

Dresden 2

Initiating Events

G

Significance: Dec 29, 2001

Identified By: NRC

Item Type: FIN Finding

Failure of the operators to maintain Unit 2 turbine first stage pressure within procedural limits and inadequate operations staff's management and oversight of the turbine shell warming evolution.

Green. Failure of the operators to maintain Unit 2 turbine first stage pressure within procedural limits and inadequate operations staff's management and oversight of the turbine shell warming evolution resulted in an initiating event (scram). This issue was more than minor because it had an actual safety impact. However, because all mitigating systems were available at the time of the scram, this finding was considered to be of very low safety significance (4A03.2).

Inspection Report# : [2001020\(pdf\)](#)**Significance:** N/A Nov 13, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to have a fire extinguisher readily available, as required by station procedures, while performing hot work activities

No Color. The inspectors identified a Non-Cited Violation of Technical Specification 5.4.1 concerning the licensee's failure to have a fire extinguisher readily available, as required by station procedures, while performing hot work activities in the unit 2 catwalk and unit 2 heater bay areas (NCV 50-237/01-19-01). Based on group 1 questions, this issue was more than minor because it had a credible impact on safety, in that, equipment damage and personnel injury could have occurred. Although this deficiency affected one of the fire protection defense-in-depth elements, this issue screened out of the fire protection significance determination process. Based on a yes answer to question 6 in group 3, this was a No Color violation (1R05).

Inspection Report# : [2001019\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to ensure that the vertical supports were reinstalled on the Unit 2 control rod system hydraulic control units' supply headers

Green. The inspectors identified a Non-Cited Violation concerning the licensee's failure to ensure that the vertical supports were reinstalled on the Unit 2 control rod system hydraulic control units' supply headers following a plant modification (NCV 50-237/01-17-01). This issue was more than minor because without the supports a seismic event could lead to a breach of the supply header. However, the issue had very low safety significance because each control rod affected by a breach of the supply header would fail to the fail-safe position. Additionally, the likelihood of a seismic event occurring was very low (1R20).

Inspection Report# : [2001017\(pdf\)](#)

G

Significance: Aug 16, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to ensure that foreign material exclusion area requirements were adhered to while performing work activities on the Unit 2/3 Reactor Building Crane.

Green. The inspectors identified a Non-Cited Violation concerning the licensee's failure to ensure that foreign material exclusion area requirements were adhered to while performing work activities on the Unit 2/3 Reactor Building Crane. The event had minimal safety significance because no foreign material entered the spent fuel pool and no mitigating systems would be affected by this issue (1R20).

Inspection Report# : [2001015\(pdf\)](#)

G

Significance: Feb 16, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Two instrument maintenance technicians failed to follow a surveillance procedure which resulted in an unexpected half scram.

On February 16, 2001, two instrument maintenance technicians failed to follow a surveillance procedure which resulted in an unexpected half scram. Additionally, the technicians inadvertently rendered the 'A' channel of the scram discharge volume high-level scram input logic inoperable. Failure to follow the procedure while performing the surveillance test was considered a Non-Cited Violation of Dresden Technical Specifications.

This finding, if left uncorrected, would become a more significant concern and could cause an increase in the frequency of an initiating event because with the plant in this unrecognized condition operators could inadvertently complete the scram initiation logic. This finding did have a credible impact on safety; however, because only the initiating event cornerstone is affected and associated assumptions have no other impact than slightly increasing the likelihood of an uncomplicated reactor scram, this finding is considered to be of very low safety significance (Green) (Section 1R14).

Inspection Report# : [2001008\(pdf\)](#)

G**Significance:** Jan 04, 2001

Identified By: NRC

Item Type: FIN Finding

A scram occurred on U2 due to deficient configuration control while performing work on a switchyard circuit breaker

On November 30, 2000, a scram occurred on Unit 2 due to deficient configuration control while performing work on a switchyard circuit breaker. Substation construction personnel manipulated twelve additional switches without procedure guidance. These actions resulted in improper restoration of the circuit breaker which caused the scram. The inspectors reviewed this issue using the significance determination process and determined that this issue was of very low risk significance because all the required emergency core cooling systems and risk significant equipment were available. (Section 1R14).

Inspection Report# : [2000021\(pdf\)](#)G**Significance:** Nov 14, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Incorrect calibration on local power range monitor on Unit 3 and Unit 2 local power range monitor not properly returned to service.

On October 9, 2000, instrument maintenance personnel on Unit 3 incorrectly set a calibration current for local power range monitor (LPRM) 48-25C and inappropriately manipulated LPRM 24-41A switch from bypass to operate. On October 10, 2000, instrument maintenance failed to return LPRM 24-25C from bypass to the operate position on Unit 2. Each of these errors involved a failure to follow procedures and were considered examples of a non-cited violation of Technical Specifications. The inspectors reviewed these issues using the significance determination process and determined that these issues were of very low risk significance because no actual loss of safety function occurred (Section 1R22.1).

Inspection Report# : [2000016\(pdf\)](#)G**Significance:** Sep 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Incorrect fuse removed

On August 28, 2000, an instrument mechanic removed a fuse from the wrong reactor protection system motor-generator bus causing an unexpected half scram. The mechanic's failure to follow the procedure while performing this work was considered a Non-cited Violation (NCV) of Technical Specifications. The inspectors considered this event to be of very low safety significance because no actual loss of safety function occurred. (Section 1R13.1).

Inspection Report# : [2000013\(pdf\)](#)G**Significance:** Sep 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Wrong Contactor specified

On May 8, 2000, a materials engineer specified an incorrect contactor coil to be installed in the reactor protection system motor generator set feed breaker. During subsequent testing on September 2, 2000, the breaker tripped and the breaker cubicle was damaged. The failure to properly implement design control measures to ensure installation of the correct contactor was considered a NCV of 10 CFR Part 50, Appendix B, Criterion III, Design Control. The inspectors reviewed this issue using the significance determination process and determined that this event was of very low risk significance because failure of the contactor coil would not have prevented the motor-generator set from performing its safety function. (Section 1R13.2).

Inspection Report# : [2000013\(pdf\)](#)

Mitigating Systems

G**Significance:** Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to ensure that proper clearance was maintained between stored equipment and a Unit 2 torus temperature indicator cable.

Green. The inspectors identified a Non-Cited Violation concerning the failure to ensure that proper clearance was maintained between stored equipment and a Unit 2 torus temperature indicator cable. The event had minimal safety significance because the other train of torus temperature monitoring was available and the licensee restored the inoperable train within the Technical Specifications allowed outage time of 30 days.

Inspection Report# : [2001013\(pdf\)](#)G**Significance:** Jun 08, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Review of Modification

A Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III "Design Control," was identified for an inadequate design review of modifications made to the Unit 2 and Unit 3 emergency core cooling system suction strainer flanges. The design review failed to account for the loss of metal at the flange bolt holes due to corrosion and lacked a technical basis for the use of hybrid formula and acceptance criteria derived from differing Code Editions and Sections. This finding was greater than minor because, if left uncorrected, it could have become more significant in that, loss of metal at the bolt holes due to corrosion, could have eventually weakened the flanges to the point that failure would occur under accident loads. If these flanges failed during a large break loss of coolant accident, debris generated by this accident would enter emergency core cooling systems and could cause wide spread component failures (e.g., pumps, heat exchangers, spray nozzles). This finding was of very low safety significance because the licensee determined that the flanges were operable and only the mitigating event cornerstone was affected.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Jun 08, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Surveillance Test Acceptance Criterion

A Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XI "Test Control," was identified for inadequate acceptance criteria for Containment Cooling Service Water and Low Pressure Coolant Injection flow rate measurements in surveillance DOS 1500-12. The surveillance criteria failed to incorporate or consider the calculated uncertainty of the flow rate instrumentation used in the test. This finding was greater than minor because, if left uncorrected, it could have become more significant. Following a Loss of Coolant Accident (LOCA) after a planned future power uprate when margins are reduced, flows less than the analytical limit could result in torus water temperature exceeding the limit specified and exacerbating existing net positive suction head deficiencies with the emergency core cooling system pumps. The finding was of very low safety significance. There were no occurrences identified where the pumps in either system were inoperable.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Feb 11, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to shut down within 12 hrs following isolation of root valve 3-1554C-HV which rendered both ADS trip systems inoperable

On March 24, 2000, during the performance of surveillance testing, the licensee identified that an instrument header root valve which isolates the 100 psi permissive pressure switches for the automatic depressurization system was closed. As a result, the automatic depressurization system permissive interlock associated with the 3C low pressure coolant injection pump was rendered inoperable. The licensee did not restore operability to the automatic depressurization trip system within the allowed outage time of TS 3.2.B, "Emergency Core Cooling System Actuation." Failure to meet the requirements of TS 3.2.B was a non-cited violation. The inspectors reviewed this issue using the significance determination process and concluded that the event had very low safety significance since the automatic depressurization system permissive switches associated with the remaining five emergency core cooling system pumps were unisolated and operable.

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Jan 26, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to appropriately evaluate thermal performance test data associated with the isolation condensers to assure that test requirements have been satisfied. 10 CFR 50 App B Criterion XI.

One Non-Cited Violation was identified for the licensee's failure to appropriately evaluate test data associated with measuring the thermal performance of the isolation condensers to assure that test requirements had been satisfied. The safety significance of this finding was very low because the affected mitigation system remained operable. This issue was considered more than minor, because if left uncorrected, it could impact the ability of the licensee to detect degradation or loss of isolation condenser function.

Inspection Report# : [2001006\(pdf\)](#)

G

Significance: Jan 26, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to enter and appropriately evaluate the concern for the isolation condenser shell side integrity (condition adverse to quality) in the corrective action system. 10 CFR 50 App B, Criterion XVI

One Non-Cited Violation was identified for the licensee's failure to enter in the corrective action system and appropriately evaluate a concern for the isolation condenser shell side integrity. The safety significance of this finding was very low because the affected mitigation system remained operable. This issue was considered more than minor, because it was not adequately evaluated since identification in 1996, and it had the potential to challenge accident mitigation associated with a tube rupture in the isolation condenser.

Inspection Report# : [2001006\(pdf\)](#)

G

Significance: Jan 04, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure of the fire marshal to properly evaluate fire drill

On November 20, 2000, the fire marshal failed to conclude that the unannounced fire drill was unsatisfactory after the drill's expected response time was not met. The time was exceeded when a fire brigade member could not don his gear and the licensee requested an alternate fire brigade member. Failure to follow the procedure in evaluating the drill was considered a Non-Cited Violation of Technical Specifications.

Inspection Report# : [2000021\(pdf\)](#)

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

HPCI system pipe replacement modification

On September 22, 2000, the inspectors' review of an operability evaluation for pipe replacement on the high pressure coolant injection system identified that the licensee had performed an inadequate like-for-like replacement parts evaluation in that yield strength differences were not considered. The failure to properly implement design control measures to ensure the equivalent replacement of safety-related piping was considered a NCV of 10 CFR Part 50, Appendix B, Criterion III, Design Control. The inspectors reviewed this issue using the significance determination process and determined that this event was of very low risk significance because the strength difference did not significantly change the seismic calculations and the operability of the high pressure coolant injection system was not impacted. (Section 1R15).

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Aug 10, 2000

Identified By: NRC

Item Type: FIN Finding

Operating Flood Barrier Surveillance had not been completed and maximum safe water level placards in the reactor building were missing

The inspectors, and independently the licensee, noted that Dresden Technical Surveillance Procedure 0020-04, "Operating Flood Barrier Surveillance," Revision 6, had not been completed even though the procedure was supposed to be performed once every refueling cycle. The inspectors also noted that maximum safe water level placards in the reactor building were missing. The placards were used in Dresden Emergency Operating Procedure 0300-01, "Secondary Containment Control." Through a Significance Determination Process Phase 1 screening, the inspectors concluded that the findings did not involve the degradation of equipment designed to mitigate a flooding initiating event or the loss of any safety function that contributed to external event-initiated core damage accident sequences. The findings were of very low safety significance. (Section 1R06)

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Jun 27, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to follow operability evaluation procedure

The licensee failed to declare the 2D containment cooling service water pump inoperable and repair the pump after discovering evidence of leakage from a weld on the pump's discharge piping. A Non-Cited Violation (NCV) was documented for failing to follow procedures during execution of the operability evaluation to address leakage from an ASME Class 3 system. The unavailability of the 2D containment cooling service water pump was of very low risk significance due to the availability of other mitigating systems. (Section R15).

Inspection Report# : [2000007\(pdf\)](#)

Barrier Integrity

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Improperly changed tap setting

On September 27, 2000, the licensee discovered that the overvoltage coil tap setting for the undervoltage relays on Bus 34 (4160 KV) had been changed without using the station's design control process. This error would have resulted in the loss of the 'C' and 'D' containment cooling service water pumps during a loss of offsite power transient. The licensee's failure to implement sufficient design control measures for changing the overvoltage coil tap setting was considered a NCV of 10 CFR Part 50, Appendix B, Criterion III, Design Control. The safety significance of this issue was minimal due to the availability of the 'A' and 'B' containment cooling service water pumps. (Section 1R20b.1).

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

The 'A' feedwater header check valves & both the 'B' inboard & outboard main steam line valves failed local leak rate tests

On September 19, 2000, the licensee made an emergency notification system (ENS) call under 50.72 (b)(2)(i) to the NRC regarding local leak rate test (LLRT) failures of both the inboard and outboard 'A' header feedwater check valves (FWCVs). The licensee determined that the leakage for each valve was unquantifiable because the test volume would not hold pressure. As a result, this leakage exceeded the containment pathway leakage values allowed by the Primary Containment Leakage Rate Testing Program. The licensee made a follow-up ENS call to the NRC on September 20, 2000, after LLRT results on the 'B' inboard and outboard main steam isolation valves (MSIV) indicated that leakage from each valve also exceeded the TS maximum allowed leakage value of a total of 46 standard cubic feet per minute for all four main steam lines. The inspectors reviewed this issue using the containment integrity significance determination process and determined that these failures were of very low risk significance because even though the valves leaked, they did shut, and therefore, did not constitute a large early release pathway. (Section 1R20.2).

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Sep 29, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure of the corrective action program to properly evaluate inservice inspection related corrective actions.

The inspectors identified two examples of a failure of the corrective action program to properly evaluate inservice inspection related corrective actions. While reviewing original construction radiographs to better characterize an indication found during a 1999 ultrasonic examination of a core spray weld, the licensee failed to evaluate an indication discovered on the film which had not been dispositioned on the original reader sheet. In a second instance, the licensee did not properly evaluate the required inspection scope expansion when two snubbers were found with defects. The safety significance of these issues was considered very low based on the absence of adverse consequences and the fact that the licensee has another outage opportunity to resolve the examinations. Failure to promptly identify and correct issues found during the examination of ASME Code piping and components was considered a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" (Section 40A1).

Inspection Report# : [2000017\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

G

Significance: Dec 29, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

High Radiation Area Access Controls During Radwaste Shipping Cask Loading

Failure to properly establish a barricade at the entrance to a high radiation area, as required by procedure. This finding was determined to be of very low safety significance because no individual actually entered an area with high radiation levels, radiological consequences were minimal, and the licensee's ability to assess worker dose was not compromised (2OS1).

Inspection Report# : [2001020\(pdf\)](#)

G

Significance: Dec 29, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

High Radiation Area Access Requirements Not Met During Radwaste Shipping Cask Loading.

Failure to obtain a briefing from the radiation protection staff prior to entry into a posted high radiation area during the loading of a radwaste shipping cask. This finding was determined to be of very low safety significance because no individual actually entered an area with high radiation levels, radiological consequences were minimal, and the licensee's ability to assess worker dose was not compromised (2OS1).

Inspection Report# : [2001020\(pdf\)](#)

G

Significance: Oct 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Control HEPA Equipped Portable Vacuum Units as Required by Procedure

A Non-Cited Violation of Technical Specification 5.4.1 was identified for the failure to control high efficiency particulate air (HEPA) filter equipped portable vacuums to prevent their unauthorized use and tampering, as required by station procedure. This finding included a cross-cutting element as a causal factor related to the effectiveness of the licensee's corrective actions, because similar HEPA vacuum unit control problems were identified and documented by the licensee on several other occasions during 2001 (Section 20S2.5). This finding was determined to be of very low safety significance because unauthorized use of the improperly controlled vacuums did not occur; consequently, a substantial potential for an overexposure did not exist relative to vacuum use.

Inspection Report# : [2001019\(pdf\)](#)

G**Significance:** Sep 25, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Locked High Radiation Area Access Control Technical Specification and Procedure Violation

Failure to maintain the entry door to a high radiation area with radiation levels greater than 1000 mrem/hr (Unit-2 High Pressure Heater Bay/X-Area) locked as required by Technical Specification 5.7.2. Additionally, the licensee failed to adequately implement its high radiation area control procedure because: (1) a pre-job brief was not provided to all individuals that entered the area; (2) individuals leaving the area did not challenge the door to ensure it was latched/secured; and (3) radiation protection staff were not contacted upon worker egress from the area to verify proper door closure and latching. Since the inspector concluded that area radiation levels, coupled with the limited duration of the problem before it was licensee identified, precluded a substantial potential for an overexposure, the incident was determined to be of very low safety significance.

Inspection Report# : [2001019\(pdf\)](#)G**Significance:** Sep 29, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Locked High Radiation Area Access Control Violation

Failure to ensure that an access gate to a locked high radiation area was properly secured and latched upon egress from the area, and failure to designate and document an Access Control Guard, as required by station procedure. This finding was determined to be of very low safety significance because no unauthorized entry into the inadequately secured high radiation area occurred and a substantial potential for an overexposure did not exist (Section 20S1.2).

Inspection Report# : [2000018\(pdf\)](#)G**Significance:** Jul 14, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Radiological Survey re. TIP Work

GREEN. A non-cited violation of the requirements in 10 CFR 20.1501 was identified for failure to evaluate the radiological hazards associated with work on the transversing incore probe (TIP) drive mechanism motor. Although the TIP work was not adequately planned and the radiological hazards were not adequately assessed prior to commencement of work, a substantial potential for an overexposure did not exist and the licensee's ability to assess dose was not compromised. Consequently, this finding was determined to be of very low safety significance (Section 20S1.2).

Inspection Report# : [2000012\(pdf\)](#)

Public Radiation Safety

G**Significance:** Dec 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Calibration of the Radwaste Liquid Effluent Radiation Monitor

Failure to calibrate the radwaste liquid effluent radiation monitor to encompass the entire instrument response range including its alarm function. This finding was determined to be of very low safety significance because proper instrument response and linearity to radiation was determined throughout most of the instrument's required response range, and because the licensee's ability to assess dose to the environment from liquid effluent releases was not impaired by the calibration problem (2PS1.4).

Inspection Report# : [2001020\(pdf\)](#)G**Significance:** May 15, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Emergency Response Telephone Number (Shipment of RadWaste)

Green. The NRC inspector identified a Non-Cited Violation concerning the failure of the licensee to provide an adequate emergency response telephone number for a shipment of radioactive waste. The designated emergency response telephone number documented on the NRC waste manifest (shipping papers) was not continuously monitored while the shipment was in transit as required by 49 CFR 172.604. The safety significance of this finding was very low because no emergencies occurred while the shipment was in transit; therefore, an emergency responder did not use the emergency response telephone number. In addition, an alternate telephone number was also included within the shipping paperwork that was monitored throughout the shipment.

Inspection Report# : [2001011\(pdf\)](#)

Physical Protection

Significance: N/A Jun 15, 2000

Identified By: NRC

Item Type: FIN Finding

Root cause for performance of protected area security equipment issues was inadequate practices and procedures that involved scheduling and work activities of maint for protected area security equip

The licensee conducted a comprehensive evaluation for the causes of the conditions that resulted in this performance indicator being an issue of low to moderate safety significance (White). The evaluation identified that the root cause for the performance of protected area security equipment issue was inadequate practices and procedures that involved the scheduling and work activities of maintenance for protected area security equipment. Licensee corrective actions were implemented. Those actions appeared effective to improve security equipment performance in the first quarter of 2000. Overall performance for the indicator remained in the white response band, however, continued effectiveness of corrective actions are expected to turn the indicator green by the third quarter (September) 2000.

Inspection Report# : [2000010\(pdf\)](#)



Significance: G Jun 09, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

A non-cited violation was identified, a supervisor had authorized six personnel unescorted access to two vital areas, their duties did not require access to these areas

The inspector identified a Non-Cited Violation in that, a licensee supervisor had authorized six personnel unescorted access to two vital areas, even though their duties (work-related need) did not require access to those areas. The failure was caused by human error because the supervisor on two separate occasions failed to take the time to refer to procedural guidance when designating and reviewing vital area access status. Corrective actions were implemented. None of the referenced individuals had actually gained access to the two vital areas.

Inspection Report# : [2000008\(pdf\)](#)

Miscellaneous

Significance: N/A Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to ensure adequate and timely corrective actions were taken for the as-found deficient condition of the stored equipment in close proximity to a Unit 2 torus temperature indicator cable.

No Color. The inspectors identified a Non-Cited Violation for the licensee's failure to ensure adequate and timely corrective actions were taken for the as-found deficient condition of the stored equipment in close proximity to a Unit 2 torus temperature indicator cable. The risk significance of this issue was minimal because while the deficient condition existed, the other train of torus temperature monitoring was available.

Inspection Report# : [2001013\(pdf\)](#)

Significance: N/A Jan 18, 2001

Identified By: NRC

Item Type: FIN Finding

Corrective action program was functional and typically identified and corrected conditions adverse to quality.

The inspectors concluded that the corrective action program was functional and typically identified and corrected conditions adverse to quality. In general, the inspectors found that station personnel effectively identified and entered problems into the corrective action program using condition reports. The significance threshold for entering issues into the program appeared appropriate. Planned actions were tracked by computer or were closed to other document systems such as engineering requests or work requests. There were some examples of performance weakness with the corrective action process. All the examples identified were of very low significance. These included deficiencies which were not documented or for which corrective actions were not completed. Also, in several evaluations of deficiencies, the scope of the review was too narrow, and failed to pursue performance of deficiencies beyond the specific issue documented although broader implications were identifiable. Lastly, while corrective actions were generally effective, there were some long-term equipment issues involving age-related problems or difficult technical issues which had not been fully resolved.

Inspection Report# : [2001004\(pdf\)](#)

Significance: N/A Jan 04, 2001

Identified By: NRC

Item Type: FIN Finding

Human performance errors identified that affected or had the potential to affect plant operations during this period

The inspectors identified human performance errors that affected or had the potential to affect plant operations during this period. These errors represented a continuation of human performance problems across various station departments. The fire marshal failed to determine that the unannounced fire drill had failed. An instrument maintenance technician caused the inadvertent opening of an electromatic relief valve. A Unit 2 scram occurred due to poor configuration control during work on a switchyard breaker. Although each individual issue was low in risk significance, the incidents indicated a performance trend of problems with control, review, and performance of activities. (Section 40A4).

Inspection Report# : [2000021\(pdf\)](#)

Significance: N/A Jan 04, 2001

Identified By: NRC

Item Type: FIN Finding

A contaminated area posting was not properly established

On November 8, 2000, the inspectors identified that a contaminated area posting was not properly established. The licensee's subsequent corrective actions identified other deficient postings. The licensee's corrective actions were considered inadequate because the inspectors subsequently identified an additional deficient posting. The risk significance of this issue was minimal because there was no spread of contamination during the period the deficient postings existed (40A2)

Inspection Report# : [2000021\(pdf\)](#)

Significance: N/A Nov 14, 2000

Identified By: NRC

Item Type: FIN Finding

Three human performance errors during this period that affected plant operations and safety-related equipment.

The inspectors identified three human performance errors that affected plant operations during this period. A declining trend in human performance was noted involving errors made by different station departments. Instrument maintenance made several errors during calibration activities on Units 2 and 3. Operators incorrectly generated an out-of-service card for the 3B H₂O₂ monitor. Maintenance mechanics failed to properly reassemble the 1B main steam isolation valve. Although each individual issue was low in risk significance, the incidents indicated a performance trend of problems with control, review, and performance of maintenance related activities (Section 40A4)

Inspection Report# : [2000016\(pdf\)](#)

Significance: N/A Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

Recent events and issues were attributed to deficient human performance

The inspectors identified a number of events that affected operations and safety-related equipment which involved elements of human performance deficiencies. A failure of an instrument mechanic to remove the correct fuse from the reactor protection bus resulted in the receipt of an unexpected half-scream in the control room (See Section 1R13.1). Engineering personnel's incorrect selection of a 120 VAC contactor coil in the "B" reactor protection system motor-generator set breaker resulted in the motor-generator set failure when placing the equipment back in service (See Section 1R13.2). An incorrect overvoltage coil tap setting on the undervoltage relays on Bus 34 would have resulted in the loss of the 'C' and 'D' containment cooling service water pumps during a loss of offsite power transient (See Section 1R20.1). An engineer performed an inadequate parts evaluation for a piping replacement modification on the high pressure coolant injection system (See Section 1R15). All the events indicated a lack of self-check and/or peer-check. While the risk of the individual events was very low, the number of incidents indicated a performance trend of problems with control, review, and performance of maintenance related activities. (Section 40A4)

Inspection Report# : [2000013\(pdf\)](#)



Significance: G Aug 10, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to comply with Technical Specifications due to the untimely submittal of an American Society of Mechanical Engineers code relief request

The licensee submitted Licensee Event Report 50-237/2000-003-00 because the licensee failed to comply with Technical Specifications due to the untimely submittal of an American Society of Mechanical Engineers code relief request. This violation is being treated as a NCV, consistent with Section VI.A.1, of the NRC Enforcement Policy. The inspectors used the Significance Determination Process analysis to determine the safety significance of the event, and concluded that the finding did not represent an actual loss of safety function. The event was of very low safety significance. (Section 40A3)

Inspection Report# : [2000011\(pdf\)](#)



Significance: G Aug 10, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Testing of 250 vdc systems did not meet Technical Specification surveillance requirements due to a design error in establishing the worst case battery load profile

The licensee submitted Licensee Event Report (LER) 237/1998-013-00 because historical testing of 250 vdc systems did not meet Technical Specification surveillance requirements due to a design error in establishing the worst case battery load profile. This violation is being treated as a non-cited violation (NCV), consistent with Section VI.A.1, of the NRC Enforcement Policy. The inspectors used the Significance Determination Process analysis to determine the safety significance of the event, and concluded that the finding did not represent an actual loss of safety function. The event was of very low safety significance. (Section 40A3)

Inspection Report# : [2000011\(pdf\)](#)

Last modified : March 01, 2002