

March 16, 2004

Mr. Christopher M. Crane  
President and Chief Nuclear Officer  
Exelon Nuclear  
Exelon Generation Company, LLC  
4300 Winfield Road  
Warrenville, IL 60555

SUBJECT: DRESDEN NUCLEAR POWER STATION, UNITS 2 AND 3  
NRC INSPECTION REPORT 05000237/2004003; 05000249/2004003

Dear Mr. Crane:

On February 2, 2004, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Dresden Nuclear Power Station, Units 2 and 3. The enclosed inspection report documents the inspection findings which were discussed on February 2, 2004, with Mr. D. Bost 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, compliance with the Commission's rules and regulations, and with the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the samples selected for review, there were no findings of significance identified during this inspection. The team concluded that, in general, problems were being properly identified, evaluated, and corrected. Although problems have occurred with the evaluation and resolution of some issues, they have been of very low safety significance (GREEN.) The reviews performed by program coordinators and managers maintained consistent input to the process. Problems, when they arose, involved the line departments implementing timely or effective corrective actions.

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Sincerely,

*/RA/*

Mark A. Ring, Chief  
Branch 1  
Division of Reactor Projects

Docket Nos. 50-237; 50-249  
License Nos. DPR-19; DPR-25

Enclosure: Inspection Report 05000237/2004003; 05000249/2004003  
w/Attachment: Supplemental Information

cc w/encl: Site Vice President - Dresden Nuclear Power Station  
Dresden Nuclear Power Station Plant Manager  
Regulatory Assurance Manager - Dresden  
Chief Operating Officer  
Senior Vice President - Nuclear Services  
Senior Vice President - Mid-West Regional  
Operating Group  
Vice President - Mid-West Operations Support  
Vice President - Licensing and Regulatory Affairs  
Director Licensing - Mid-West Regional  
Operating Group  
Manager Licensing - Dresden and Quad Cities  
Senior Counsel, Nuclear, Mid-West Regional  
Operating Group  
Document Control Desk - Licensing  
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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-237; 50-249  
License Nos: DPR-19; DPR-25

Report No: 05000237/2004003; 05000249/2004003

Licensee: Exelon Generation Company

Facility: Dresden Nuclear Power Station, Units 2 and 3

Location: 6500 North Dresden Road  
Morris, IL 60450

Dates: January 5 through February 2, 2004

Inspectors: R. Lerch, Project Engineer  
M. Jordan, NRC Contractor  
C. Phillips, Operator License Examiner  
D. Smith, Senior Resident Inspector  
M. Sheikh, Resident Inspector

Approved by: Mark A. Ring, Chief  
Branch 1  
Division of Reactor Projects

Enclosure

## **SUMMARY OF FINDINGS**

IR 05000237/2004003; 05000249/2004003; 01/05/2004 - 02/02/2004; Dresden Nuclear Power Station, Units 2 and 3; Baseline Inspection of the Identification and Resolution of Problems.

The inspection was conducted by two region-based inspectors, two resident inspectors, and an NRC contractor. No findings of significance were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

### **Identification and Resolution of Problems**

The inspectors concluded that the licensee's corrective action program was effective at promoting the identification and resolution of issues. Typically, items were identified, entered into the process and given appropriate assignment of significance and priority. There were several examples; however, where the licensee's staff failed to adequately implement timely and effective actions. All of the examples noted in the two year assessment period were of very low significance, GREEN, and therefore did not represent serious compromises of the program. Review of issues by program coordinators and managers provided for consistent program application. The threshold for issue initiation, publicity provided to the program, and the ability to generate condition reports by computer or paper promoted a capable program

### **Licensee Identified Violation**

A violation of very low safety significance, which was identified by the licensee, has been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. The violation and corrective action tracking number is listed in Section 4OA7 of this report.

## REPORT DETAILS

### 4. OTHER ACTIVITIES (OA)

#### 4OA2 Problem Identification and Resolution (71152B)

##### .1 Problem Identification

###### a. Inspection Scope

The inspectors reviewed Corrective Action Program procedures, condition reports (CRs), trending documents and assessment documents. Inspectors also interviewed and discussed program implementation with the plant staff.

###### b. Assessment

No significant issues were identified. The issues in CRs were usually appropriately identified and documented. The threshold for CR initiation was defined to include enhancements which was a low threshold. The licensee also relied on the work request process for identifying and correcting equipment deficiencies. The process to generate a CR was generally easy to use and the rate of CR generation was stable. Condition Reports were generated on a computer system; but a paper form was also available.

##### .2 Prioritization and Evaluation of Issues

###### a. Inspection Scope

The inspectors reviewed issues in corrective action documents for proper categorization and evaluation. Inspectors observed licensee Corrective Action Program Coordinators (CAPCO) and Management Review Committee meetings to evaluate the screening and assignments of priority and responsibility. Various assessments by departments and Nuclear Oversight were also reviewed to assess program performance.

###### b. Assessment

During the past two years, several issues of very low significance (GREEN) were identified as Non-Cited Violations where issue evaluation or prioritization was lacking. Inspectors also identified several evaluations or corrective actions that were narrow in scope. Although no issues of significance were found, poor documentation and closure of tracking items without tracking the corrective action to completion were weaknesses that inspectors observed. The CAPCOs were providing very valuable reviews and oversight, but had missed the examples found by inspectors.

###### Failure to Reinstall Control Power Fuses

The inspectors identified incomplete documentation in CR 128130, "Breaker Fails to Trip During Div 2 UV Due to CP Fuses Not On." The licensee performed an apparent cause evaluation (ACE) for why control power fuses had not been reinstalled in a motor control center during restoration of that motor control center. Two non-licensed operators were

involved in the error; however, the ACE only addressed the first non-licensed operator and made no mention of the second non-licensed operator. Therefore, ACE 128130, did not provide a complete description of the event to ensure that an independent reviewer could assess the identified corrective actions. The licensee's corrective actions included coaching the two individuals and revising a procedure. The licensee generated CR198239 for inadequate documentation.

#### Maintenance Work on a Protected Pathway

The inspectors identified inadequate corrective action and incomplete corrective action closure in CR 139445, "2B CCSW Pump." This issue involved a maintenance mechanic removing an end cap on a safety-related pump which was in service. In addition, the pump had a protected pathway sign in front of it. The sign was placed near equipment to inform workers that the pump should not be worked on because other pumps were out-of-service. The licensee performed an ACE which identified corrective actions that provided training and heightened awareness on NOT working on equipment that had a protected pathway sign. The NRC documented a Non-Cited Violation for working on equipment without proper authorization. The licensee generated CR 154676, which stated that the ACE should be reopened to address this deficiency. The ACE was reopened and reviewed, however, there was no reference to CR 154676 to assist the reviewer in re-evaluation of the ACE. Therefore, the determination was made that the previously documented corrective actions were appropriate and no additional actions were warranted. In addition, the inspectors noted that one of the corrective actions for the ACE was to have the human performance coordinator take this issue to the human performance peer group and determine if the pre-job brief procedure needed revision. The decision of the peer group was to be provided to the Maintenance Director; however, this feedback did not occur, although this corrective action had been closed out.

#### Degradation of the Diesel Generator Cooling Water Pumps (DGCWP)

The evaluation was flawed for CR 148389, "Unit 3 DGCWP IST Flow Rate Trend Adverse." This CR addressed a degradation of the diesel generator cooling water pumps (DGCWP) identified by inservice testing (IST). Based on flow degradation, a prediction was made as to when the pump flow would not meet IST requirements and would be considered inoperable. This prediction for operability was narrowly focused in that it did not include the length of time the pumps would be needed during an accident. The pump was replaced in January of 2004 with a predicted replacement date of August of 2004, so actual pump operability was not exceeded. Condition Report 198229 was issued to address this concern.

#### Electronic Document Retrieval

Immediate corrective action was lacking for CR 191086, "NSO's delayed/unable to retrieve electronic documents needed to prepare a clearance order." The corrective action addressed "...global ..." resolution, but was narrowly focused and did not address the immediate problem with on-shift personnel needs to obtain electronic documents to prepare clearance orders. After discussions with the NRC, the licensee issued Daily Orders to assist the shift personnel in providing directions on how to use the electronic system to acquire the documents needed.



### Poor Tracking of Actions to Closure

Several examples of inadequate tracking documentation were identified by inspectors. The following CRs had actions specified, but no tracking documentation provided.

CR 1266969, "Leakage Discovered on Drywell Pedestal During DTS 1600 06. In the supervisory review section of the CR was a statement: "Notified OCC personnel. An outage action item has been scheduled to perform a visual inspection of the drywell to reactor building bellows following cavity drain down from D3R17." No assignment was made to this CR to assure the action was completed nor was there a reference to a tracking mechanism (date, number, etc.) for the outage action item.

CR 86084 "OPEX Review of NON QC-01-087" In the review section for this operating experience (OPEX) CR under Question 4 was a statement: "Dresden station will implement the software after approval by Corporate RP." This corrective action had no assignment to track this item to assure the action was accomplished. During this inspection no documentation was provided to assure this revision was incorporated at Dresden. This issue was entered into the corrective action process by CR 00198515.

CR 165123, "NOS Identified Category 1 Procedure Use Issues in Chemistry." In assignment 12, "Root Cause Review Corrective Action to Prevent Recurrence: Implement Chemistry Fundamental Plan," an assessment of the effectiveness of corrective actions was accomplished and a statement was made that, "More rigorous adherence to the plan is required. First Line Supervisor's (FLS's) have been coached and the senior manager will follow up in Mid-January 04 to determine if progress has been made...The policy will be revised to require FLS's to review all data sheets ..." There was no documentation as to the tracking mechanism which was used to ensure these corrective actions were completed.

CR 75274, "OPEX Review of NON BW-01-070" In the completion notes to Assignment 10, for Dresden, a statement was made: "The GENERIC issue of refurbished motors needs to be reviewed and evaluated by the maintenance motor component specialist. A sub-assignment needs to be created for electrical maintenance for this evaluation." There was no reference as to the tracking mechanism which was used to ensure this corrective action was completed. CR 00198613 was issued to address this concern.

### .3 Effectiveness of Corrective Action

#### a. Inspection Scope

The inspectors reviewed the corrective actions specified in corrective action documents for effectiveness. Condition Reports were also reviewed for repeat issues and trends. Selected effectiveness reviews performed by the licensee were reviewed as were licensee trending and self-assessments.

#### b. Assessment

Although corrective actions for several issues were identified as ineffective in the last two years, they were assessed to be of very low safety significance. The NRC recorded

NCVs for repeated ineffective repairs on the High Pressure Coolant Injection (HPCI) motor gear unit and cracks on main steam isolation valve (MSIV) accumulator lines. Other issues which were repetitive were identified in the corrective action process. Refueling bellows on Unit 3 had been identified as leaking as far back as 1988. The U2 G6 control rod drive thermal-couple had not been working since 1998, and repetitive breaking off of feedwater chemical sample probes was revealed in 2003. In general however, the licensee's corrective actions for the samples reviewed were appropriate and appeared to have been effective. The licensee generated CRs when they identified a corrective action which was either inadequate or inappropriate.

Inspectors had several observations that some practices undermined the effectiveness of the corrective action program. Immediate corrective actions that had been taken were often listed in CRs, but the implementing documentation was not referenced, so no connection to work orders, procedure changes, training requests or tailgate sessions was available. Tailgate training sessions were used as corrective actions although these training sessions are very informal, without much documentation of the message delivered, and no attendance list. One tailgate session was delivered just before the fourth of July. Counseling of individuals was often specified as a corrective action without identifying the cause of poor performance or all the people involved.

#### Reactor Pressure High

The inspectors reviewed CR158419, "Inadvertent Entry into TS 3.4.10, Reactor Pressure High." The licensee performed an ACE and specified assignment 22 to add the MWth parameter to the operators' hourly panel checks as a corrective action. However, during the inspectors' review of the completed corrective actions for this ACE, this parameter had been deleted from the checks. The licensee subsequently generated CR 198627 to determine why the parameter was deleted from the operators hourly panel checks and added the parameter back to the hourly checks.

#### Unit 2 Control Rod Drive (CRD) G-6 Thermocouple Open

In 1998, the licensee identified that the Unit 2 control rod drive (CRD) G-6 thermocouple was open. Work order (WO) #98107946 was generated by the licensee to address this issue. Subsequent troubleshooting was unable to determine the cause of the open thermocouple; therefore, the work order was closed and another generic work ticket was later opened to track this deficiency. The licensee continued working on the resolution of this problem until October 2003. At that time, the licensee decided to replace the position indication probe to address this problem as well a shorted pin issue. After the work was completed, WO 00532394 01, documenting the post-maintenance test for these two deficiencies was closed. However, the post-maintenance test only indicated "Ops tested sat," and lacked any specific details as to what was actually tested and verified. Although this work order was closed, the open thermocouple still existed. Subsequently on January 16, 2004, the inspectors questioned the status of CRD G-6 since it was documented in the Dresden Operating Surveillance 0300-06, "Control Rod Drive Abnormality Record," Revision 16. The unit operator informed the inspector that a ticket had been written to address this deficiency; however, upon further investigation, the operator determined that the ticket had been canceled; therefore, the operator generated a new service work request (127855). Also, the inspectors noted that control room operators were not making log entries for high temperature conditions on CRDs.

The licensee generated CR 198626 which documented this deficiency; however, the licensee coded this CR as a Level 5 (enhancement). This coding indicated that the corrective actions specified for this deficiency, which was to log all high temperature conditions of CRs, were enhancements. However, the operators should have been logging them before and thus did not meet the definition of a Level 5. The inspectors held subsequent discussions with regulatory assurance and operations personnel on this issue and the licensee changed the CR to a Level 4.

#### Tailgate Training

Condition Report 148389, Assignment 16, listed a corrective action to tailgate with Design Engineering lessons-learned from a design error in a modification package which caused an accelerated degradation of the diesel generator cooling water pump. The "In progress notes," indicated that the tailgate was conducted on July 2, 2003 on Wednesday before the Fourth of July. However, no documentation was made to assure all appropriate individuals received the tailgate training.

#### .4 Assessment of Safety-Conscious Work Environment

##### a. Inspection Scope

Inspectors interviewed employee concerns program staff, reviewed CRs and trends in CR generation. A limited number of licensee staff members were questioned about use of the corrective action process.

##### b. Assessment

No issues with willingness to identify issues were identified. The rate of CR generation and the issues going through the program were indicative of staff safety consciousness. Licensee messages and communications, as well as program accessibility by computer or paper CR generation, all encouraged raising concerns. The employee concerns program was publicized and readily accessible.

#### 4OA3 Event Follow-up (71153)

##### .1 Review of Open Items

##### a. Inspection Scope

The inspectors reviewed a violation and three licensee event reports (LER) to ensure that the issues documented in the report were adequately addressed in the licensee's corrective action program. The inspectors also interviewed plant personnel and reviewed operating and maintenance procedures to ensure that generic issues were captured appropriately. The inspectors reviewed operator logs, the Updated Final Safety Analysis Report, and other documents to verify the statements contained in the LER.

b. Findings

(CLOSED) VIO 50-237/02-15-05;50-249/02-15-05: Operator license renewal request contained inaccurate information on 1/29/04. The corrective actions to prevent recurrence addressed the issues and were completed by the due dates. The corrective actions appeared to be effective in preventing recurrence. This item is closed.

(CLOSED) LER 50-249/2003-001-00: Drywell Radiation Monitor Detector Not Fully Inserted. On August 27, 2003, at approximately 1300 hours (CDT), an Instrument Maintenance Department Technician confirmed that Unit 3 drywell radiation monitor detector 3B was approximately 23.5 inches from full insertion. The functions of the Drywell Radiation Monitors are to provide a primary containment isolation signal due to high radiation per Technical Specification (TS) 3.3.6.1, "Primary Containment Isolation Instrumentation," and post-accident radiation monitoring capability to control room operators during potential accident situations per TS 3.3.3.1, "Post Accident Monitoring (PAM) Instrumentation." Engineering performed an evaluation and determined that the Unit 3 detector 3B could not perform its TS functions in the as-found partially inserted condition. This condition had existed since October 23, 2002. The investigation identified the root cause as inadequate procedural direction in the placement of the detector in its penetration. The corrective action to prevent recurrence was to revise Dresden procedure DIS-1700-16, "Drywell High Radiation Monitor Group 2 Isolation Functional and Calibration Tests," to clarify that the detector be fully inserted into the penetration until the detector is in contact with the inner surface of the penetration.

The licensee documented the problem in CR 173159 and completed the corrective actions. This finding constitutes a finding of minor significance that is not subject to enforcement action in accordance with Section IV of the NRC's enforcement policy. This LER is closed.

(CLOSED) LER 50-237/2003-005-00: Main Steam Isolation Valve Leakage Exceeding TS Limit December 18, 2003. See Section 4OA7, Licensee Identified Violation.

(CLOSED) LER 50-237/2003-004-00: Unit 2 [High Pressure Coolant Injection] HPCI System Inoperable Due To Leaking Gland Seal Leak Off Pump Check And Regulating Valves.

On October 6, 2003, the Unit 2 HPCI system pump was realigned from its normal suction water supply, the condensate storage tank (CST), to its backup supply which was the suppression pool. This realignment was necessitated by a surveillance failure of the HPCI torus high level switch; however, upon realignment, the gland seal leak off pump started automatically on a high water level in the gland seal leak off (GSLO) condenser. In this alignment, the GSLO pump does not have a discharge flow path, unless the HPCI system was operating. Therefore, the licensee aligned the HPCI pump suction back to the CST to allow the GSLO condenser to be pumped down. Since the HPCI system still had an inoperable torus high level switch, which required the realignment to the suppression pool, and was back in its normal alignment, the HPCI system was declared inoperable.

The licensee's investigation into this issue revealed that the GSLO pump discharge check and regulating valves were leaking. Corrective actions implemented by the

licensee included: 1) preparing a new procedural requirement to perform periodic seat leakage testing on these two valves for both units; 2) replacing the GLSO pump check valve; and 3) replacing the float assembly of the level switch, although, the licensee could not determine the cause of why the HPCI torus high level switch failed.

This LER is closed.

#### 4OA6 Meetings

##### Exit Meeting

The inspectors presented the inspection results to Mr. D. Bost and other members of the licensee's staff on February 2, 2004. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

#### 4OA7 Licensee Identified Violation

The following violation of very low significance was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Manual, NUREG-1600, for being dispositioned as Non-Cited Violation.

##### LER 50-237/2003-005-00, dated December 18, 2003, Unit 2 Main Steam Isolation Valve Leakage Exceeds TS Limit

On October 19, 2003, during the autumn 2003 Unit 2 refueling outage, the licensee performed local leak rate testing on all the main steam isolation valves in accordance with the primary containment leakage rate testing program. Testing results indicated the following leakage rate for the respective A through D main steam isolation lines, 0.2, 1.1, 57.1 and 35.9 standard cubic feet per hour (scfh). Therefore, the licensee determined that the combined leak rate for all main steam isolation valve leakage paths exceeded the TS Surveillance Requirement 3.6.1.3.10 leakage limit of 46 scfh. The total as-found primary containment leakage including the main steam isolation valve leakage was 209.7 scfh which was well below the total allowable leakage of 432.3 scfh assumed in the accident analyses.

The licensee conducted a root cause investigation into this problem which concluded that the cause was a loss of line contact at the valve seat/disk interface. These valves are normally open during plant operations with the valves seats in the steam flow path. Therefore, six out of the eight valves had degradation of the knife-edge on the valve seat which caused the loss of line contact at the seat/disk interface. The licensee repaired the valves and subsequent retesting of the valves, on October 25, 2003, was satisfactory.

This issue was determined to be more than minor because it could reasonably be viewed as a precursor to a significant event, if left uncorrected it would become a more significant safety concern, and it is associated with the integrity of the reactor containment.

The inspectors completed a significance determination of this issue using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process (SDP), "Appendix H, "Containment Integrity SDP," dated April 21, 2000. The inspectors evaluated how the leakage rates would have affected containment performance if a core damage event had occurred while the MSIVs were leaking. The inspectors assessed the affect on containment for the MSIVs and determined that the leakage failures would be a "Type B" finding and the leakage should be treated as a suppression pool bypass concern since the release would be straight out the main steam lines. Furthermore, the inspectors concluded that the leakage from these lines did not constitute a large early release because at least one of the following conditions had been met:

- a. Either of the leaking MSIVs can be shown to have closed.
- b. The turbine stop valves would have successfully closed.
- c. The leakage control system would have been available and the main steam line leakage would have been within the capacity of the standby gas treatment system.

Technical Specification Surveillance Requirement 3.6.1.3.10, required verification that the combined leakage rate for all MSIV leakage path is less than or equal to 46 standard cubic feet per hour when tested at greater than or equal to 25 psig. Contrary to the above, on October 19, 2003, the combined leakage rate for all MSIV leakage path was determined to be 94.3 standard cubic feet per hour which is a violation of TS Surveillance Requirement 3.6.1.3.10. The licensee entered this issue into its corrective action program as CR 181805. The valves were satisfactorily tested after being repaired. Also, the licensee plans to periodically inspect all of the main steam isolation valves and revise the main steam isolation valve repair procedure to reflect machining seats instead of lapping.

This LER is closed.

ATTACHMENT: SUPPLEMENTAL INFORMATION

## SUPPLEMENTAL INFORMATION

### KEY POINTS OF CONTACT

#### Licensee

D. Bost, Plant Manager  
M. Carey, Training Director  
R. Conklin, Radiation Protection Supervisor  
G. Dorsey, Chemistry Manager  
E. Flick, Plant Engineering Manager  
D. Galanis, Design Engineering Manager  
G. Gates, Ops CAPCO  
G. Graff, Operating  
J. Griffin, Regulatory Assurance - NRC Coordinator  
J. Hansen, Regulatory Assurance Manager  
M. Kusnick, Nuclear Oversight and Employee Concerns  
S. Livecchi, Chemistry CAPCO  
T. Loch, Supervisor, Design Engineering  
S. McCain, Corporate Emergency Preparedness Manager  
M. McGivern, System Engineer  
D. Nestle, Radiation Protection Technical Manager  
R. Nichols, Training CAPCO  
M. Overstreet, Radiation Protection Supervisor  
C. Payne, Information Technology  
M. Pavey, Radiological Protection CAPCO  
J. Sipek, Nuclear Oversight Director  
R. Speek, Corporate Employee Concerns Investigator  
B. Surges, Licensed Operator Requalification Training Lead  
C. Symonds, Dresden Training Director.  
F. Winter, Site CAPCO

#### Nuclear Regulatory Commission

M. Ring, Chief, Branch 1, Division of Reactor Projects

## LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

### Opened

None

### Closed

50-237; 249/2002-015-02	VIO	Operator License Renewal Request Inaccurate
50-249/2003-001-00	LER	Drywell Radiation Monitor Detector Not Fully Inserted
50-237/2003-004-00:	LER	Unit 2 HPCI System Inoperable Due To Leaking Gland Seal Leak Off Pump Check And Regulating Valves
50-237/2003-005-00	LER	Unit 2 Main Steam Isolation Valve Leakage Exceeds TS Limit

### Discussed

None.



## LIST OF ACRONYMS USED

ACE	Apparent Cause Evaluation
CAPCO	Corrective Action Program Coordinator
CR	Condition Report
CRD	Control Rod Drive
CST	Condensate Storage Tank
FLS	First Line Supervisor
GSLO	Gland Seal Leak Off
HPCI	High Pressure Coolant Injection
IMC	Inspection Manual Chapter
IST	Inservice Testing
LER	Licensee Event Report
MSIV	Main Steam Isolation Valve
PARS	Publicly Available Records
NRC	Nuclear Regulatory Commission
OPEX	Operating Experience
scfh	Standard Cubic Feet Per Hour
SDP	Significance Determination Process
TS	Technical Specification
VIO	Violation
WO	Work Order

## LIST OF DOCUMENTS REVIEWED

The following is a list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspectors reviewed the documents in their entirety but rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

### Condition Reports Generated in Response to the Inspection

#### Condition Reports

#### **DRESDEN PI&R DOCUMENTS REVIEWED**

019038	Breaker Predefines with Wrong Dates; 11/10/99
035244	D2000-05121: Liner Leakage Noted During Perf of DTS 1600-06; 09/21/00
075274	Dresden OPEX Coordinator Initial Review NON BW-01-070; 09/14/01
086084	Dresden OPEX Coordinator Initial Review NON QC-01-087; 12/11/01
089246	SBO Starting Air Compressor Common Cause Analysis; 01/07/02
093902	OPEX Review of NON PB-02-011; 02/05/02
101885	Adverse Trend Identified -Configuration Control; 04/01/02
109748	Ops CCA Identifies a Common Cause, Procedure Non-adherence; 05/29/02
117632	NRC IN2002-24 Heat Collectors on Fire Sprinklers; 07/31/02
119042	OE 12660 and 12300 Failure of the Feedwater Check Valve; 08/12/02
120944	GE Letter AC02-11 & 12 MS Piping Notification, EPU related; 08/28/02
122325	Part 21 on Rosemount Model 1153 pressure transmitters; 09/09/02
126965	Leakage Discovered on Drywell Pedestal During DTS 16000-06; 10/10/02
126777	Chemistry Cobalt 60 Levels Elevated at Start of D3R17; 10/09/02
127079	Nondestructive Examination Rejectable Indication; 10/12/03
127092	Foreign Material Found on Core Plate; 10/13/02
127352	Two Cracks Found in the Biological Shield Wall Outer Plate; 10/15/02
127529	Foreign Material in the Annulus; 10/15/02
128130	Breaker Fails to Trip During Div 2 Uv Due to Cp Fuses Not on; 10/19/02
128203	Main Feed 480v Breaker at Bus 38 Failed to Close; 10/20/02
132159	Adverse Trend Identified in Low Level Contaminations; 11/15/02
134156	Equipment Failure Investigation Report - MCC 28-1, F1 D/G DOTP; 12/05/02
135406	Dresden on-line /off-line FDLRX mismatch; 12/12/02
138515	High FCL Following Load Drop
142723	Results of 480V inspection of CR105X auxiliary contacts; 02/03/03
144701	Operability Scope Not Fully Defined; 02/14/03
144887	Operability Evaluation Expectations Not Met; 02/17/03
145061	CR 105X Aux Contactor Troubleshooting Sequence of Events; 02/18/03
145080	Operability Evaluation Scope Not Properly Defined; 02/18/03
148389	Unit 3 DGCWP IST Flow Rate Trend Adverse; 03/10/03
148688	DGCWP Condition Vendor Report; 03/06/2003
151287	Crack in MSIV "A" Accumulator, EPN # 3-0220-82; 03/29/03
154676	ACE 139445 should address more than protected pathway sign issues 04/18/03
156818	Adverse Trend for Unit Reactivity Anomaly; 05/01/03
158419	Inadvertent Entry into TS 3.4.10, Reactor Pressure High; 05/12/03
160655	External Foreign Material Contamination of CRD Lines; 05/27/03
165123	NOS Identified Category 1 Procedure Use Issue in Chemistry; 06/26/03

171238 NRC IN 2002-27 Recent Fires at Nuclear Power Plants; dated 10/10/03  
 172029 Packing leak on 1201-7 valve; 08/13/03  
 172179 Procedure Rvision Required to Aid in Performance Monitoring; 08/19/03  
 173092 4kV Horizontal Breaker Failures; 08/26/03  
 173159 2/3 Post Accident Rad Monitor Detectors not Fully Inserted; 08/27/03  
 173179 SSDI identifies Potential HPCI Design Inadequacy; 08/26/03  
 179654 U2 HPCI GSLO PMP auto starting; 10/07/03  
 181718 Incorrect Timing for Dewatering the CW System; 10/18/03  
 181805 Main Steam Isolation Valve Leakage in Excess of Allowable Technical Specification Value; 10/10/03  
 182542 Trip of 2A SBO D/G Starting Air Compressor; 10/23/03  
 184845 EDCAPCO IDs High quality D2R18 valve unexpected CM; 11/05/03  
 187975 Water Dripping from D/W Liner Sand Pocket Drain; 11/20/03  
 191086 Wasted Man Hours to Retrieve Drawing for Clearance Orders; 12/16/03  
 192454 Expectation Exceeded for CRs Open with All Assignments Closed; 12/23/03  
 193494 Water Dripping from D/W Liner Sand Pocket Drain; 01/05/04  
 194058 ACIT 181718-16 Closed Without Performing Required Actions; 01/08/04  
 195038 EDCAPCo IDs RCR 186050 CAPR and CAs not Created; 01/14/04  
 195088 IMD Work Packages not Placed on Hold for Walkdown; 01/13/04  
 195472 EDCAPCo IDs 3 CAs for CR 180401 were Inadequately Closed; 01/15/04  
 196395 FASA Identifies Areas for Improvement; 01/20/04

Additional Documents:

Procedure, 480 Volt manually Operated Air Circuit Breaker (ACB) Operation, DOP 6700-07, Revision 6  
 Procedure, Control Rod Drive Abnormality Record, DOS 0300-06, Revision 16  
 Procedure, Operating Experience, LS-AA-115, Revision 3  
 Procedure, Corrective Action Program, LS-AA-125, Revision 6  
 Procedure, Employee Concerns Program, EI-AA-101, Rev 3  
 Procedure, Employee Concerns Program Trending Tool, EI-AA-101-1002, Rev 0  
 Procedure, System Performance Monitoring and Analysis, ER-AA-2003, Revision 2  
 CR titles from the Unit 2 Fall 2001 refueling outage (D2R17)  
 CR titles from the Unit 2 Fall 2003 refueling outage (D2R18)  
 CR titles from the Unit 3 Fall 2002 refueling outage (D3R17)  
 CR titles from the Unit 3 Fall 2000 refueling outage (D3R16)  
 WR titles from the Unit 2 Fall 2003 refueling outage (D2R18)  
 WR titles from the Unit 2 Fall 2001 refueling outage (D2R17)  
 DTS 1600-6; Drywell Liner Leakage Inspection; Revision 0  
     -Unit 2 Completed document dated 11/13/90  
     -Unit 3 Completed document dated 4/1/88  
 DTS 1600-6; Drywell Liner Leakage Inspection; Revision 6  
     -Unit 2 Completed document dated 10/18/03  
     -Unit 3 Completed document dated 10/10/02  
 Management Review Committee Meeting Agenda 1/14/04  
 Management Review Committee Meeting Agenda 1/15/04  
 Management Review Committee Meeting Agenda 1/21/04  
 Management Review Committee Meeting Agenda 1/22/04  
 Department Corrective Action Program Coordinators (DCAPCO) Review Meeting 01/13/04  
 DCAPCO Review Meeting 01/14/04

DCAPCO Review Meeting on January 27, 2004  
 Management Review Committee Evaluation Meeting (Wednesday) 01/14/04  
 WO 99211381; D3 RFL PM Drywell liner leakage inspection; 08/17/02  
 WO 99219953; D3 RFL PM UT Inspection of Drywell Liner; 10/13/02  
 WO 00488723; D2 RFL PM Liner leakage insp per DTS 1600-06; 10/18/03  
 WO 00585846; Remove tape and perform NDE on HCU stainless lines; 06/10/2003  
 WO 00585851; Remove tape and perform NDE on HCU stainless lines; 06/10/2003  
 WO 00585852; Remove brown blob and NDE on HCU stainless steel piping; 06/10/2003  
 WO 00532394-01; Unit 2 CRD HCU 26 - 23 Drive Temperature; 10/30/03  
 OOS 00011424 Bus 39 Inspection/outage work; 10/09/02  
 Scorecards performed on senior reactor operators and reactor operators from May 1, 2003 through June 28, 2003  
 December 2003 Maintenance Corrective Action Program Coordinator Trending Data  
 Refueling Outages Outage Control Center Logs for Fall 2000 and Fall 2002  
 Dresden Station Self Assessment for 2nd Quarter 2003  
 Dresden Station Self Assessment of SOER 02-4 Recommendation 2, 5/7/03  
 Dresden Station Plan of the Day 1/27/2004  
 Drawing B-670; Reactor Building Framing Sections and Details, Sheet 2; Revision B  
 Drawing 3-CISI-1000; IWE Component detail drywell floor core bore hole locations and details, Sheets 2A and 2B; Revision A  
 Maintenance FASA - Corrective Action Program; 01/20/04  
 Plant Health Committee Meeting on January 5, 2003  
 Reinforcing The Fundamental of Safe Nuclear Operation For Maintenance, "MA-AA-1081," Revision 1  
 Nuclear Oversight Corporate Comparative Audit report 2003 Corrective Action Program Audit

Condition Reports Written to correct NRC identified issues during this report:

197732	CA Closure Action Not Documented; 01/09/04
198134	Actions of CR154676 not Implemented Properly; 01/29/04
198148	Closure Documentation for CAPR 151287-51 Could Be Improved; 01/29/04
198151	CAs 139445-18 and 147890-12 closed improperly; 01/29/04
198229	Potential Concern with Predictive Maintenance for DGCWP; 01/29/2004
198239	Inadequate Documentation for ACE 128130; 01/30/04
198300	Error Found on DWG B670 During PI&R Inspection; 01/29/2004
198459	NRC PI&R Identified Rigor of Documentation; 01/30/04
198613	Inadequate Closure Documentation of ATI 75274 Task 13; 1/30/2004
198626	CRD High Temp Alarms Not Logged in Operator Log; 01/30/04
198627	MWth Indication Deleted from Operators Hourly Panel Checks; 01/30/04
198686	CRD G-6 Thermocouple not PMT'd After Pipe Replacement; 01/31/04
195694	Rework Eval 186790 Classification Changed from MD to ID; 01/16/04