UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PA 19406-1415

November 6, 2008

Mr. John T. Carlin
Vice President, R.E. Ginna Nuclear Power Plant
R.E. Ginna Nuclear Power Plant, LLC
1503 Lake Road
Ontario, New York 14519

SUBJECT: R. E. GINNA NUCLEAR POWER PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000244/2008010

Dear Mr. Carlin:

On September 26, 2008, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your R. E. Ginna Nuclear Power Plant. The enclosed report documents the inspection results, which were discussed on September 26, 2008, with you and other members of your staff.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and the conditions of your license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

Based on the samples selected for review, the inspection team concluded that Ginna was generally effective in identifying, evaluating and resolving problems. Ginna personnel consistently identified problems and entered them into the corrective action program at a low threshold. In general, Ginna prioritized issues commensurate with the safety significance of the problems. Although the team determined that the implementation of the corrective action program at Ginna was generally effective and that the documentation and tracking of corrective actions have improved, the team identified some weaknesses in the area of evaluation of issues, timeliness of evaluations, and the implementation of effective corrective actions.

This report documents one NRC-identified finding and one self-revealing finding of very low safety significance (Green). One of these findings was determined to involve violations of NRC requirements. However, because this violation was of very low safety significance and because it was entered into your corrective action program, the NRC is treating this as a non-cited violation (NCV), in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this NCV, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U.S. 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, U.S. Nuclear Regulatory Commission, Washington, D.C., 20555-0001; and the NRC Resident Inspector at the R. E. Ginna Nuclear Power Plant.

In accordance with Title 10 of the Code of Federal Regulations Part 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web Site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Raymond J. Powell, Chief
Technical Support & Assessment Branch
Division of Reactor Projects

Docket No. 50-244
License Nos. DPR-18

Enclosure: Inspection Report No. 05000244/2008010
w/ Attachment: Supplemental Information

cc w/encl:
M. J. Wallace, Vice - President, Constellation Energy
B. Barron, President, CEO & Chief Nuclear Officer, Constellation Energy Nuclear Group, LLC
P. Eddy, Electric Division, NYS Department of Public Service
C. Donaldson, Esquire, Assistant Attorney General, New York Department of Law
C. Fleming, Esquire, Senior Counsel, Nuclear Generation, Constellation Nuclear Energy Nuclear Group, LLC
D. Wilson, Director, Licensing, R.E. Ginna Nuclear Plant , LLC
P. Tonko, President and CEO, New York State Energy Research and Development Authority
J. Spath, Program Director, New York State Energy Research and Development Authority
G. Bastedo, Director, Wayne County Emergency Management Office
M. Meisenzahl, Administrator, Monroe County, Office of Emergency Preparedness
T. Judson, Central New York Citizens Awareness Network

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Sincerely,

/RA/

Raymond J. Powell, Chief
Technical Support & Assessment Branch
Division of Reactor Projects

Docket No. 50-244
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Distribution w/encl:
S. Collins, RA
M. Dapas, DRA
D. Lew, DRP
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S. Williams, RI OEDO
R. Nelson, NRR
D. Pickett, PM, NRR
B. Vaidya, PM, NRR
G. Dentel, DRP
N. Perry, DRP
J. Hawkins, DRP
K. Kolaczyk, DRP, Senior Resident Inspector
S. Kennedy, DRP, Senior Resident Inspector, Calvert Cliffs
M. Marshfield, DRP, Resident Inspector
A. Klett, NRR
J. Ayala, DRP
M. Rose, DRP, OA
Region I Docket Room (with concurrences)
ROPreports@nrc.gov (All IRs)

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.:	50-244
License No.:	DPR-18
Report No.:	05000244/2008010
Licensee:	Constellation Energy, R. E. Ginna Nuclear Power Plant, LLC
Facility:	R. E. Ginna Nuclear Power Plant
Location:	Ontario, New York
Dates:	September 8 - 26, 2008
Team Leader:	S. Kennedy, Senior Resident Inspector, Calvert Cliffs, DRP
Inspectors:	M. Marshfield, Ginna Resident Inspector, DRP A. Klett, Reactor Operations Engineer, NRR J. Ayala, Project Engineer, DRP
Approved by:	Raymond J. Powell, Chief Technical Support & Assessment Branch Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000244/2008-010; 9/8/2008 – 9/26/2008; R. E. Ginna Nuclear Power Plant; Biennial Baseline Inspection of the Identification and Resolution of Problems; one violation and one finding were identified in the effectiveness of corrective actions.

This team inspection was performed by one NRC Region I senior resident inspector, one NRC regional inspector, one NRC headquarters inspector, and one resident inspector. Two findings of very low safety significance (Green) were identified during this inspection. One of the findings was classified as a non-cited violation (NCV). The significance of most findings is indicated by their color (Green, White, Yellow, Red) using NRC Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Identification and Resolution of Problems

The inspectors concluded that Ginna was generally effective in identifying, evaluating and resolving problems. Ginna staff identified problems and entered them into the corrective action program (CAP) at a low threshold. The inspectors determined that, in general, Ginna appropriately screened issues for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. The inspectors determined that the implementation of the CAP at Ginna was generally effective and that the tracking of corrective actions has improved. However, the inspectors noted weaknesses in the rigor of evaluations, the timeliness of completion of apparent cause evaluations (ACEs), and the implementation of effective corrective actions. The inspectors determined that operating experience (OE) information was appropriately considered for applicability, and corrective and preventive actions were taken as needed. Self-assessments, Quality and Performance Assessment audits, and other assessments were effective in identifying issues. Based on interviews, observations of plant activities, and reviews of the CAP and the Employees Concerns Program (ECP), the inspectors determined that site personnel were willing to raise safety issues and document them in the CAP.

A. NRC-Identified and Self-Revealing Findings

Cornerstone: Initiating Events

- Green. The inspectors identified a finding of very low safety significance for Constellation's failure to take timely corrective actions to address repetitive failures of the "C" instrument air compressor (IAC). The "C" IAC had a history of tripping on high blow-off pressure since 2000 including at least 5 trips since May 2006. Ginna determined that the cause of the trips was due to back leakage through the IAC discharge check valve and/or master control panel design deficiencies. Although a design upgrade was considered several times since 2002, each upgrade of the "C" IAC was subsequently cancelled. Following the latest trip on September 9, 2008, Ginna declared the "C" IAC inoperable until the completion of the master controller upgrade later this year. Ginna entered this issue into their CAP for resolution.

The finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events cornerstone and affects the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during power operations. Specifically, unnecessary transients on the instrument air header increased the likelihood of a loss of instrument air. A loss of instrument air would cause the main steam isolation valves to close and result in a reactor trip. The inspectors determined that the finding was of very low safety significance because the finding did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment would not be available, or increase the likelihood of a fire or internal/external flood. This finding has a cross-cutting aspect in the area of problem identification and resolution in that Ginna did not periodically trend and assess information associated with the "C" IAC trips to identify programmatic and common cause problems. (P.1(b)) (Section 4OA2.a.3.i)

- Green. The inspectors identified a self-revealing non-cited violation of Technical Specification 5.4.1.a, "Procedures," for Constellation's failure to establish and maintain an adequate procedure for testing the reactor trip breakers. This resulted in the inadvertent isolation of letdown while restoring from reactor trip breaker testing and the subsequent lifting of pressurizer power operated relief valves (PORVs). At the time of the test, the reactor plant was shutdown and the pressurizer was water solid. With letdown flow isolated and the charging system in manual operation, pressurizer pressure increased above the low temperature overpressure protection set point which caused the PORVs to actuate. Ginna determined that the procedure did not provide adequate guidance for the restoration of the simulated pressurizer level following completion of the test. Ginna entered this issue into their corrective action program for resolution. Planned corrective actions included upgrades to the reactor trip breaker test procedures and a review of instrument and control procedures.

  The finding is more than minor because it is associated with the procedure quality attribute of the Initiating Event cornerstone and affects the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown operations. Specifically, the inadvertent lifts of PORVs could lead to a loss of reactor coolant system inventory and pressure control. This finding was of very low safety significance because Ginna maintained adequate mitigation capability for the current plant state and the event was not considered a loss of control condition. 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, corrective actions following a similar issue were not completed (and compensatory actions were not in place) in a timely manner which could have prevented this event. (P.1(d)) (Section 4OA2.a.3.ii)

B. Licensee-Identified Violations

None.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (Biennial - IP 71152B)

a. Assessment of the Corrective Action Program

1. Inspection Scope

The inspectors reviewed the Ginna's CAP procedures which described the process for documenting and resolving issues by the initiation of condition reports (CRs). The CRs were subsequently screened for operability and reportability, categorized by significance, and assigned for further evaluation, resolution, and/or trending.

The inspectors reviewed CRs selected across the seven cornerstones of safety in the NRC's Reactor Oversight Process. The inspectors selected a risk-informed sample of CRs that had been processed through the CAP and that had been issued since the last NRC Problem Identification and Resolution inspection conducted in August 2006. The inspectors considered risk insights from the station's risk analyses to focus the sample selection on risk-significant systems and components. The samples focused on, but were not limited to, these systems. The inspectors expanded the corrective action review to five years for evaluation of Ginna's 125 volt DC system and the residual heat removal system (RHR).

The inspectors reviewed CRs to assess whether Ginna personnel adequately identified problems in a timely manner commensurate with their significance. The issues reviewed encompassed the full range of evaluations, including root cause analysis reports (RCARs) and apparent cause evaluations (ACEs). CRs that were assigned lower levels of significance which did not include formal cause evaluations were reviewed to ensure that they were appropriately classified. The inspectors' review included the appropriateness of the assigned significance, the scope and depth of the causal analysis, and the timeliness of resolution. The inspectors assessed whether the evaluations identified likely causes for the issues and identified appropriate corrective actions to address the identified causes. Ginna's timeliness in implementing corrective actions and effectiveness in precluding recurrence for significant conditions adverse to quality were also reviewed by the inspectors. The inspectors assessed the disposition of operability and reportability issues, the consideration of extent of condition, generic implications, common cause, and previous occurrences. The inspectors observed daily CR screening meetings in which Ginna personnel reviewed new CRs for prioritization and assignment. The inspectors also observed Management Review Committee meetings during which Ginna managers reviewed RCARs and certain ACEs, reviewed associated corrective action assignments, assessed corrective action effectiveness, and otherwise provided general oversight of the corrective action process. In addition, for selected systems exceeding their maintenance rule goals or performance criteria, the inspectors reviewed maintenance preventable functional failures for indications of weaknesses in Ginna's CAP. The inspectors also

conducted plant tours and walked down risk significant systems to assess whether Ginna was identifying equipment issues at a low threshold. The inspectors reviewed CRs for adverse trends and repetitive problems to determine whether corrective actions were effective in addressing the broader issues. The inspectors also reviewed CRs associated with selected non-cited violations (NCVs) and findings to determine whether Ginna properly evaluated and resolved the issues. The CRs and other documents reviewed, as well as key personnel contacted, are listed in the Attachment to this report.

2. Assessment

Identification of Issues

Based on the samples selected and plant tours, the inspectors concluded that Ginna personnel identified problems and entered them into the CAP at a low threshold. In addition, the inspectors concluded that Ginna personnel identified trends at low levels and entered them into their CAP. The inspectors did, however, identify undocumented degraded conditions during walkdowns, specifically:

- During a walkdown of the relay room, the inspectors noted that the door between the relay room and the relay annex room was not self-closing. The inspectors noted that this condition was contrary to National Fire Protection Association (NFPA) Standard 12A, "1301 Halon Systems," which requires that openings in halon enclosures be compensated for with automatic closures. The inspectors determined that this condition was a minor violation of Ginna's license condition 2.C.3 for the failure to implement and maintain in effect all fire protection features. The inspectors determined that this issue is minor, and not subject to enforcement action in accordance with the NRC's Enforcement Policy, due to the door was not found open and the door has a security alarm. The inspectors noted that there appeared to be a weakness in Ginna procedure FPS-15, "Fire Door Identification, Inspection and Maintenance," which does not specifically ensure testing of the self-closing features of doors. Ginna entered this issue into their CAP as CR-2008-007827.

- During a walkdown of the containment spray system, the inspectors identified a contaminated area under the "B" containment spray pump discharge drain that was not posted. Ginna documented this deficiency in CR-2008-007719. The inspectors determined that this issue is minor because it did not result in an unplanned or unintended dose to workers.

- During a walkdown of the RHR system, the inspectors identified several issues that warranted entry into Ginna's CAP. The inspectors identified an oil leak on motor operated valve 704B, the RHR train "A" hot leg suction valve; poor housekeeping in the RHR pump room; and no lighting in the RHR pump room and the RHR heat exchanger room. Ginna entered these issues into their CAP as CR-2008-007726, CR-2008-007731, CR-2008-007733, and CR-2008-007736. The inspectors determined that these issues are minor because the oil leak did not affect the

operability of the motor operated valve; the degraded lighting condition did not involve emergency lighting and did not result in any operational errors due to poor lighting; and the poor housekeeping issue had no safety impact.

Additionally, the inspectors reviewed CR-2008-006362 which documented that the "A" containment spray pump oil sample was late. Through further inspection, the inspectors learned that the water content was at the warning level. However, the inspectors determined that a CR was not written to document the water content results and the condition was not entered into the CAP as required by Ginna's lubrication oil program procedure, IP-OIL-1. Ginna entered this issue into their CAP as CR-2008-008162. The inspectors determined that this issue is minor because although the water content was at the warning level, the oil sample was not out of specification.

Prioritization and Evaluation of Issues

The inspectors determined that, in general, Ginna appropriately prioritized and evaluated issues commensurate with the safety significance of the identified problem. CRs were screened for operability and reportability, categorized by significance, and assigned to a department for evaluation and resolution.

The inspectors noted weaknesses in the timeliness of completion of some ACEs and weaknesses in the rigor of various evaluations. While most causal analyses were of good quality, some cause analyses did not meet the requirements of Ginna's CAP guidance. In addition, the inspectors noted that the justification or basis for conclusions in some evaluations such as prompt determinations and maintenance rule evaluations was not always documented in the evaluation. Although the inspector identified several weaknesses in this area, there were no violations of any regulatory requirements. The inspectors identified examples of these weaknesses included:

- Ginna procedures require that cause analysis be completed within 30 days or an extension be granted. The inspectors noted several occasions where Ginna was challenged with the completion of ACEs within 30 days. A delay in completion of the ACE results in a delay of corrective actions which could lead to recurrence of issues.

- The inspectors reviewed CR-2007-007441 which documented that the "B" charging pump had a belt failing. The inspectors noted that prompt determination was weak in that it stated the mechanics "believed" that the belts will last until the next scheduled replacement. However, the CR provided no basis for this conclusion.

- The inspectors reviewed CR-2006-004517 and its associated ACE which documented a potential imminent failure of the "C" charging pump due to a lack of lubrication of the varidrive. The ACE concluded that there were no equipment failure and the maintenance rule evaluation determined that the "C" charging pump could have performed its function. The inspectors determined that there was no justification or basis provided for either conclusion. Ginna documented this deficiency in CR-2008-008175.

- The ACEs for recent battery charger failures (CR-2008-003301 and CR-2008-005512) did not consider that electrolytic capacitors failure due to aging could potentially impact other structures, systems, or components. Although the ACE appropriately considered that this condition could apply to other battery chargers, the review was limited in scope and did not address other system, structures, and components as required by CNG-CA-1.01-1005, "Apparent Cause Evaluation." Ginna documented this deficiency in CR-2008-008171.

Effectiveness of Corrective Actions

The inspectors concluded that corrective actions for identified deficiencies were generally timely and adequately implemented. Administrative controls were usually in place to ensure that corrective actions were completed as scheduled and reviews were performed to ensure the actions were implemented as intended. In some cases, Ginna appropriately self-identified ineffective or improper closeout of corrective actions. However, the inspectors determined that Ginna has been challenged with preventing issues from recurring. The inspectors noted several instances where corrective actions were not fully effective; corrective actions were not fully implemented; and corrective actions were not implemented in a timely manner. Ginna's performance in this area is demonstrated by the following examples:

- The "C" IAC had a history of tripping on high blow-off pressure since 2000 including at least 5 trips since May 2006. A finding associated with untimely corrective actions is discussed in Section 4OA2.a.3.i.

- The inspectors reviewed CR-2008-008331 associated with the inadvertent lift of two pressurizer PORVs during the May 2008 refueling outage due to an inadequate procedure for testing reactor trip breakers. An NCV with a cross-cutting aspect of untimely corrective actions is discussed in Section 4OA2.a.3.ii.

- The inspectors reviewed NCV 2008002-02 for the failure to promptly identify and correct out-of-specification lubricating conditions. Following the NCV and prior to the completion of final corrective actions, the issue repeated because there were no compensatory actions in place to ensure that lube oil samples were submitted in a timely manner. Ginna identified that four oil samples were sent to the vendor late and resulted in untimely analysis of the samples. The inspectors determined that the issue is minor because the four late samples were later discovered to be within specified limits.

- The inspectors reviewed CR-2006-005236 and the associated RCAR which documented that Ginna inadvertently isolated the containment ventilation isolation (CVI) system while performing core alterations during the 2006 refueling outage. The RCAR for this event determined that corrective actions from a 2005 event may have prevented the 2006 CVI event. However, these corrective actions were not timely and were not completed for two years. The inspectors noted that the 2006 CVI event was

dispositioned as a license identified violation of very low safety significance (Green) in Ginna Inspection Report 05000244/2006005.

- The inspectors reviewed Part 21 Report 2007-25-00 concerning analog electronic circuit cards in Basler emergency diesel generator (EDG) voltage regulators. The inspectors noted that the Part 21 applied to Ginna and that Ginna had appropriately entered this issue into their CAP for resolution as CR-2007-006803. Ginna conducted an inspection of the EDG voltage regulator circuit cards. However, the inspectors determined that not all corrective actions associated with this issue were completed. Specifically, a repetitive task to inspect EDG automatic voltage regulator cards every 18 months was not created as required. Ginna entered this issue concerning the failure to complete corrective actions into their CAP as CR-2008-008152. The inspectors determined that this issue is minor because it did not result in a reasonable doubt on the operability of the EDG.

3. Findings

i. "C" Instrument Air Compressor Repetitive Failures

Introduction. The inspectors identified a finding of very low safety significance for Constellation's failure to take timely corrective actions to address repetitive failures of the "C" instrument air compressor (IAC).

Description. The inspectors noted that the "C" IAC had a history of tripping on high blow-off pressure since 2000 including five trips since May 2006. Ginna determined that the cause of the trips was due to back leakage through the IAC discharge check valve and/or master control panel design deficiencies. Following the "C" IAC trips in 2002 and 2003, Ginna's planned corrective actions included an upgrade of the master control panel based on the vendor's recommendations. However, Ginna subsequently canceled the upgrade due to funding considerations. On December 20, 2006, the "C" IAC tripped on high blow-off air pressure and was declared inoperable. The standby IACs auto-started and were placed in service as the lead air compressors. The vendor again recommended upgrading the master controller and recommended replacing the discharge check valve due to excessive back leakage. Ginna replaced the discharge check valve but decided not to upgrade the master control panel at that time. In April 2008, following several additional "C" IAC trips, Ginna decided to upgrade the master control panel with the vendor's recommended model. The new master control panel is scheduled to be installed later this year. The upgrade master control panel does not require that IAC blow-off pressure be monitored and the vendor determined that this is not a critical parameter that is required to be monitored.

Based on a review of applicable CRs, associated ACEs, and interviews with Ginna personnel, the inspectors determined that a major contributing cause of this finding was that Ginna did not adequately trend deficiencies associated with the "C" IAC. The inspectors determined that there were no trend CRs associated with "C" IAC deficiencies. As a result, Ginna responded to each IAC trip in a discrete manner rather than evaluate the condition of the "C" IAC in the aggregate.

The performance deficiency associated with this finding is that Ginna did not adequately address deficiencies associated with repetitive failures of the “C” IAC in a timely manner.

Analysis. The finding is more than minor because it affected the equipment performance attribute of the Initiating Events cornerstone objective of limiting the likelihood of events that upset plant stability at power. Specifically, unnecessary transients on the instrument air header increased the likelihood of a loss of instrument air. A loss of instrument air would cause the main steam isolation valves to close and result in a reactor trip. The inspectors determined that the finding was of very low safety significance (Green) through performance of a Phase 1 SDP in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." Specifically, the finding did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment would not be available, or increase the likelihood of a fire or internal/external flood. This finding has a cross-cutting aspect in the area of problem identification and resolution in that Ginna did not periodically trend and assess information associated with the “C” IAC trips to identify programmatic and common cause problems. (P.1.(b))

Enforcement. There were no violations of regulatory requirements because the IACs are not safety-related. Ginna entered this issue into their CAP as CR-2008-008173. **(FIN 05000244/2008010-01: Untimely Corrective Actions Associated With the “C” Instrument Air Compressor)**

ii. Inadequate Procedure for Testing Reactor Trip Breakers

Introduction: The inspectors identified a self-revealing NCV of Technical Specification 5.4.1.a, “Procedures,” for Constellation’s failure to establish and maintain an adequate procedure for testing the reactor trip breakers. This resulted in the inadvertent isolation of letdown while restoring from reactor trip breaker testing and led to the lifting of the pressurizer PORVs.

Description: On May 8, 2008, Ginna technicians were conducting testing on the “B” train reactor trip breakers in accordance with PT-32B-SD, “Reactor Trip Logic Test Train B.” Procedure PT-32B-SD is performed at the end of a refueling outage to ensure that reactor trip breaker safety functions are operable prior to the post-outage reactor start-up and operational period. At the time of the test, the reactor plant was shutdown and the pressurizer was water solid. Because the pressurizer was water solid, the pressurizer level was simulated at approximately 50 percent on all three channels by placing the pressurizer instrument test switch to “test.” This step cleared the high pressurizer level reactor trip signal so that the reactor trip breaker test could be conducted. After completion of the reactor trip breaker test, the pressurizer level instrument test switch was returned to the normal position. This introduced a momentary zero pressurizer level indication to the system. The zero level signal caused a letdown isolation signal to be generated and closed air operated valve AOV-427 which isolated letdown. With letdown flow isolated and the charging system in manual operation, pressurizer pressure increased above the low temperature overpressure protection set point which caused the

PORVs to actuate. The operators took actions to restore letdown to normal and stabilized the primary plant.

The inspectors reviewed the prompt investigation and the ACE to assess the cause of the events and the corrective actions. Ginna determined that the cause of the event was an inadequate procedure which gave no warning or direction to operators to place letdown in manual. Also, previous experience and undocumented knowledge had not been incorporated into the procedure. Specifically, step 6.25.4, of PT-32B-SD, for restoring pressurized level if simulated, instructs the operator to "Remove test equipment and restore channels using Attachment 2." The step provided no caution that this action may impact other systems in the plant. In addition, Attachment 2 to the procedure was simply a tabular representation of all the potential signals which may have to be simulated to complete the test and provided no guidance to the operator.

The inspectors determined that corrective actions following a similar issue were not completed in a timely manner such that the cause of the issue recurred. On March 16, 2007, a reactor trip occurred when the "B" main steam isolation valve unexpectedly closed at 100 percent power. Ginna determined that the cause of the event was due to insufficient details in the maintenance procedure and a reliance on knowledge and skill-based activities during performance of maintenance procedures without an incorporation of that knowledge into critical steps and key actions. Following the March 2007 event, Ginna initiated a corrective action to conduct a comprehensive maintenance procedure upgrade project to identify steps completed using knowledge base and skill of the craft, and to revise the procedures as necessary to prevent this issue from recurring. However, the inspectors determined that, at the time of the May 2008 event, Procedure PT-32B-SD had not yet been reviewed as part of the procedure upgrade project and that there were no compensatory actions in place. Thus, the inspectors concluded that corrective actions following a similar issue were not completed (and compensatory actions were not in place) in a timely manner which could have prevented the May 2008 event associated with the inadvertent lift of the PORVs.

Planned corrective actions following the May 2008 event included upgrades to the reactor trip breaker test procedures; a check of all other instrument & control procedures requiring simulation for possible impacts from restoring simulations; and modification of the work review process to add a detailed review of procedures that have not been through an upgrade program.

The performance deficiency associated with this issue is that Ginna did not establish and maintain an adequate procedure for testing the reactor trip breakers. This resulted in the inadvertent isolation of letdown while restoring from reactor trip breaker testing and led to the lifting of the PORVs.

Analysis. The finding is more than minor because it is associated with the procedure quality attribute of the Initiating Event cornerstone and affects the cornerstone objective of limiting those events that upset plant stability and challenge critical safety functions during shutdown operations. Specifically, the inadvertent lifts of the PORVs could lead to a loss of reactor coolant system inventory and pressure control. This finding was determined to

be of very low safety significance (Green) using Phase 1, Appendix G, Attachment 1, Checklist 4 of IMC 0609. This finding screened to green because Ginna maintained adequate mitigation capability for the current plant state and the event was not considered a loss of control condition. 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, corrective actions following a similar issue were not completed (and compensatory actions were not in place) in a timely manner which could have prevented the May 2008 event associated with the inadvertent lift of the PORVs. (P.1.(d)).

Enforcement. Technical Specification 5.4.1.a, “Procedures,” requires, in part, that the applicable procedures recommended in Appendix A of Regulatory Guide (RG) 1.33, “Quality Assurance Program Requirements (Operations),” shall be established, implemented and maintained. RG 1.33, Section 3, which states, in part, "Instructions for energizing, filling, venting, draining, startup, shutdown, and changing modes of operation should be prepared, as appropriate, for the following systems," includes the reactor control and protection system. Contrary to the above, prior to May 8, 2008, Ginna did not establish and maintain an adequate procedure for testing the reactor trip breakers. This led to the inadvertent lifting of PORVs while the plant was shutdown. Because this issue was determined to be of very low safety significance and has been entered into Ginna’s corrective action system as CR-2008-008331, this violation is being treated as an NCV consistent with Section VI.A.1 of the NRC Enforcement Policy. **(NCV 05000244/2008010-02, Inadequate Procedure for Testing Reactor Trip Breakers)**

b. Assessment of the Use of Operating Experience

1. Inspection Scope

The inspectors selected a sample of industry OE issues to confirm that Ginna had evaluated the OE information for applicability and had taken appropriate actions, when warranted. The inspectors reviewed OE documents to ensure that Ginna appropriately considered the underlying problems associated with the issues for resolution via their CAP. The inspectors chose the RHR system and the 125 volt DC system for an extended review over the past 5 years. A list of the documents reviewed is included in the Attachment to this report.

2. Assessment

The inspectors determined that Ginna appropriately considered industry OE information for applicability to the plant. The inspectors verified that Ginna had entered items determined to be applicable into the CAP and taken adequate corrective actions to address the issues. External and internal OE were utilized and considered as part of RCARs and ACEs for supporting the development of lessons learned and corrective actions for CAP issues. The inspectors, however, identified two instances where OE was not appropriately applied:

- The inspectors attended a Plant Operations Review Committee in which an operational decision making issue (ODMI) was reviewed concerning high reactor coolant pump vibration issues. The inspectors noted that the ODMI did not include a discussion of OE. This was contrary to CNG-OP-1.01-1001, "Operational Decision Making." Ginna entered this issue into their CAP as CR-2008-008317. The inspectors determined that this issue is minor because it involved an administrative requirement that had no safety impact.

- The inspectors reviewed CR-2008-003301 and CR-2008-005512 which documented battery charger failures of the BYCB1 battery charger. Although the ACEs listed previous site and external OE, contrary to CNG-CA-1.01-1005, "Apparent Cause Evaluations," it did not state how the OE applied to the event, and why previous lessons learned were ineffective at preventing the issue. Ginna entered this issue into their CAP as CR-2008-008172. The inspectors determined that this issue is minor because it involved an administrative requirement that had no safety impact.

3. Findings

No findings of significance were identified in the area of OE.

c. Assessment of Self-Assessments and Audits

1. Inspection Scope

The inspectors reviewed a sample of Quality Performance and Assessment (QPA) audits, including the most recent audit of the CAP and departmental self-assessments. This review was performed to determine if problems identified through these evaluations were entered into the CAP system, and whether the corrective actions were properly completed to resolve the deficiencies. The effectiveness of the audits and self-assessments was evaluated by comparing audit and self-assessment results against self-revealing and NRC-identified findings, and observations during the inspection. The inspectors also reviewed the most recent Safety Culture Survey report and discussed actions taken and planned with Ginna management to determine if appropriate action had been taken to address identified issues. A list of documents reviewed is included in the Attachment to this report.

2. Assessment

The inspectors concluded that self-assessments, QPA audits, and other assessments were critical, thorough, and effective in identifying issues. The inspectors observed that these audits and self-assessments were completed in a methodical manner by personnel knowledgeable in the subject. The audits and self-assessments were completed to a sufficient depth to identify issues that were subsequently entered into the CAP for evaluation. Corrective actions associated with the issues were implemented commensurate with their safety significance. The inspectors noted that Ginna's audits and self-assessments were consistent with the inspectors' observations. The inspectors

determined that the Safety Culture Survey provided insights into the safety culture of the site workforce. Ginna managers evaluated the results and initiated appropriate actions to focus on areas identified for improvement.

3. Findings

No findings of significance were identified in the area of audits and self-assessments.

d. Assessment of Safety Conscious Work Environment (SCWE)

1. Inspection Scope

During the interviews with staff personnel, the inspectors assessed whether there were issues that may represent challenges to the free flow of information or factors at the site that could produce a reluctance to raise safety concerns. In support of this, the inspectors assessed whether staff were willing to enter issues into the CAP or raise safety concerns to their management and/or the NRC. The inspectors also interviewed the station ECP coordinator to determine the number and types of issues being raised into the program and the program's effectiveness at addressing potential safety issues.

2. Assessment

The inspectors determined that the plant staff were aware of the importance of having a strong SCWE and expressed a willingness to raise safety issues. No one interviewed had experienced retaliation for safety issues raised, or knew of anyone who had failed to raise issues. All persons interviewed were knowledgeable of the CAP and ECP. Based on these limited interviews, the inspectors concluded that there was no evidence of an unacceptable SCWE.

3. Findings

No findings of significance were identified related to SCWE.

4OA6 Meetings, Including Exit:

On September 26, 2008, the inspectors presented the inspection results to Mr. John Carlin, Site Vice President, and other members of the Ginna staff, who acknowledged the findings. The inspectors verified that no proprietary information reviewed during the inspection was retained.

ATTACHMENT: Supplemental Information

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel
J. Carlin, Vice President, Ginna
D. Holm, Plant Manager
A. Allen, Director, Performance Improvement
B. Cizin, Engineer
N. Conicella, Director, Quality Assurance
D. Crowley, Senior Engineer
D. Dean, General Supervisor, Shift Operations
S. Eckert, Supervisor, Security Access and FFD
K. Garnish, Shift Manager
R. Everett, Supervisor, Primary Systems Engineering
J. Jackson, Supervisor, Engineering, Instrument and Controls
T. Hedges, Emergency Preparedness Manager
P. Hutner, Manager, Employee Concerns Program
F. Maciuska, General Supervisor, Operations Support
F. Mis, Acting General Supervisor of Radiation Protection
J. Pacher, Manager, Nuclear Engineering Services
E. Palmer, General Supervisor, Security Operations
P. Swift, General Supervisor, Systems Engineering
D. Wilson, Director, Licensing

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000244/2008010-01	FIN	Untimely Corrective Actions Associated With the “C” Instrument Air Compressor. (Section 4OA2.a.3.i)
05000244/2008010-02	NCV	Inadequate Procedure for Testing Reactor Trip Breakers. (Section 4OA2.a.3.ii)

Discussed

05000244/2008002-02	NCV	Failure to Promptly Identified and Correct Out-of-Specification Lubricating Oil Condition. (Section 4OA2.a.2)

LIST OF DOCUMENTS REVIEWED

Audits and Self-Assessments

OPS-06-01-G, Conduct of Operations
EPP-07-01-G, Emergency Preparedness Program
SEC-07-01-G, Security/Access Authorization/Fitness for Duty
DES-08-01G, Engineering and Design Program
QPA Assessment Report 2008-0013, Corrective Actions for Identified Procedure Issues
QPA Assessment Report 2008-0022, Use of CAP to Address Declining Trend in the Emergency Preparedness KPI for Drill and Exercise Performance
QPA Assessment Report 2008-0050, Operations Use of the CAP to Improve Departmental Performance
QPA Assessment Report 2008-0057, QPA Findings, Effectiveness of Evaluation and Corrective Actions
QPA Assessment Report 2008-0058, Scheduled Activity to Swap battery chargers on 'B' Train Battery per Procedure P-15.44
QPA Assessment Report 2008-0009, Evaluate the effectiveness of the resolution of problems identified in management training observations
QPA Assessment Report 2008-0027, Subject: Maintenance Use of the Corrective Action Program
QPA Assessment Report, QPA Findings, Effectiveness of Evaluation and Corrective Actions
Snapshot Self-Assessment SA-2008-000178, Effectiveness Review for Implementation of New Procedure IP-FFD-07, Overtime Work Policy
SA 2008-000118, Plant Modifications and 50.59 Processes
SA 2008-000099, Periodic Maintenance Effectiveness Assessment
Audit MAI-07-01-G, Maintenance Program, dated April 23, 2007
Audit RPP-07-01-G, Radiation Protection Program, dated September 20, 2007
Audit CHE-07-01-G, Ginna Chemistry, dated March 30, 2007
Site Self-Assessment, GNP FME, dated June 20, 2008

Condition Reports

CR-2001-0012	CR-2006-002960	CR-2006-004153	CR-2006-006398
CR-2003-2036	CR-2006-002975	CR-2006-004164	CR-2006-006399
CR-2003-2111	CR-2006-003086	CR-2006-004420	CR-2006-006400
CR-2005-1335	CR-2006-003090	CR-2006-004517	CR-2006-006405
CR-2005-1481	CR-2006-003331	CR-2006-004529	CR-2006-006406
CR-2005-1482	CR-2006-003366	CR-2006-004551	CR-2006-006407
CR-2005-1500	CR-2006-003439	CR-2006-004743	CR-2006-006624
CR-2005-1994	CR-2006-003462	CR-2006-004787	CR-2006-006651
CR-2005-3218	CR-2006-003588	CR-2006-004868	CR-2006-006656
CR-2005-6868	CR-2006-003717	CR-2006-004916	CR-2006-006686
CR-2006-1029	CR-2006-003731	CR-2006-004929	CR-2006-006776
CR-2006-1134	CR-2006-003801	CR-2006-005236	CR-2006-006968
CR-2006-1899	CR-2006-003857	CR-2006-005429	CR-2006-007006
CR-2006-002796	CR-2006-003932	CR-2006-005452	CR-2006-007189
CR-2006-002954	CR-2006-004150	CR-2006-006040	CR-2006-007240

CR-2006-007346	CR-2007-004536	CR-2007-008404	CR-2008-002782
CR-2006-007383	CR-2007-004590	CR-2007-008457	CR-2008-002946
CR-2007-000204	CR-2007-004591	CR-2007-008557	CR-2008-003064
CR-2007-000769	CR-2007-004651	CR-2007-008565	CR-2008-003069
CR-2007-000796	CR-2007-004818	CR-2007-008771	CR-2008-003100
CR-2007-000814	CR-2007-004907	CR-2007-008841	CR-2008-003240
CR-2007-000954	CR-2007-004935	CR-2007-008927	CR-2008-003301
CR-2007-001016	CR-2007-005021	CR-2007-008955	CR-2008-003326
CR-2007-001210	CR-2007-005193	CR-2008-000058	CR-2008-003377
CR-2007-001425	CR-2007-005213	CR-2008-000061	CR-2008-003379
CR-2007-001435	CR-2007-005243	CR-2008-000202	CR-2008-003385
CR-2007-001608	CR-2007-005332	CR-2008-000355	CR-2008-003412
CR-2007-001916	CR-2007-005389	CR-2008-000366	CR-2008-003513
CR-2007-001975	CR-2007-005463	CR-2008-000411	CR-2008-004132
CR-2007-002095	CR-2007-005500	CR-2008-000471	CR-2008-004138
CR-2007-002126	CR-2007-005544	CR-2008-000497	CR-2008-004166
CR-2007-002128	CR-2007-005562	CR-2008-000508	CR-2008-004291
CR-2007-002129	CR-2007-005633	CR-2008-000509	CR-2008-004291
CR-2007-002172	CR-2007-005777	CR-2008-000511	CR-2008-004308
CR-2007-002292	CR-2007-005901	CR-2008-000547	CR-2008-004326
CR-2007-002344	CR-2007-005902	CR-2008-000614	CR-2008-004426
CR-2007-002474	CR-2007-005913	CR-2008-000680	CR-2008-004459
CR-2007-002614	CR-2007-005944	CR-2008-000693	CR-2008-004470
CR-2007-002794	CR-2007-006039	CR-2008-000796	CR-2008-004568
CR-2007-002796	CR-2007-006039	CR-2008-000837	CR-2008-004620
CR-2007-002827	CR-2007-006137	CR-2008-000962	CR-2008-004641
CR-2007-002855	CR-2007-006263	CR-2008-000993	CR-2008-004750
CR-2007-002857	CR-2007-006372	CR-2008-001103	CR-2008-004764
CR-2007-003005	CR-2007-006405	CR-2008-001185	CR-2008-004892
CR-2007-003135	CR-2007-006475	CR-2008-001286	CR-2008-004916
CR-2007-003265	CR-2007-006686	CR-2008-001295	CR-2008-004938
CR-2007-003414	CR-2007-006768	CR-2008-001420	CR-2008-004955
CR-2007-003445	CR-2007-006803	CR-2008-001430	CR-2008-005015
CR-2007-003447	CR-2007-006962	CR-2008-001472	CR-2008-005073
CR-2007-003577	CR-2007-006996	CR-2008-001682	CR-2008-005272
CR-2007-003595	CR-2007-007098	CR-2008-001796	CR-2008-005320
CR-2007-003730	CR-2007-007128	CR-2008-001852	CR-2008-005430
CR-2007-003732	CR-2007-007143	CR-2008-001890	CR-2008-005437
CR-2007-003744	CR-2007-007153	CR-2008-001909	CR-2008-005493
CR-2007-003774	CR-2007-007206	CR-2008-002018	CR-2008-005512
CR-2007-003845	CR-2007-007220	CR-2008-002024	CR-2008-005557
CR-2007-003846	CR-2007-007242	CR-2008-002071	CR-2008-005814
CR-2007-004004	CR-2007-007260	CR-2008-002072	CR-2008-005896
CR-2007-004070	CR-2007-007395	CR-2008-002075	CR-2008-005899
CR-2007-004116	CR-2007-007412	CR-2008-002330	CR-2008-005920
CR-2007-004272	CR-2007-007441	CR-2008-002625	CR-2008-005955
CR-2007-004306	CR-2007-007561	CR-2008-002698	CR-2008-006035
CR-2007-004508	CR-2007-007711	CR-2008-002732	CR-2008-006219

CR-2008-006362	CR-2008-007333	CR-2008-007726*	CR-2008-007905*
CR-2008-006370	CR-2008-007360	CR-2008-007728*	CR-2008-008064*
CR-2008-006372	CR-2008-007365*	CR-2008-007731*	CR-2008-008084
CR-2008-006449	CR-2008-007458	CR-2008-007733*	CR-2008-008116*
CR-2008-006455	CR-2008-007469	CR-2008-007736*	CR-2008-008137*
CR-2008-006563	CR-2008-007547	CR-2008-007738	CR-2008-008152
CR-2008-006583	CR-2008-007548	CR-2008-007741	CR-2008-008152*
CR-2008-006740	CR-2008-007599	CR-2008-007765*	CR-2008-008162*
CR-2008-006993	CR-2008-007679	CR-2008-007799*	CR-2008-008171*
CR-2008-007053	CR-2008-007682	CR-2008-007801*	CR-2008-008173*
CR-2008-007118	CR-2008-007682	CR-2008-007827*	CR-2008-008175*
CR-2008-007183	CR-2008-007716*	CR-2008-007827*	
CR-2008-007298*	CR-2008-007719*	CR-2008-007901	

*NRC Identified During Inspection

Drawings

33013-1261, Containment Spray, Revision 30
33013-0652, 480 Volt One Line Wiring Diagram, Revision 25
33013-1247, Auxiliary Coolant Residual Heat Removal, Revision 40
33013-1867, Sh 1, Control Room Emergency Zone and Control Room Emergency Air Treatment System, Revision 2
33013-1867, Sh 2, Control Room Emergency Zone and Control Room Emergency Air Treatment System, Revision 0
33013-1900, Sh 1, Instrument Air Compressors, Receivers, Filters, and Dryers, Revision 10
33013-1900, Sh 2, Instrument Air Compressors, Receivers, Filters, and Dryers, Revision 12
03202-0102, 125 VDC Power Distribution System One Line Diagram, Revision 15

Miscellaneous

Fire Protection Program, Revision 4B
Technical Specifications, Amendment 104, Revision 50
Technical Requirements Manual, Revision 35
Updated Final Safety Analysis Report
NFPA 12A, Halon 1301 Fire Extinguishing Systems
Security Component Health Report, 2nd Qtr 2008
ODMI for Reactor Coolant Pump A as a result of CR-2008-006103
T-36.4, “Temporary Cooling Water to Various Service Water Loads,” Revision 0 dtd 9/14/00

Non-Cited Violations and Findings Reviewed

NCV 2006-002-01, Identification of the Storage of Combustible Materials Without a Transient Combustibles Permit.
NCV 2006-002-03, Identification that Fire Brigade Training Drills were not Completed in the Fourth Quarter of 2005
NCV 2006-004-02, Failure to Make a 10 CFR 50.72(b)(3)(v)(A) Notification
FIN 2006-004-03, Did Not Conduct a Thorough Operability Assessment and Identify That the "C" SAFW was Degraded
FIN 2006-005-03, Failure to Maintain the Containment Penetration Cooling System in Accordance with the UFSAR and System Drawings

NCV 2006-006-03, Failure to Use OE to Identify an Incorrect TS Basis for the AFW and SAFW Systems
NCV 2007-002-01, Ginna Communicators Not Adequately Trained to Implement EPIP 5-7
NCV 2006-005-01, ECCS Rendered Inoperable While in Mode 4
NCV 2007-002-02, Failure of "B" MSIV Due to Inadequate Design Control
NCV 2007-004-01, Failure to Correctly Calibrate Lead and Lag Timing Modules for the OTDT Reactor Protection Trip Channels
NCV 2007-004-02, Failure to Correct 'C' SAFW Room Cooler Head Gasket Leakage
NCV 2007-006-01, Inadequate Evaluation of Residual Heat Removal Pump NPSH for Containment Sump Recirculation Scenarios
NCV 2008-002-01, Did Not implement Scaffolding Procedure Requirements
NCV 2008-002-02, Failure to Promptly Identify and Correct Out-of-Specification Lubricating Oil Conditions

Procedures
CNG-CA-1.01, Corrective Action Program, Revision 0001
CNG-CA-1.01-1000, Fleet Corrective Action Program, Revision 0100
CNG-CA-1.01-1001, Management Review Committee, Revision 0001
CNG-CA-1.01-1002, Corrective Action Review Board, Revision 0001
CNG-CA-1.01-1003, Performance Improvement Coordinators, Revision 0001
CNG-CA-1.01-1004, Root Cause Analysis, Revision 0001
CNG-CA-1.01-1005, Apparent Cause Evaluation, Revision 0100
CNG-CA-1.01-1006, Common Cause Analysis, Revision 0001
CNG-CA-1.01-1007, Trending, Revision 0000
CNG-CA-1.01-1010, Use of OE, Revision 0000
CNG-OP-1.01-1000, Operational Decision Making, Revision 0000
CNG-OP-1.01-1002, Operability Determination, Revision 0000
CNG-MN-4.01-1002, Work Order Screening and Prioritization, Revision 00001
CNG-AM-1.01, Equipment Reliability, Revision 0000
CNG-AM-1.01-1018, Preventive Maintenance Program, Revision 00100
CNG-MN-1.01-1005, Scaffold Control, Revision 00100
CNG-QL-1.01-1007, Quality Performance Assessment Process, Revision 00100
IP-CAP-1, Ginna Condition Reporting, Revision 02800
PT-32B-SD, Reactor Trip Logic Test Train B, Rev 14, dtd 2/8/07
ND-NRP, Maintenance Rule Program, Revision 0
EP-3-S-0308, Maintenance Rule Scoping, Revision 8
EP-3-S-0310, Maintenance Rule Maintenance Preventable Functional Failures, Revision 00400
EP-3-S-0312, Periodic Maintenance Effectiveness Assessment, Revision 4
GME-42-99, Control Room Ventilation, Revision 4, Attachment 1
IP-OIL-1, Lubrication Oil Program, Revision 00000
M-11.4.13, Charging Pump Drive Lubrication and Inspection, Revision 01600
A-1406.1, Requirements for Installation of Scaffolding, Revision 03701
FPS-15, Fire Door Identification, Inspection and Maintenance, Revision 02703
RSSP-2.1, Safety Injection Functional Test, Revision 06400

System Health Reports
Auxiliary Feed Water System, 2nd Quarter 2008
Main Steam System, 2nd Quarter 2008

Reactor Coolant System, 2nd Quarter 2008
Residual Heat Removal System, 2nd Quarter 2008
Control Building Ventilation, 2nd Quarter 2008
Radiation Monitoring System, 2nd Quarter 2008
Containment Structures, 2nd Quarter 2008
125 Volt DC System, 2nd Quarter 2008
Safety Injection System, 2nd Quarter 2008

Work Orders
WO20601680
WO20800810
WO20803031
WO20601679
WO20601690
WO20802696
WO20703974
WO20500707

LIST OF ACRONYMS

ACE	Apparent Cause Evaluation
ADAMS	Agencywide Documents Access and Management System
AOV	Air Operated Valve
CAP	Corrective Action Program
CR	Condition Report
CVI	Containment Ventilation Isolation
DC	Direct Current
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
ECP	Employee Concerns Program
EDG	Emergency Diesel Generator
IAC	Instrument Air Compressor
IMC	Inspection Manual Chapter
NCV	Non-cited Violation
NFPA	National Fire Protection Association
NRC	Nuclear Regulatory Commission
NRR	Nuclear Reactor Regulation
ODMI	Operational Decision Making Issue
OE	Operating Experience
PARS	Publicly Available Records System
QPA	Quality Performance and Assessment
PORV	Power Operated Relief Valve
RCAR	Root Cause Analysis Report
RG	Regulatory Guide
RHR	Residual Heat Removal
SCWE	Safety Conscious Work Environment
SDP	Significance Determination Process