

Dresden 3

Initiating Events



Significance: Jun 30, 2002

Identified By: NRC

Item Type: FIN Finding

Deficient Human Performance Associated with Offgas System Testing Contributed to a Manual Scram of Unit 3

A finding was identified involving deficient human performance during off-gas system testing, which resulted in operators manually initiating a scram of Unit 3 on May 4, 2000, due to degrading condenser vacuum conditions and increasing condensate inlet temperature. This finding was more than minor because the event was potentially an initiating event. This event had minimal safety significance because the operator action of scrambling the unit was consistent with plant procedures and pre-briefed in accordance with conservative decision making philosophy. (Section 4OA3.10)

Inspection Report# : [2002008\(pdf\)](#)



Significance: Feb 07, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to include proper post-maintenance verification techniques in the maintenance and operations procedures

The inspectors identified a Non-Cited Violation for inadequate post-maintenance testing on the 3B reactor recirculation pump motor generator set which resulted in an operator being unable to trip the pump following a pump run-up event and a subsequent reactor scram (NCV 50-249/02-03-05). This finding was considered more than minor because it had an actual impact on reactor safety. The inability to trip the reactor recirculation pump from the control room resulted in the pump tripping without normal coastdown and an abrupt change in core flow, reactor vessel level and feedwater flow. These conditions resulted in a scram (or initiating event). However, because all other mitigating equipment was available and operated normally, this finding was considered to be of very low safety significance (4AO3.2).

Inspection Report# : [2002003\(pdf\)](#)

Mitigating Systems



Significance: Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Adequacy of the Plant-Referenced Simulator to Conform With Simulator Requirements Specified in 10 CFR 55.46

Green. The inspectors identified a Non-Cited Violation (NCV) of 10 CFR 55.46(d)(1), "Continued Assurance of Simulator Fidelity" due to the licensee's failure to adequately maintain simulator fidelity for two discrepancies, that had both an actual and potential plant impact. The deficiencies included an incorrect first stage pressure turbine trip reactor scram bypass setpoint and the incorrect operation of the reactor water cleanup (RWCU) room temperature instrument recorder. This finding was more than minor because the incorrect first stage pressure turbine trip reactor scram bypass setpoint in the simulator had an actual impact on the plant. The incorrect simulator setpoint led to inaccurate training, that subsequently failed to adequately alert the licensed operators of the potential impact of first stage pressure conditions during an actual reactor startup following the Unit 2 power uprate. The lack of simulator fidelity combined with the operators' lack of awareness/attention to the plant effects from the turbine first stage pressure led to an actual reactor scram during the November 7, 2001, reactor startup (see Licensee Event Report 50-237/2001-005-00). Although an actual reactor scram occurred due to high turbine first stage pressure, the finding is of very low safety significance because the discrepancy was on the simulator and the actual plant responded as expected to the high turbine first stage pressure and all safety-related equipment functioned properly. The incorrect operation of the temperature instrument recorder led to an incorrect emergency classification by the Shift Manager during the recent licensed operator requalification annual operating examination. The finding is also of very low safety significance because the discrepancy was on the simulator and the real recorder in the plant functioned properly. Furthermore, no actual plant emergency occurred and there was no actual impact on equipment or personnel safety. (1R11.3)

Inspection Report# : [2002017\(pdf\)](#)



Significance: Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform an Adequate Assessment of Risk When High Pressure Coolant Injection System was Unavailable

Green. The inspectors identified a Non-Cited Violation of 10 CFR Part 50.65 due to the licensee's failure to perform an adequate assessment of risk during maintenance on the high pressure coolant injection system. The inspectors concluded that the issue was more than minor since the finding involved a change in risk level from Green to Yellow and, if left uncorrected, could become a more significant safety concern. This conclusion was based on the fact that an adequate assessment of risk could have led to additional management strategies including establishment of protected pathways for redundant mitigating systems.(1R13)

Inspection Report# : [2002017\(pdf\)](#)

Significance: TBD Oct 04, 2002

Identified By: NRC

Item Type: URI Unresolved item

FAILURE OF THE REQUAL TRAINING PROGRAM TO ENSURE THAT 54 LICENSED OPERATORS TOOK A WRITTEN EXAM FOR THE PERIOD JAN 10, 2000, THROUGH JAN 4, 2002, AS REQUIRED BY 10 CFR 55.59

To Be Determined. One apparent violation of USNRC requirements was identified by the licensee. A comprehensive written examination for the 24 month requalification period defined by the licensee as January 10, 2000, through January 4, 2002, was not administered to the operators by the station training department personnel within the time frame required by 10 CFR 55.59, causing 54 licensed operators to not be in compliance with 10 CFR 55.53 (h) on January 5, 2002. This issue will be tracked as an unresolved item pending USNRC review of the circumstances surrounding it.

Inspection Report# : [2002015\(pdf\)](#)

Significance: TBD Oct 04, 2002

Identified By: NRC

Item Type: URI Unresolved item

FAILURE OF REQUAL TRAINING PROGRAM TO ENSURE THAT 28 LICENSED OPERATORS TOOK A WRITTEN EXAM FOR THE PERIOD OF JAN 30, 1998, THROUGH JAN 30, 2000, AS REQUIRED BY 10 CFR 55.59

To Be Determined. One apparent violation of USNRC requirements was identified by the licensee. A comprehensive written examination for the 24 month requalification period defined by the licensee as January 30, 1998, through January 30, 2000, was not administered to the operators by the station training department personnel within the time frame required by 10 CFR 55.59, causing 28 licensed operators to not be in compliance with 10 CFR 55.53 (h) on January 31, 2000. This issue will be tracked as an unresolved item pending USNRC review of the circumstances surrounding it.

Inspection Report# : [2002015\(pdf\)](#)

Significance: TBD Oct 04, 2002

Identified By: NRC

Item Type: URI Unresolved item

FAILURE OF REQUALIFICATION TRAINING PROGRAM TO ENSURE THAT 10 LICENSED OPERATORS TOOK AN ANNUAL OPERATING TEST DURING THE 2001 CALENDAR YEAR

To Be Determined. One apparent violation of USNRC requirements was identified by the licensee. An operating examination for the calendar year 2001 was not administered to the operators by the station training department personnel within the time frame required by 10 CFR 55.59, causing 10 licensed operators to not be in compliance with 10 CFR 55.53(h) on January 1, 2002. This issue will be tracked as an unresolved item pending USNRC review of the circumstances surrounding it.

Inspection Report# : [2002015\(pdf\)](#)

Significance: TBD Oct 04, 2002

Identified By: NRC

Item Type: URI Unresolved item

OPERATOR LICENSE RENEWAL REQUEST CONTAINED INACCURATE INFORMATION

To Be Determined. One apparent violation of USNRC requirements was identified by the licensee. The licensee provided inaccurate information to the USNRC in an operator license renewal request. The USNRC approved the license renewal request based on the inaccurate information that was provided. The license renewal request would not have been granted with the correct information provided. This issue will be tracked as an unresolved item pending USNRC review of the circumstances surrounding it.

Inspection Report# : [2002015\(pdf\)](#)



Significance: G Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

The licensee routinely failed to follow the procedure for installing, inspecting and removing scaffolding.

The inspectors identified that the licensee routinely failed to follow the procedure for installing, inspecting and removing scaffolding as indicated by several examples of incorrectly installed scaffolding. This finding was repetitive and indicated weakness in problem identification and resolution. This finding was considered more than minor because the inspectors' continued identification of this issue during the inspection period demonstrated routine failure to follow the scaffolding installation and inspection procedure. The finding was determined to be of very low safety significance because all of the safety-related equipment affected by the scaffolding remained fully capable of performing all of their

safety functions. This finding was dispositioned as a Non-Cited Violation. (1R04)
Inspection Report# : [2002012\(pdf\)](#)



Significance: Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

The licensee failed to follow the procedure for ensuring timely fire watch response.

The inspectors identified that the licensee failed to follow the procedure for ensuring timely fire watch response. This finding was repetitive and indicated weakness in problem identification and resolution. This finding was considered more than minor because the inspectors' continued identification of this issue demonstrated that failure to follow the fire watch procedure was a repetitive problem. This finding was considered to be of very low safety significance because no fire occurred and there was no actual impact on equipment or personnel safety. This finding was dispositioned as a Non-Cited Violation.

Inspection Report# : [2002012\(pdf\)](#)



Significance: Jun 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Potential to Lift Standby Liquid Control Pump Discharge Relief Valves During ATWS (Anticipated Transients Without Scram) Transient

A finding involving a Non-Cited Violation was identified for failure to comply with 10 CFR 50.62 due to the potential to lift standby liquid control system relief valves during an anticipated transient without scram on Unit 3. This finding was considered more than minor because the issue affected the function of a mitigating system. The risk significance of this issue was determined to be very low because the standby liquid control system could be recovered during an anticipated transient without scram event. Cycling of the relief valves would not prevent most of the borated solution from being injected into the reactor pressure vessel, and the licensee was able to demonstrate that the station remained within the acceptance criteria of their original anticipated transient without scram analyses during the relief valve lifts. (Section 1R15)

Inspection Report# : [2002008\(pdf\)](#)



Significance: May 10, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Reactor Water Level Could Drop Below Top of Active Fuel in the Event of Fire

The inspectors identified, that in the event of a fire, reactor water level could decrease to below top of active fuel. Although the licensee had taken credit for tripping the reactor recirculation pumps, the procedures for alternative safe shutdown did not direct operators to trip the pumps. The additional heat load from the reactor recirculation pumps would cause additional reactor coolant to be lost through the safety relief valves resulting in a lower reactor water level than assumed. The failure to ensure reactor water level would remain above the top of active fuel is a violation of 10 CFR 50, Appendix R, Section III.L.2.b. The finding was greater than minor because the failure to ensure that reactor water level would remain above the top of active fuel resulted in a reduction of safety margin. The finding was determined to be Green because the water level would remain above two thirds core height and core damage would not occur. Because the finding was of very low safety significance, and the finding was captured in the licensee's corrective action system, this finding is being treated as a NCV consistent with Section VI.A.1 of the NRC Enforcement Policy (Section 1R05.1.b.1).

Inspection Report# : [2002006\(pdf\)](#)



Significance: Mar 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Prepare Supporting Operability Documentation for Additional Safety Related Components with Missing Lock Washers in the Auxiliary Contact Assembly in the Motor Control Center Cubicle

A Non-Cited Violation was identified for the licensee's failure to prepare supporting operability documentation for 36 safety related 480 volt MCC cubicles which had missing lock washers in their auxiliary contact assemblies (NCV 50-237/249/02-04-04). The finding was of very low safety significance because it was determined that all 36 degraded components were operable (40A2).

Inspection Report# : [2002004\(pdf\)](#)



Significance: Mar 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Actions for Missing Reactor Protection System Cable Tray Covers

A Non-Cited Violation was identified for the licensee's failure to promptly identify and correct the condition of missing reactor protection system (RPS) cable tray covers. The finding was of very low safety significance because in each case two other RPS channels are routed in a different location which are sufficient to allow the RPS system to perform its intended safety function (4OA2).

Inspection Report# : [2002004\(pdf\)](#)

G

Significance: Mar 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Ineffective Corrective Actions for Test Equipment

A Non-Cited Violation was identified for the licensee's failure to correct conditions adverse to quality when station personnel incorrectly connected test equipment to the emergency diesel generator. The finding was of very low safety significance since the incorrect connection did not have any adverse impact on the plant.

Inspection Report# : [2002004\(pdf\)](#)

G

Significance: Feb 07, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate surveillance procedure for the isolation condenser initiation time delay relay

The inspectors identified a Non-Cited Violation for an inadequate surveillance procedure for calibrating the reactor high pressure initiation time delay relays for the Isolation Condenser which left the relays without any margin for drift. This resulted in three out of the four time delay relay settings being found out-of-tolerance and in noncompliance with the Technical Specification requirements. This out-of-tolerance condition could have prevented the Isolation Condenser from receiving an initiation signal within the 15-second Technical Specification time limit (NCV 50-249/02-03-02). This finding was considered more than minor because it could be reasonably viewed as a precursor to a significant event.

Failure to consider instrument drift while performing instrument calibrations can result in equipment being outside of allowable limits over the surveillance period. However, because the isolation condenser system did not lose the ability to perform its safety function and all other mitigating systems were available this finding was considered to be of very low safety significance (1R22).

Inspection Report# : [2002003\(pdf\)](#)

G

Significance: Feb 06, 2002

Identified By: NRC

Item Type: FIN Finding

The inspectors determined from operator log entries that the station blackout diesel (SBO) 2A air compressor breaker had tripped approximately 20 times since March 2001.

The inspectors determined from operator log entries that the station blackout diesel (SBO) 2A air compressor breaker had tripped approximately 20 times since March 2001. The repetitive trips were documented by operations in the control room logs; however, the licensee did not initiate a condition report for each trip. The corrective actions taken by the licensee to correct this problem were ineffective and a common cause analysis was initiated in January 2002. Also, a rework evaluation was not initiated until questioned by the inspectors in January 2002. Lack of timely and effective action is a corrective action issue that is more than minor because if left uncorrected, would become a more significant safety concern for SBO diesel availability. However, the safety significance was very low because with a second air start train available, the breaker trips did not make an SBO diesel unavailable.

Inspection Report# : [2002002\(pdf\)](#)

G

Significance: Feb 06, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

The 2A component cooling service water (CCSW) pump failed the quarterly surveillance due to high vibrations.

The 2A component cooling service water (CCSW) pump failed the quarterly surveillance due to high vibrations on 8/16/01. Foreign material was found obstructing the pump and an apparent cause evaluation (ACE) was assigned to the issue. The ACE identified three similar fouled CCSW pumps in the previous 10 months. Subsequently a common cause analysis was assigned for the 11 fouling events which had occurred since 1985. Failure to correct the causes for CCSW foreign material intrusion from 11/14/00 and 12/07/00 to 8/16/01 was a Non-Cited Violation of Appendix B. The issue of fouling component cooling service water pumps had an actual impact on safety, so it was more than minor. However, when the 2A pump was found fouled on 8/16/01, flow was reduced, but not stopped, and the other component cooling service water pumps were available, therefore the safety significance for this occurrence was concluded to be very low (Green).

Inspection Report# : [2002002\(pdf\)](#)

Significance: TBD Oct 16, 2001

Identified By: NRC

Item Type: URI Unresolved item

Two examples of inadequate fill and vent procedures for the HPCI system.

TBD. A violation of 10 CFR Part 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings with two examples was identified for the inadequate fill and vent procedures for the HPCI system. Two procedures failed to include the intermediate high point vent valves, which would allow air to reside in more than 40 feet of HPCI discharge piping. This finding was greater than minor because it had a credible impact on safety, in that, the inadequate procedures allowed a significant volume of air to remain in the HPCI discharge piping, making it susceptible to a significant water hammer. The significance of the finding can not be determined until the licensee completes the evaluation of the HPCI system's past operability for this condition. This item is considered an Unresolved Item pending completion of the licensee's evaluation (Section 1R15.b.5).

Inspection Report# : [2001021\(pdf\)](#)

Significance: TBD Oct 16, 2001

Identified By: NRC

Item Type: URI Unresolved item

The operability of the HPCI system with a degraded pipe support was indeterminate.

TBD. The operability of the HPCI system with a degraded pipe support was indeterminate because the licensee did not repair the support, took no action to prevent recurrence of the hydraulic transient that had damaged the support, and did not evaluate the system for recurrence of the transient. The system remained in this degraded condition for at least 70 days, without assurance that it could perform its safety function until, through intervention by the NRC, additional support discrepancies were identified, the degraded support was repaired, and a significant amount of air was vented from the discharge piping. The support damage had been caused by a water hammer due to voids in the discharge piping. The HPCI system would have experienced another water hammer because no actions were taken to eliminate the voids, and the damage to the system from another water hammer may have rendered the system inoperable. The significance of the finding has not yet been determined by the licensee, and this item is considered an Unresolved Item (Section 1R15.b.1).

Inspection Report# : [2001021\(pdf\)](#)

Inspection Report# : [2002008\(pdf\)](#)

Significance: TBD Oct 16, 2001

Identified By: NRC

Item Type: URI Unresolved item

Failure to provide adequate documentation in an operability determination as required by licensee procedures.

TBD. A violation of 10 CFR Part 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, for failing to provide adequate documentation in an operability determination as required by licensee procedures. The documentation provided in Operability Determination No. 01-031, as required by Dresden Procedure RS-AA-105, Operability Determination Process, was inadequate because it did not consider any water hammer loads in evaluating the HPCI system operability with a degraded support. Because the support had not been repaired, the system's response to the hydraulic transient was not bounded by the previous event. Also, since no action had been taken to prevent recurrence of the transient, the system was vulnerable to another water hammer. This finding was greater than minor because it had a credible impact on safety, in that, it was a contributing cause of the HPCI system operability not being ensured for more than 70 days. The significance of the finding can not be determined until the licensee completes the evaluation of the HPCI system's past operability for this condition. This item is considered an Unresolved Item pending completion of the licensee's evaluation (Section 1R15.b.2).

Inspection Report# : [2001021\(pdf\)](#)

Significance: TBD Oct 16, 2001

Identified By: NRC

Item Type: URI Unresolved item

Four examples of inadequate corrective action associated with a damaged pipe support on the HPCI discharge piping.

TBD. A violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, with four examples for inadequate corrective action associated with a damaged pipe support on the HPCI discharge piping. The initial corrective actions did not promptly repair the degraded support, determine the cause of the load that damaged the support, or prevent recurrence of the load. The subsequent root cause evaluation did not determine the cause of the water hammer or initiate corrective actions to prevent recurrence of a water hammer. Additional corrective actions did not promptly identify another pipe support with discrepancies, and activities to determine the cause of the water hammer failed to promptly identify pertinent pressure transient data. This finding was greater than minor because it had a credible impact on safety, in that, it was a contributing cause of the HPCI system operability not being ensured for more than 70 days. The significance of the finding can not be determined until the licensee completes the evaluation of the HPCI system's past operability for this condition. This item is considered an Unresolved Item pending completion of the licensee's evaluation (Section 1R15.b.3).

Inspection Report# : [2001021\(pdf\)](#)

Significance: TBD Oct 16, 2001

Identified By: NRC

Item Type: URI Unresolved item

Inadequate surveillance procedure resulted in a significant amount of air in the HPCI discharge piping.

TBD. A violation of Technical Specification Surveillance Requirement 3.5.1.1 for inadequate surveillance procedure which resulted in a significant amount of air in the HPCI discharge piping. The procedure failed to specify venting the system while the pump suction was aligned to the condensate storage tank. This finding was greater than minor because it had a credible impact on safety, in that, the inadequate surveillance failed to detect a large volume of air in HPCI discharge piping, making it susceptible to a significant water hammer. The significance of the finding can not be determined until the licensee completes the evaluation of the HPCI system's past operability for this

condition. This item is considered an Unresolved Item pending completion of the licensee's evaluation (Section 1R15.b.4).
Inspection Report# : [2001021\(pdf\)](#)

Significance: TBD Oct 16, 2001

Identified By: NRC

Item Type: URI Unresolved item

The allowable temperature on the HPCI discharge pipe following an injection valve stroke test did not ensure that a steam void had not formed upstream of the injection valve.

TBD. A violation of 10 CFR Part 50, Appendix B, Criterion XI, Test Control for having acceptance criteria in a surveillance procedure that had no bases and were not contained in design documents. The allowable temperature on the HPCI discharge pipe following an injection valve stroke test did not ensure that a steam void had not formed upstream of the injection valve. This finding was greater than minor because it had a credible impact on safety, in that, the failure to ensure that voids had not formed in the HPCI discharge piping made it susceptible to a significant water hammer. The significance of the finding can not be determined until the licensee completes the evaluation of the HPCI system's past operability for this condition. This item is considered an Unresolved Item pending completion of the licensee's evaluation (Section 1R15.b.6).

Inspection Report# : [2001021\(pdf\)](#)

Significance: TBD Oct 16, 2001

Identified By: NRC

Item Type: URI Unresolved item

Inadequate corrective action associated with a 1989 event in which HPCI discharge piping had significant steam voids.

TBD. A violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, for inadequate corrective action associated with a 1989 event in which HPCI discharge piping had significant steam voids. The location points for the temperature monitoring could not detect steam void formation in the HPCI discharge piping. This finding was greater than minor because it had a credible impact on safety, in that, the failure to ensure that voids had not formed in the HPCI piping due to valve leakage made it susceptible to a significant water hammer. The significance of the finding can not be determined until the licensee completes the evaluation of the HPCI system's past operability for this condition. This item is considered an Unresolved Item pending completion of the licensee's evaluation (Section 1R15.b.7).

Inspection Report# : [2001021\(pdf\)](#)

Barrier Integrity

Emergency Preparedness



Significance: G Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

The inspectors identified a Non-Cited Violation of Technical Specification 5.5.3 for the failure to fully implement the program for post accident sampling.

The inspectors identified a Non-Cited Violation of Technical Specification 5.5.3 for the failure to fully implement the program for post accident sampling to ensure the capability to obtain containment (drywell) atmosphere samples under accident conditions, as required by chemistry procedures (Section 2OS3.2). The finding included a cross-cutting element as a contributing factor related to the licensee's problem identification and corrective actions because the problem was identified by the licensee but not adequately evaluated or promptly corrected. The finding was determined to be of very low safety significance because the high radiation sampling (post accident sampling) system, which included equipment for containment air sampling, was installed consistent with the licensee's Updated Final Safety Analysis Report, the equipment was recently demonstrated to be operable, and because alternate means of sampling the containment atmosphere and assessing core degradation under accident conditions were available. (2OS3)

Inspection Report# : [2002012\(pdf\)](#)

Occupational Radiation Safety



Significance: G Feb 01, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to perform routine radiological surveys in accordance with procedures

The inspector identified a Non-Cited Violation of Technical Specification 5.4.1 concerning the failure of the licensee to conduct required, routine radiological surveys in accordance with the frequencies specified in its radiation protection procedures and instructions. The finding was of very low significance because the late and missed surveys did not result in an unidentified radiological hazard and did not result in a substantial potential for an overexposure of an individual.

Inspection Report# : [2002003\(pdf\)](#)

G

Significance: Feb 01, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to perform post-dive surveys of divers in accordance with procedures

During the Fall 2001 refueling outage, the licensee failed to perform post-dive surveys of divers in accordance with the applicable radiation protection procedure. Specifically, the licensee performed the surveys following a rinse of the divers, which had the potential to remove radioactive material that may have been used for future characterization and dose assessment. The inspector identified a Non-Cited Violation of Technical Specification 5.4.1 associated with that failure. The finding was of very low safety significance because underwater surveys of the divers did not identify abnormally high dose rates on the divers' equipment, which resulted in a low potential for the licensee incorrectly assessing the divers' doses.

Inspection Report# : [2002003\(pdf\)](#)

Public Radiation Safety

Physical Protection

G

Significance: Jul 31, 2002

Identified By: NRC

Item Type: FIN Finding

Security personnel who participated in a performance exercise demonstrated a reduced level of proficiency than that necessitated by the licensee's established protective strategy plan.

The inspector observed that security personnel who participated in a performance exercise on July 18, 2002, demonstrated a reduced level of proficiency than that necessitated by the licensee's established protective strategy plan. The finding affected safety because it demonstrated a reduced level of proficiency needed to support the licensee's established protective strategy. This finding was evaluated through the SDP and determined to be of very low safety significance because no intrusions had occurred, and there had not been greater than two findings in the last four quarters. There is no specific requirement for this specific demonstration of proficiency in the licensee's approved security plan; therefore, no violation occurred (Section 3PP3).

Inspection Report# : [2002013\(pdf\)](#)

G

Significance: Apr 19, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to search several items prior to their access to the protected area.

The inspector identified a failure to search several items prior to their access to the protected area (NCV 50-237/02-09-01; 50-249/02-09-01). This finding had a credible impact on safety because unauthorized material could have entered the site undetected, and the failure to conduct an adequate search is a violation of the NRC approved Dresden security plan. This finding was evaluated through the SDP and determined to be of very low safety significance. The failure represented a vulnerability in the licensee's access control program; however, it was not a malevolent act, and there had not been greater than two similar findings in the last four calendar quarters (Section 3PP2).

Inspection Report# : [2002009\(pdf\)](#)

Miscellaneous

Significance: N/A Mar 31, 2002

Identified By: NRC

Item Type: FIN Finding

Four Instances Where the Licensee Failed to Identify and Implement Effective Corrective Actions

The inspectors identified four instances where the licensee failed to promptly identify and correct conditions adverse to quality. In the first instance, during the licensee followup actions for missing lock washers in auxiliary contacts for safety related motor control center cubicles, the licensee failed to prepare supporting operability documentation for an additional 36 safety related components. In the second instance, the isolation condenser experienced a second water hammer after the licensee failed to initiate a condition report after a previous water hammer in August 2001. In the third instance, the licensee failed to promptly identify and correct the condition of missing reactor protection system cable tray covers on Unit 2 which had been identified on September 28, 2001. Finally, following the incorrect connection of a test recorder during undervoltage testing for the Unit 3 emergency diesel generator on September 24, 2000, the licensee failed to identify the full extent of condition and complete previously identified corrective actions (FIN 50-237/249/02-04-07). The individual findings were of very low significance; however, the findings could have had a credible impact on safety or could have been a precursor to a significant event by affecting the availability, reliability, operability or functionality of mitigating equipment (4OA2).

Inspection Report# : [2002004\(pdf\)](#)

Significance: N/A Feb 06, 2002

Identified By: NRC

Item Type: FIN Finding

A corrective action process, procedures and practices were in place that typically identified and corrected conditions adverse to quality.

The inspectors concluded that although a corrective action process, procedures and practices were in place that typically identified and corrected conditions adverse to quality, there were a number of examples over the past year of repetitive issues indicative of ineffective corrective actions. Self-revealing issues and issues identified by outside organizations illustrated how improved evaluations were needed to fully resolve problems. The examples raised by the inspectors as findings were the repetitive tripping of station blackout diesel air compressor breakers and debris caught in component cooling service water pumps three times in the past year. These were repetitive issues, captured in the corrective action process and addressed with higher level management attention. Significant issues with ineffective corrective actions were identified in inspection reports during the year. These included Inspection Report 50-237;249/01-21 on a high pressure coolant injection system pressure transient, Inspection Report 50-237;249/01-16 on the 3B reactor building closed cooling water temperature control valve failure, and Inspection Report 50-10/01-01 and 02 on Unit 2/Unit 3 crane certification issues. For problem identification, the licensee used a low threshold for initiating most Condition Reports (CR) which supported a safety conscious work environment. The priorities assigned to issues in accordance with the program were generally appropriate, although in some instances, thorough and aggressive action to address issues was lacking.

Inspection Report# : [2002002\(pdf\)](#)

Last modified : March 25, 2003