# Dresden 2
# 1Q/2004 Plant Inspection Findings

## Initiating Events

**Significance:** G Sep 30, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Meet Technical Specification 5.4.1, Fire Protection Program Implementation for Hot Work Activities**
A self-revealing finding involving a Non-Cited Violation of Technical Specification 5.4.1 was identified for the failure of an instrument maintenance supervisor to obtain permission from the fire marshal prior to performing hot work. This human performance deficiency resulted in the automatic initiation of the halon system in the auxiliary electric equipment room.

The finding was greater than minor because it affects the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions. The issue was determined to be of low safety significance (Green) because the halon system was still operable to extinguish the fire in its incipient stage.
Inspection Report# : 2003007*(pdf)*

**Significance:** G Jun 30, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Reactor Steam Dome Pressure Exceeds Technical Specification Limit**
The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, for the operators failure to follow a procedure, in monitoring reactor pressure, during power ascension activities. This failure resulted in the licensee inadvertently operating with reactor steam dome pressure above the Technical Specification limit of 1005 psig for more than 2 hours.

The finding was considered more than minor because the issue affected the initiating events objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. However, the finding was determined to be of low safety significance because the highest reactor steam dome pressure recorded during this event remained within the design basis accident limits.
Inspection Report# : 2003006*(pdf)*

## Mitigating Systems

**Significance:** G Dec 31, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Control Room Unit Supervisor Failed to Use Valid Instrumentation for Monitoring Unit 2 Reactor Pressure**
A self-revealing finding involving a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XIV, was identified due to the control room unit supervisor's failure on November 6, 2003, to use valid instrumentation for monitoring Unit 2 reactor pressure during testing. This human performance deficiency by the control room unit supervisor, resulted in the inadvertent opening of the target rock relief valve.

This finding was more than minor because if left uncorrected the practice of using non-functioning control room instrumentation for monitoring plant parameters and conditions would become a more significant safety concern or lead to an operational event. The finding was of very low safety significance because of the availability of reactor level instrumentation; procedures for addressing loss of decay heat removal and inventory; shutdown cooling and emergency core cooling systems; and offsite and emergency power. Corrective actions by the licensee included the removal from shift of the control room operators involved in the event, revision of the appropriate procedure to clearly state which indications to use to monitor reactor pressure in the body of the procedure, implementation of station policies for addressing personnel performance issues, and assignment of senior managers to provide oversight or approval to heightened level of awareness briefings prior to their performance.
Inspection Report# : 2003011*(pdf)*

**Significance:** G Sep 30, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Re-analyze to Assure Operation of the HPCI Gland Seal Leak Off (GSLO) System at Undervoltage Conditions When the System Was Upgraded to Safety-Related Status**
A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" requirements. The licensee had not updated the controlling calculation to assure that the motors would operate with the undervoltage conditions after the HPCI gland seal leak off turbine gland steam condenser exhauster and its hotwell drain pump motors were upgraded to safety-related equipment.

This issue was more than minor because the design process allowed upgrading the motors to safety-related without assuring fulfillment of known design requirements that affected the mitigating system cornerstone objective of ensuring the availability, the reliability, and the capability of HPCI to respond to initiating events to prevent undesirable consequences. Continuous operation of the GSLO system was required to support HPCI operation because of room temperature concerns.
Inspection Report# : 2003007*(pdf)*

**Significance:** G Aug 29, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Translate Motor Operated Valve (MOV) Duty Cycle Limitations into Specifications, Drawings, Procedures, or Instructions.**
A finding was identified by the inspectors for a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." The licensee failed to translate Motor Operated Valve (MOV) duty cycle limitations into specifications, drawings, procedures, or instructions. The High Pressure Coolant Injection (HPCI) turbine trip set point was set such that the turbine would experience repetitive starts and stops in certain types of small or medium loss of coolant accidents. This cycling could potentially challenge the reliability of the 2301-8 HPCI injection motor operated valves, which have a design limit of five strokes followed by 30 minutes of cooldown time.

The issue was more than minor because this vulnerability affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of the HPCI system.
Inspection Report# : 2003008*(pdf)*

**Significance:** G Aug 29, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Protect Equipment From the Effects of a Postulated High Energy Line Break**
The inspectors identified a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." Although previously identified by the licensee, the licensee failed to protect equipment required to shut down the reactor and maintain it in a safe shutdown condition from the environmental effects of a postulated high energy steam line break. A High Energy Line Break (HELB) in the HPCI system could make the swing diesel, required by both Units 2 and 3, inoperable.

This issue was more than minor because the Unit 2/3 swing diesel generator and associated engineered safety features systems could be degraded by the HELB conditions.
Inspection Report# : 2003008*(pdf)*

**Significance:** G Aug 29, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Promptly Identify and Correct a Malfunction Within the High Pressure Coolant Injection (HPCI) System Motor Gear Unit (MGU).**
A finding was identified by the inspectors for a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions." The licensee failed to promptly identify and correct a malfunction within the High Pressure Coolant Injection (HPCI) system Motor Gear Unit (MGU). Operators identified that the MGU did not operate as designed on May 25, 2001. After two unsuccessful attempts to correct the problem, troubleshooting was accomplished on November 6, 2002, which identified degradation within the MGU motor. The motor was replaced, returning the system to full functionality, on March 12, 2003.

This issue was more than minor because the lack of timeliness associated with resolution of this issue impacted the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of the HPCI system.
Inspection Report# : 2003008*(pdf)*

**Significance:** G Aug 29, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Take Appropriate Corrective Action for Multiple Failures of Safety Related 4160V Circuit Breakers.**
A finding was identified by the inspectors for a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions." The licensee failed to take appropriate corrective action for multiple failures of safety related 4160V circuit breakers.

This issue is more than minor because it affected the mitigating system cornerstone objective of equipment reliability, in that failure of circuit breakers to operate on demand could cause loss of function of safety related loads needed to mitigate an accident.
Inspection Report# : 2003008*(pdf)*

**Significance:** G Jun 30, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to follow work order rendered the Unit 2 "D" Electromatic Relief Valve Inoperable**
A self-revealed Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, was identified for the failure of two electricians to install a jumper and perform concurrent verification in accordance with a work order on June 13, 2003. This rendered the Unit 2 "D" electromatic relief valve (ERV) inoperable.

This finding was more than minor because it affected the mitigating systems cornerstone objective. However, the finding was of very low significance because there was no loss of safety function in that four of the five ERVs remained operable.
Inspection Report# : 2003006*(pdf)*

**Significance:** G Jun 30, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Degraded Mechanical Penetration Fire Barriers**
The inspectors identified a Non-Cited Violation of the Unit 2 and 3 operating licenses for 34 mechanical penetration seals not containing the required minimum of 8" of ceramic fire blanket to establish a 3-hour rated fire barrier.

The finding was more than minor because it affected the mitigating systems cornerstone objective. However, the finding was of low safety significance because for 33 of the 34 seals, no credible fire scenarios could be developed due to physical configuration of post-fire safe shutdown equipment on either side of the penetration seals or the deficient penetration seals were not used to protect safe shutdown capability. For the remaining penetration, the inspectors determined that the recovery actions in the isolation condenser room could be successfully implemented and ensure safe shutdown of the plant.
Inspection Report# : 2003006*(pdf)*

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

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## Miscellaneous

**Significance: SL-III** Aug 29, 2003
Identified By: NRC
Item Type: VIO Violation
**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.

A Severity Level III violation was issued by letter dated August 29, 2003.
Inspection Report# : 2002015*(pdf)*
Inspection Report# : 2004003*(pdf)*

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