectors performed a complete walkdown of the 125 volt direct current (DC) distribution system. The inspectors verified proper circuit breaker alignments, assessed component material condition, reviewed completed surveillance tests, outstanding maintenance, and design issues. The inspectors also sampled RG&E's corrective actions associated with Action Report (AR) Nos. 1999-1203 (B train reactor trip relay flags found dropped out) and 1999-1210 (125 volt DC components may be operating at higher than rated voltages). Ginna's updated final safety analysis report, technical specifications, and probabilistic safety assessment were used as references.

Additionally, the inspectors conducted a partial walkdown of component cooling water train A, while train B was out of service for maintenance.

b. Findings

No findings of significance were identified.

### 1R08 Inservice Inspection Activities

a. Inspection Scope

The inspector selected samples of inservice inspection (ISI) activities for inspection based on a review of the inspection procedure objectives, risk ranking of safety significant systems being examined, and the type of nondestructive examinations (NDE) being performed on those systems during the refueling outage.

The inspector performed a review of three types of NDE activities including volumetric, surface, and visual examinations to verify the effectiveness of monitoring degradation in risk significant systems, structures, and components. The performance of ultrasonic and penetrant tests of welds H and CSW-1 in the residual heat removal system were observed and evaluated by the inspector for compliance with the requirements of the ASME (American Society of Mechanical Engineers) boiler and pressure vessel code. The inspector reviewed RG&E's inspection results from visual inspections of the containment dome, various penetrations, and bolting performed for compliance with

ASME section XI, class MC and metallic liners of class CC components. Also, a review was conducted of selected results of eddy current examinations of steam generator tubing during the 1999 refueling outage. Radiographs of welding activities were reviewed for welds #2, 5, 7 and repairs 2R1, 2C, 2C2, 5R1, and 5R2 on pipe spools for installation of bypass valves 3614 and 3615 and associated fittings in the main steam system. The review verified flaw identification, size, location, and accept/reject determination. Review of repair radiographs verified removal of rejectable indications and restoration of each weld joint to within ASME code requirements by repair welding. The inspector also reviewed radiographs of replacement fittings installed with welds #1, 2, and 3 downstream of valve 4619 in the service water system to verify that replacement activities satisfied the requirements of ASME sections IX and XI. Test results were evaluated to verify indications were appropriately identified, recorded, and dispositioned. Final radiographic test results (including repairs) were evaluated to verify that no rejectable indications or defects were accepted for continued service.

Brazing activities performed during the repair of the containment fan motor cooler, Work Order (WO) No. 19903635, Component ACA10 cooling water supply header, were evaluated for compliance with the requirements of ASME section IX. In addition, the inspector evaluated the repair activity for appropriate problem identification, cause determination, and corrective actions.

The inspector reviewed AR No. 2000-1338 (errors in weld procedure qualifications #6, 7, 8, 9, 19 and 20), which was initiated during this inspection period for resolution of inspector observations. AR No. 2000-0853 (leak downstream of valve 4619) was also reviewed to evaluate problem identification and corrective actions.

b. Findings

No findings of significance were identified.

#### 1R12 Maintenance Rule Implementation

a. <u>Inspection Scope</u>

The inspectors reviewed RG&E's maintenance rule implementation for the following equipment performance problems. This inspection evaluated system scoping, performance criteria/goal monitoring, and problem classification.

- Standby auxiliary feedwater system valve 9629B failed to open, AR No. 2000-1292
- Power operated relief block valve 516 failed to close, AR No.2000-1416
- Source range nuclear instrument N-32 exceeded performance criteria, AR Nos. 1997-1592, 2000-1134, 2000-1172, 2000-1409

### b. Findings

No findings of significance were identified.

### 1R13 Maintenance Risk Assessments and Emergent Work Control

### a. Inspection Scope

The inspectors evaluated the effectiveness of risk assessments performed for scheduled maintenance on the component cooling water system (WO Nos. 19904383 and 19904384). This inspection used risk assessment results from RG&E's online risk monitoring software. In addition, the inspectors verified that RG&E's risk management actions were consistent with those described in procedure IP-PSH-2, "Integrated Work Schedule Risk Management."

The inspectors also reviewed RG&E's emergent work controls for troubleshooting activities on the A motor driven auxiliary feedwater pump (AR Nos. 2000-1576 and 2000-1586).

b. Findings

No findings of significance were identified.

### 1R14 Personnel Performance During Non-Routine Plant Evolutions

a. Inspection Scope

The inspectors reviewed personnel performance during an unplanned manual reactor trip on October 21. Control room operators had manually tripped the reactor in response to having lost one of the two operating circulating water pumps. This inspection verified that operator response was in accordance with station procedures through interviews with control room personnel and a review of data collected during and following the event.

The inspectors also evaluated licensee event report (LER) Nos. 05000244/2000-03-00 and 05000244/2000-04-00, which documented technical specification violations due to personnel error. This review was performed to determine if operator actions following the events were in accordance with procedures and training. These LERs are further discussed in sections 4OA3 and 4OA7 of this report.

b. Findings

No findings of significance were identified.

### 1R15 Operability Evaluations

### a. Inspection Scope

The inspectors reviewed RG&E's evaluations associated with the following ARs to verify that system operability is properly justified.

 No. 2000-1267
No. 2000-1293
No. 2000-1293
Safety injection accumulator level transmitter LT-934 found out of tolerance.
No. 2000-1395
Low service water flow found during surveillance testing.

### b. Findings

No findings of significance were identified.

### 1R17 Permanent Plant Modifications

### a. Inspection Scope

The inspectors reviewed the following plant change records (PCRs) to verify that the modifications did not degrade the affected system's design bases, licensing bases, or performance capability. This inspection included reviews of associated engineering evaluations, visual observations of related maintenance activities, reviews of post modification testing, and verification of selected document updates.

- PCR No. 1999-0089 Main steam non-return check valve upgrade.
- PCR No. 2000-0041 Install fuses in emergency diesel generator control panel for screen house cables.

### b. Findings

No findings of significance were identified.

#### 1R19 Post Maintenance Testing

#### a. <u>Inspection Scope</u>

The inspectors reviewed the post maintenance tests for the following work orders (WOs) to verify that RG&E appropriately demonstrated the affected system's ability to perform its intended safety function.

•	WO No. 20002893	Inspect and replace blown fuse in containment
		isolation signal for valve AOV-955.
•	WO No. 20003035	Re-pack C charging pump.

b. Findings

No findings of significance were identified.

### 1R20 Refueling and Outage Activities

#### a. Inspection Scope

### Monitoring of Shutdown Activities

The inspectors observed plant cooldown activities to determine if technical specification cooldown limits were maintained. The inspectors also reviewed RG&E's problem identification and resolution activities for a licensee identified violation involving both source range nuclear instruments being inoperable during plant cooldown. The associated licensee event report (No. 05000244/2000-03-00) and non-cited violation are discussed in sections 4OA3 and 4OA7, respectively.

### Licensee Control of Outage Activities

This inspection involved frequent plant tours and observations of activities such as plant configuration control, risk management, maintenance, testing, and equipment clearances (i.e., tagouts). The inspectors also performed walkdowns of equipment and associated instrumentation to verify that systems such as residual heat removal, spent fuel pool cooling, and electrical power were operating properly.

#### **Refueling Activities**

The inspectors observed portions of reactor cavity flood-up/drain-down, reactor disassembly/reassembly, and fuel movements in the containment and at the spent fuel pool. The inspectors also watched core mapping activities to verify that fuel assemblies were correctly located in the reactor. This inspection also included a review of RG&E's compliance with refueling technical specifications.

#### Monitoring of Restart Activities

The inspectors observed portions of various restart activities including plant heat up, containment closure, reactor start up, and physics testing. This inspection consisted of direct observations in the control room; a review of various completed start up procedures, including physics testing results; and periodic verification of technical specifications. The inspectors also reviewed RG&E's problem identification and resolution activities for a licensee identified violation involving two containment recirculation fan coolers being inoperable during the transition from mode 5 to mode 4. The associated licensee event report (No. 05000244/2000-04-00) and non-cited violation are discussed in sections 40A3 and 40A7, respectively.

### b. Findings

No findings of significance were identified

- 1R22 Surveillance Testing
- a. Inspection Scope

The inspectors witnessed the performance and/or reviewed test data for the following activities to verify that the tests demonstrate the associated system's functional capability and operational readiness.

- RSSP-2.1 Safety injection system functional test.
- RSSP-2.2 Diesel generator load and safeguard sequence test.
- RSSP-7.0 Control rod drop test.
- PTT-23.6 Containment isolation valve leak rate testing letdown line from reactor coolant system (penetration 112).
- b. Findings

No findings of significance were identified.

### 2. RADIATION SAFETY

### **Occupation Radiation Safety [OS]**

### 2OS2 ALARA Planning and Controls

a. <u>Inspection Scope</u>

The inspector evaluated the effectiveness of various controls to minimize and equalize personnel exposure for tasks conducted during the refueling outage. The inspector reviewed pertinent information regarding cumulative exposure history, current exposure trends, and ongoing activities to assess RG&E's effectiveness in establishing exposure goals and keeping personnel exposure as low as reasonably achievable (ALARA).

Performance of selected work groups was observed, including those groups performing reactor reassembly and reactor cavity decontamination. The inspector reviewed the associated exposure controls specified for selected jobs, and attended pre-job ALARA briefings for eddy current testing of reactor in-core thimbles, seal return filter replacement, power range detector replacements, and reactor cavity drain down. For these tasks, the inspector interviewed selected workers on their knowledge of the relevant radiation work permit (RWP), dosimetry setpoints, and job-site radiological conditions.

Individual exposure records were reviewed for completed tasks and for those currently in-progress. The adequacy of whole body and extremity dosimetry was evaluated. The

dose assessment methodology and whole body counting data was reviewed for a worker who received an internal exposure.

Independent radiation surveys were performed in areas of the containment building, auxiliary building, and intermediate building to confirm posted survey results and assess the adequacy of RWPs associated with tasks performed in these areas.

The inspector observed technicians performing radioactive source/functional checks on a variety of portable survey instruments and contamination counting equipment.

Selected locked high radiation areas located in the containment building, auxiliary building, and intermediate building were physically checked and the keys to these areas were inventoried. Through review of photographs and survey data, the inspector evaluated the posting and barriers to control access to transient high radiation areas in the auxiliary and intermediate buildings that were temporarily installed during fuel transfer.

Additionally, the inspector evaluated the adequacy of RG&E's respiratory protection and air sampling programs. The inspector evaluated the use of personal air samplers and continuous air monitors to measure potential airborne radioactive contamination occurring during reactor cavity decontamination activities. The training and qualification records for selected workers who were required to wear respiratory protection while working in the cavity were reviewed.

The inspector reviewed the following ARs, initiated during the refueling outage, relating to the control of personnel exposure and work activities to determine if the issues were identified in a timely manner and that appropriate corrective actions were taken to resolve the issue:

- 2000-1173 Containment air flow anomaly.
- 2000-1175 Whole body count data for personnel contamination.
- 2000-1194 Posting of a high radiation area.
- 2000-1232 Electronic dosimetry dose rate alarm.
- 2000-1233 Electronic dosimetry dose rate alarm.
- 2000-1246 Electronic dosimetry dose rate alarm.
- 2000-1326 Personnel contamination event.
- b. <u>Findings</u>

No findings of significance were identified.

### 4. OTHER ACTIVITIES [OA]

### 4OA3 Event Follow-up

### a. Inspection Scope

Using the guidance of Inspection Procedure 71153, the inspectors reviewed the following licensee event reports to determine if RG&E's evaluation and corrective actions are reasonable and if any violations of regulatory requirements were involved:

•	No. 05000244/2000-01-00	Intermediate range channel loss of control power, due to excessive signal noise, results in reactor trip.
•	No. 05000244/2000-03-00	Source range channel not promptly discovered to be inoperable, due to personnel error, results in violation of technical specifications.
•	No. 05000244/2000-04-00	Two fans inoperable during transition from mode 5 to mode 4, due to personnel error, resulted in condition prohibited by technical specifications.

RG&E issued LER No. 05000244/2000-04-00 after the end of the inspection period; however, the inspectors' review was performed prior to the LER's issue date, and no new issues were revealed in the LER.

### b. Findings

### (Closed) LER No. 05000244/2000-01-00

This LER documented an unplanned automatic reactor trip that occurred on September 18, 2000, while operators were shutting down the plant for refueling. No complications occurred during the event. RG&E documented their evaluation and corrective actions for this issue in AR No. 2000-1121. No violations or findings of significance were identified in this review.

#### (Closed) LER No. 05000244/2000-03-00

On September 21, with the plant in mode 5, operations department management discovered that source range nuclear instrument N-32 was inoperable for approximately fourteen hours, unrecognized by control room operators. During this time, the redundant source range channel was also inoperable for maintenance. This issue screened as GREEN (very low safety significance) in the Significance Determination Process for shutdown inspection findings, since no credible dilution or reactivity addition events were identified. RG&E documented the cause (personnel error) and corrective actions for this event in AR No. 2000-1176. Corrective actions included counseling for those personnel involved and training for all operating shifts. This event involved a licensee identified violation of technical specifications (see section 40A7 of this report).

#### (Closed) LER No. 05000244/2000-04-00

On October 14, during plant heat-up from mode 5 to mode 4, control room operators discovered that two of the four containment recirculation fan coolers (CRFC) were inoperable due to their main control board switches being in the pull-stop position. This issue was determined to be GREEN (very low safety significance) in phase 2 of the Significance Determination Process for shutdown inspection findings because: 1) containment temperature and pressure limits would not have been exceeded, if a primary or secondary system rupture were to occur, since reactor coolant system temperature was only 225 degrees at the time of identification; and 2) sufficient redundant and diverse containment cooling system components were available (i.e., the other 2 CRFCs and both containment spray pumps). RG&E documented the cause (personnel error) and corrective actions for this event in AR 2000-1454. Corrective actions include personnel training and an evaluation of the administrative controls used during plant mode changes. This event involved a licensee identified violation of technical specifications (see section 4OA7 of this report).

### 40A5 Other

#### (Closed) Escalated Enforcement Item (EEI) 05000244/1999-005-01

Inadequate safety evaluation for main steam non-return check valves. The licensee failed to perform 10 CFR 50.59 safety evaluations for packing adjustments and surveillance procedure revisions that were performed in 1992, 1993, and 1999 for the main steam non-return check valves (NRVs). The activities changed the NRVs from free-swinging gravity-to-close valves, as described in the Updated Final Safety Analysis Report (UFSAR), to valves requiring up to 900 foot-pounds of torque to close. The NRC's initial inspection of this item is documented in Section E7.1 of Inspection Report 05000244/1999-005.

RG&E initiated various corrective actions following the inspection, which included: moving the position of the valve disc counter-weights (reference Section 1R17); performing calculations to assess the valves' operability; and having a third party perform an independent operability assessment. Based on the calculations, the licensee concluded adequate torque would be available to close the NRVs during a postulated main steam line rupture that could challenge the design pressure limit of the primary containment. The NRC Office of Nuclear Reactor Regulation reviewed the licensee's calculations and concluded that the valves had remained operable since the packing originally was adjusted in 1992, (reference response to Task Interface Agreement 2000-01, TAC No. MA 2721, dated October 16, 2000). Notwithstanding, the NRC also concluded that the changes involved an unreviewed safety question.

The NRC determined that the condition had very low significance because: (1) the probability of a main steam line rupture was low; (2) the degraded NRVs remained capable of performing their safety function; and (3) the NRVs were backed up by power-operated main steam isolation valves. In addition, the licensee restored the NRVs to the free-swinging condition during the last refueling outage. The inspector notes that this issue was not assigned a color (per Attachment 1) because it was identified and

documented by the NRC staff prior to implementation of the revised Reactor Oversight Process (April 2000).

10 CFR 50.59 allows licensees to change the facility and procedures as described in the safety analysis report without prior NRC approval, unless the change involves a change in the technical specifications or an unreviewed safety question. A proposed change is deemed to involve an unreviewed safety question if the probability of occurrence of a malfunction of equipment previously evaluated in the safety analysis report may be increased. Records of such changes must include a written safety evaluation that provides the bases for the determination that the change does not involve an unreviewed safety question. Failure to perform safety evaluations for the changes to the NRVs and their associated surveillance procedure, that resulted in an unreviewed safety question, was a violation of 10 CFR 50.59. However, this violation is being treated as a Non-Cited Violation (**NCV 05000244/2000-08-03**) in accordance with Section VI.A of the NRC Enforcement Policy in that the associated condition was of very low significance. The issue was entered into the licensee's corrective action process via Action Report (AR) Nos. 99-0890, 99-1000, and 99-0959.

4OA6 Meetings

### Exit Meeting Summary

On November 16, the inspectors presented their overall findings to members of RG&E management led by Mr. J. Widay. RG&E management acknowledged the findings presented and did not contest any of the inspectors' conclusions. No proprietary information was identified.

#### 40A7 Licensee Identified Violations

The following findings of very low safety significance (green), were identified by RG&E, and are violations of NRC requirements that meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for disposition as Non-Cited Violations (NCVs).

- NCV 05000244/2000-08-01 Technical Specification 3.3.1 requires, in part, that one source range nuclear instrument be operable in mode 5. On September 21, RG&E identified that no source range instruments were operable. This issue was documented in RG&E's corrective action program in AR No. 2000-1176 and in LER No.05000244/2000-03-00.
- NCV 05000244/2000-08-02 Technical Specification 3.0.4 requires, in part, that when a limiting condition for an operational mode is not met, entry into that mode shall not be made. On October 14, control room operators changed the plant from mode 5 to mode 4 with two of four required containment recirculation fan coolers inoperable. This issue was documented in RG&E's corrective action program in AR No. 2000-1454 and in LER No. 05000244/2000-04-00.



# PARTIAL LIST OF PERSONS CONTACTED

<u>RG&E</u>

J. Widay	VP, Plant Manager
P. Bamford	Primary Systems and Reactor Engineering Manager
J. Bement	Lead Technician, Radiation Protection Operations
R. Biedenbach	Safety/Fire Coordinator
D. Filkins	ALARA Technician
M. Flaherty	Configuration Support Manger
B. Flynn	Scheduling Manager
R. Forgensi	Operational Review
G. Graus	I&C/Electrical Engineering Manager
M. Harrison	Lead Technician, Radwaste Management
A. Hedges	Technician, Radiation Protection Operations
A. Herman	Principal Health Physicist
J. Hotchkiss	Mechanical Maintenance Manager
G. Joss	ISI/IST Coordinator
N. Leoni	Radiation Protection, Quality Assessment Coordinator
M. Lilley	Quality Assurance Manager
R. Marchionda	Nuclear Assessment Department Manager
C. Meighan	ALARA Coordinator
F. Mis	Acting Radiation Protection and Chemistry Manager
T. Plantz	Maintenance Systems Manager
R. Ploof	Balance of Plant Systems Engineering Manager
P. Polfleit	Corporate Emergency Planner
R. Popp	Production Superintendent
J. Smith	Maintenance Superintendent
R. Teed	Nuclear Security Supervisor
R. Watts	Nuclear Training Department Manager
J. Wayland	I&C/Electrical Maintenance Manager
T. White	Operations Manager
B. Wood	Technician, Radiation Protection Instrumentation
G. Wrobel	Nuclear Safety & Licensing Manager
	ITEMS OPENED AND CLOSED
Opened/Closed	

NCV 05000244/2000-08-01	Both source range nuclear instruments inoperable.
NCV 05000244/2000-08-02	Two of four containment recirculation fan coolers inoperable during plant mode change.
NCV 05000244/2000-08-03	Violation of 10 CFR 50.59.

<u>Closed</u>

LER 05000244/2000-01-00	Intermediate range channel loss of control power, due to excessive signal noise, results in reactor trip
LER 05000244/2000-03-00	Source range channel not promptly discovered to be inoperable, due to personnel error, results in violation of technical specifications
LER 05000244/2000-04-00	Two fans inoperable during transition from mode 5 to mode 4, due to personnel error, resulted in condition prohibited by technical specifications
EEI 05000244/1999-005-01	Inadequate safety evaluation for main steam non-return check valve.

# LIST OF ACRONYMS USED

ALARA	As Low As Reasonably Achievable
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/ (=/ (1 (/ (	
AOV	Air Operated Valve
AR	Action Report
ASME	American Society of Mechanical Engineers
CRFC	Containment Recirculation Fan Cooler
DC	Direct Current
EEI	Escalated Enforcement Item
ISI	Inservice Inspection
LER	Licensee Event Report
LT	Level Transmitter
NCV	Non-Cited Violation
NDE	Non-Destructive Examinations
NRC	Nuclear Regulatory Commission
NRV	Non-Return Check Valve
PCR	Plant Change Record
RG&E	Rochester Gas and Electric Corporation
RWP	Radiation Work Permit
UFSAR	Updated Final Safety Analysis Report
WO	Work Order

### LIST OF DOCUMENTS REVIEWED

### **Inservice Inspection Reports**

00GU154	UT Pipe Weld Examination Record (UT 208) Weld CSW-1, RHR
00GCA112	UT Calibration Record for UT 208
00GCA113	UT Thickness Calibration Record (UT 102, Weld Profile CSW-1, RHR)
00GCA125	UT Thickness Calibration Record (UT 102, Angle Determinations)
00GEV012	Volumetric Evaluation Report for 00GU154 (Weld CSW-1, RHR)
00GEV013	Surface Evaluation Report (Weld CSW-1, RHR)
00GU153	UT Pipe Weld Examination Record (UT 208) Weld H, RHR
00GEV010	Volumetric Evaluation Report for 00GU153 (Weld H, RHR)
00GEV011	Volumetric Evaluation Report for 00GU157 (Weld H, RHR)
00GCA111	UT Calibration Record for UT 208, 60 Deg
00GCA114	UT Calibration Record for UT 208, 45 Deg
00GCA115	UT Thickness Calibration Record (UT 102, Weld Profile "H" on RHR)
Containment	Dome Inspection (ASME Section IWE), Metal Containment/Liners

### **Action Reports**

2000-1338	Weld Procedure Qualification Errors (6,7,8,9,19 and 20)
2000-0853	Leak Downstream of V4619

### Welding and Brazing Procedures (Including Procedure Qualifications)

BPS 400-1Torch Brazing of Copper Alloys, P107 to P107WPS 100-35Welding Procedure for P1 to P8WPS 100-27Welding Procedure for P8 to P8WPS 100-04Welding Procedure for P1 to P1

### Radiographs

Service Water System Valve Replacement (Safety Class III) Welds #1, 2 and 3 Main Steam Isolation Valve Bypass Modification (Safety Class II) Welds #2 thru #7 on Valve 3614 (Including repairs) and Welds #2 thru #7 on Valve 3615

#### Work Orders

WO 20002141Service Water Pipe, Reducer and Elbow Replacement WO 19903635Braze Repair of Leak in Containment Fan Motor Cooler WO 20002141Replacement of Valve 4619 in Service Water System

# ATTACHMENT 1

# NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

### **Reactor Safety**

### Radiation Safety

### Safeguards

• Initiating Events

- OccupationalPublic
- Physical Protection

- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.