July 26, 2001

Mr. Oliver D. Kingsley, President
Exelon Nuclear
Exelon Generation Company, LLC
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: DRESDEN NUCLEAR POWER STATION, UNITS 2 and 3
NRC INSPECTION REPORT 50-237/01-13(DRP); 50-249/01-13(DRP)

Dear Mr. Kingsley:

On June 30, 2001, the NRC completed an inspection at your Dresden Nuclear Power Station, Units 2 and 3. The enclosed report documents the inspection findings which were discussed with Mr. Bowman and other members of your staff on June 28, 2001.

The inspection examined activities conducted under your license as they relate to safety and to compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel. Specifically, this inspection focused on resident inspection activities.

Based on the results of this inspection, the inspectors identified one No Color finding and one finding of very low safety significance (Green). These findings were determined to involve violations of NRC requirements. However, because of their very low safety significance, and because the issues have been entered into your corrective action program, the NRC is treating these issues as Non-Cited Violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny these Non-Cited Violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspectors at the Dresden Nuclear Power Station.

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Sincerely,

/RA/

Mark Ring, Chief
Branch 1
Division of Reactor Projects

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

Enclosure: Inspection Report 50-237/01-13(DRP);
50-249/01-13(DRP)

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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:	50-237/01-13(DRP); 50-249/01-13(DRP)
Licensee:	Exelon Generation Company, LLC
Facility:	Dresden Nuclear Power Station, Units 2 and 3
Location:	6500 North Dresden Road Morris, IL 60450
Dates:	May 16, 2001 through June 30, 2001
Inspectors:	D. Smith, Senior Resident Inspector B. Dickson, Resident Inspector P. Pelke, Reactor Engineer
Approved by:	Mark Ring, Chief Branch 1 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000237-01-13(DRP), 05000249-01-13(DRP), on 05/16-06/30/2001, Exelon Generation Company, Dresden Nuclear Power Station, Units 2 and 3. Equipment Alignment and Problem Identification and Resolution.

This report covers a 6-week routine inspection. The inspection was conducted by the resident inspectors and a reactor engineer. The inspection identified one Green finding which was a Non-Cited Violation, and one No Color finding which was also a Non-Cited Violation.

The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html.

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

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 (NCV 50-237/01-13-01).

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 (1R04).

Cross-Cutting Issues: Problem Identification and Resolution

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 (NCV 50-237/01-13-02).

The risk significance of this issue was minimal because while the deficient condition existed, the other train of torus temperature monitoring was available (1R04 and 4OA2).

B. Licensee Identified Findings

No findings of significance were identified.

Report Details

Summary of Plant Status

Unit 2 began the period at full power operations. On May 19, 2001, Unit 2 decreased power to 650 MWe to perform tuning of the feedwater valves. The unit was returned to full power later that day. On May 26, 2001, Unit 2 decreased power to 681 MWe when the 2A reactor feed pump developed a leak. The unit was returned to 100 percent power that afternoon. On May 27, 2001, the unit decreased power to 555 MWe to perform a Furmanite repair of a crossover relief valve. The unit was returned to 100 percent power the same day.

Unit 3 began the period at full power operations. On May 28, 2001, Unit 3 reduced load to approximately 181 MWe to repair the 1B inboard main steam isolation valve. Unit 3 was returned to full power operations later that day.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R01 Adverse Weather (71111.01)

a. Inspection Scope

The inspectors assessed the licensee's implementation of the station's summer readiness process which included a review of flood protection and summer readiness procedures.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment (71111.04)

a. Inspection Scope

The inspectors selected a redundant or backup system to an out-of-service or degraded train, reviewed documents to determine correct system lineup, and verified critical portions of the system configuration. Instrumentation valve configurations and appropriate meter indications were also observed. The inspectors observed various support system parameters to determine the operational status. Control room switch positions for the systems were observed. Other conditions, such as adequacy of housekeeping, the absence of ignition sources, and proper labeling, were also evaluated. The systems reviewed included:

Unit 2 High Pressure Coolant Injection (HPCI) System
Unit 3 Standby Liquid Control System

b. Findings

1. Improperly Stored Equipment and Inadequate Corrective Actions for the Stored Equipment under Unit 2 Torus

The inspectors identified one Green finding involving a Non-Cited Violation, and one No Color finding which also involved a Non-Cited Violation.

On June 21, the resident inspectors identified that stored equipment was in close proximity to a safety-related Unit 2 torus temperature indicator cable. The stored equipment was in an area that was posted as a permanent storage area. The resident inspectors discussed the issue with a field supervisor and questioned if the station had considered the potential adverse impact of the stored equipment on the safety-related temperature indicator cable during a seismic event when designating this area as a storage area. There were a number of processes that were ineffective in ensuring prompt and effective corrective actions were taken for this deficient condition.

The field supervisor performed a walkdown of the area and documented his observations and the inspectors' question in condition report (CR) #D2001-03411. The field supervisor failed to adequately evaluate the as-found deficient conditions to conclude that an operability issue existed. The stored equipment was within 12" of the safety-related temperature cable, but Dresden administrative procedure DAP 03-20, "Restraint of Portable Equipment," Revision 10, procedural Step F.3, required that items left unattended in an area requiring seismic restraint, with an aspect ratio less than or equal to 2, shall be stored greater than 24" from safety-related equipment or be seismically restrained. The licensee failed to ensure that the appropriate 24" clearance was maintained between the unrestrained stored equipment and the safety-related temperature cable.

Dresden Technical Specification 6.8.A.1 states that procedures shall be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A of Regulatory Guide 1.33, states, in part, that equipment control should be covered by written procedures. The licensee's failure to ensure unrestrained stored equipment with an aspect ratio less than or equal to 2 was greater than 24 inches from safety-related equipment as required by DAP 3-20 is a violation of Technical Specification 6.8.A.1. This violation is being treated as a Non-Cited Violation, consistent with Section VI.A.1, of the NRC Enforcement Policy **(NCV 50-237/01-13-01(DRP))**. This issue was entered into the licensee's corrective action program as CR D2001-03344.

The shift manager performed an inadequate prompt operability determination for this issue. Procedural Step 4.1.2 of RS-AA-105, "Operability Determination Process," Revision 0, specified that the operating shift manager perform a prompt operability determination and, that in most cases, the decision be made immediately and documented on the CR. The shift manager concluded, with input from engineering, that an operability issue did not exist with the as-found condition. This was later determined to have been an incorrect assessment. In addition, the shift manager did not document why an operability issue did not exist on the CR.

There was inadequate action by the condition review group in resolving this issue. On June 25, 2001, during the condition review group meeting it became known that the stored equipment was in an area which was not an approved storage area and therefore was not evaluated for seismic requirements. Administrative procedure AD-AA-106, "Corrective Action Program Process," Revision 3, Step 4.4.8, requires that the condition review group shall review the CR to determine if they concur with the supervisor or shift manager's recommendation for reportability and operability. If, the condition review group does not concur, then the CR shall be forwarded to the shift manager for further evaluation. Since the area was not an approved storage area, the condition review group should have forwarded the CR back to the shift manager for reevaluation of operability and because the CR lacked adequate justification for the original operability evaluation.

During the management review committee meeting on June 26, 2001, all management review committee members agreed that the station had 7 days to remove the stored equipment. This consensus was reached without having any type of technical evaluation or understanding of why 7 days was an acceptable removal period. Following the meeting, the seismic engineer took 6 hours to locate, walk down the area, and determine that the area was not a seismically approved area. The resident inspectors considered this effort untimely. Since the as-found conditions were not in compliance with DAP 03-20, the seismic engineer performed an informal operability determination which concluded that the stored equipment would not have rendered the temperature indicator inoperable due to the amount of deflection which would have been seen during a seismic event. This evaluation was not documented, which was contrary to RS-AA-105 which required that where additional analyses are required, detailed operability documentation would be prepared by engineering. The licensee failed to take appropriate corrective actions for the deficient plant conditions identified on June 21, 2001, in that the shift manager did not perform an adequate operability determination, the condition review group did not forward the CR back to the shift manager for further evaluation, and the seismic engineer did not document a formal operability determination. The stored equipment was removed on June 26, 2001.

Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion XVI, states that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, and deficiencies are promptly identified and corrected. The licensee's failure to take appropriate corrective actions for improperly stored equipment in close proximity to safety-related equipment was a violation of 10 CFR 50, Appendix B, Criterion XVI. This is a cross-cutting issue of problem identification and resolution. This violation is being treated as a Non-Cited Violation, consistent with Section VI.A.1, of the NRC Enforcement Policy **(NCV 50-237/01-13-02 (DRP))**. This issue was entered into the licensee's corrective action program as CR D2001-03411.

Failure to ensure a torus temperature indicator cable was not adversely affected by equipment stored in close proximity could have rendered one of two trains of torus temperature monitoring inoperable. The licensee's failure to properly evaluate this deficiency and continued failure to recognize that an inadequate assessment of the deficiency had been made could be a precursor to a more significant event. The

placement of stored equipment in close proximity to a safety-related torus temperature indicator cable potentially affected the operability, availability, reliability, or function of torus temperature monitoring. The improperly stored equipment could have affected the integrity of the reactor containment in an event if the capability for torus temperature monitoring was lost. 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 (1R04).

1R05 Fire Protection (71111.05)

a. Inspection Scope

The inspectors toured plant areas important to safety to assess the material condition, operation lineup, and operational effectiveness of the fire protection system and features. The review included control of transient combustibles and ignition sources, fire suppression systems, manual fire fighting equipment and capability, passive fire protection features (including fire doors), and the compensatory measures. The tour included:

Unit 2 Control Rod Drive and Containment Cooling Service Water Vault Area

Unit 2 534 Feedwater Regulating Valve and Turbine Oil Tank Areas

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

a. Inspection Scope

The inspectors assessed the licensee's implementation of the maintenance rule by determining if systems were properly scoped within the maintenance rule. The inspectors also assessed the licensee's characterization of failed structures, systems, and components, and determined whether goal setting and performance monitoring were adequate. The assessment included:

Unit 2 and 3 Nitrogen Makeup/Drywell Pneumatic
Unit 2 and 3 Condensate/Condensate Booster Pump

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation (71111.13)

a. Inspection Scope

The inspectors evaluated the effectiveness of the risk assessments performed before maintenance activities were conducted on structures, systems, and components and verified how the licensee managed the risk. The inspectors evaluated whether the licensee had taken the necessary steps to plan and control emergent work activities.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed operability evaluations to ensure that operability was properly justified and the component or system remained available, such that no unrecognized increase in risk occurred.

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors reviewed post maintenance test results to confirm that the tests were adequate for the scope of the maintenance being performed, and that the test data met the acceptance criteria.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed surveillance testing on risk-significant equipment. The inspectors assessed whether the selected plant equipment could perform its intended safety function and satisfy the requirements contained in the Technical Specifications. Following the completion of the test, the inspectors determined that the test equipment was removed and the equipment returned to a condition in which it could perform its intended safety function. The review included:

Unit 2 and 3 High Pressure Coolant Injection (HPCI) Quarterly Surveillance

b. Findings

Warm Fast Start Operability Surveillance Test Acceptance Criteria

On May 25, 2001, Dresden's operators performed Dresden Operating Surveillance procedure DOS 2300-03, "High Pressure Coolant Injection Operability Verification," Revision 67. The surveillance consisted of performing a warm-fast start of the HPCI system and was completed as part of the in-service testing program. The purpose of this warm-fast start was to ensure that the HPCI system could meet the design basis automatic startup time requirement as described in the Updated Final Safety Analysis Report (UFSAR), Chapter 6. The required starting time from an initial actuation signal to design flow was 25 seconds. Section 6.3.2.3.2 of the UFSAR stated that the HPCI system was designed to pump 5600 gallons per minute (gpm) into the reactor vessel within a reactor pressure range of 165 psi to 1135 psi. The loss-of-coolant-accident (LOCA) analysis requirement for flow was greater than 5000 gpm. At the design flow rate, DOS 2300-03 required a discharge pressure of 98 psi above reactor pressure (1218-1280 psi) to account for the discharge piping head losses and for considering the torus instead of the condensate storage tank as supply.

The inspectors' review of DOS 2300-03 determined that prior to conducting the test, test throttle valve 2-2301-10 was aligned to the condensate storage tank to have HPCI achieve the required design flow and discharge pressure. Surveillance data indicated that the time and design flow requirements had been met. However, the discharge pressure was 1125 psi which was below the specified discharge pressure range. In response to the low discharge pressure, an operator adjusted valve, 2-2301-10 and noted that HPCI's discharge flow dropped from 5200 gpm to approximately 4700 gpm. The HPCI flow controller did not automatically restore flow to design flow rate; therefore, the operator placed the controller in manual slow raise mode and flow did not increase (the licensee later determined that a faulty switch caused this problem). Subsequently, the controller was placed in manual fast raise mode, and discharge flow later increased above 5000 gpm. The operators determined that the surveillance acceptance criteria had been met and declared the HPCI system operable. However, the inspectors considered that the system was not operable because the design flow was achieved outside the time limit requirement of 25 seconds.

Section 14.2.4.1.33, Revision 0, of the UFSAR, "HPCI," described the initial system testing acceptance criteria for the HPCI system. This section stated that the "Criteria" during this test was for the HPCI turbine, from the initial start signal, to come up to full speed (0 to 4000 revolution per minutes (rpm)) with the pump at full flow conditions of 5600 gpm. The section also stated that with a design flow of 5600 gpm the discharge pressure head should be 1165 psi.

The acceptance criteria listed in operability surveillance DOS 2300-03 did not include this pump discharge pressure; and therefore, did not meet the intent of the surveillance test requirements as described in the UFSAR, Chapter 6 and Chapter 14.

The inspectors were continuing to evaluate the results of DOS 2300-03 at the end of the inspection period; therefore, this issue is considered an **Unresolved Item (URI) 50-237/01-13-03(DRP)**.

HPCI Flow Controller Dead Band

During DOS 2300-03, the operators adjusted test throttle valve, 2-2301-10 to increase the pump discharge header pressure to a range of 1218 psi to 1280 psi. During the throttling evolution the HPCI system failed to automatically respond to the pressure increase and required the operator to take manual control of the HPCI controller.

Dresden's Improved Technical Specifications Bases stated that "HPCI is designed to provide core cooling for a wide range of pressures. Upon receipt of an initiation signal, the HPCI turbine stop valve and turbine steam supply valve open simultaneously and the turbine accelerates to a specified speed. As the HPCI flow increases, the turbine control valves are automatically adjusted to maintain design flow." Additionally, Section 6.3.3.1.3.1 of the UFSAR stated that "Operation of the HPCI subsystem is automatic and requires no manual intervention."

The inspectors questioned the licensee on whether the HPCI system was fully functional since the HPCI controller did not automatically respond. The licensee informed the inspectors that the failure of the HPCI system to respond to the increased discharge head was caused by the controller's dead band. On an initiation signal the HPCI turbine increased from 0 to 4000 rpm using the motor speed changer. Once the turbine's shaft was at the high speed stop (4000 rpm) the system's motor gear unit, which operated between 2000-4000 rpm, took control. The motor speed changer received a flow signal from the HPCI controller which was set at 5600 gpm and came up to speed. However, the HPCI turbine came off the motor gear unit's high speed stop, to prevent flow overshoot (<5600 gpm). The HPCI turbine speed was between 3900 and 4000 rpm which would not allow the controller to reset. Therefore, as the discharge pressure was increased, the controller was not able to respond by increasing turbine speed. The turbine speed needed to decrease below 3900 rpm to reset the controller. The licensee stated that in the LOCA analysis described in Section 6.3.3.1.3.2 of UFSAR, reactor pressure would not increase as HPCI injects into the reactor core. Instead, when water injected system pressure would decrease and flow would increase until reaching 5600 gpm. The motor gear unit would then slow the turbine and the motor gear unit high speed stop limit would automatically reset at 3900 rpm. Thus operation of the HPCI system would be automatic and would require no manual intervention.

The inspectors were continuing to evaluate DOS 2300-03 at the end of the inspection period; therefore, this was considered an **Unresolved Item (URI) 50-237/01-13-04(DRP)**.

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

As described in 1R04 of this report, the inspectors identified a deficient plant condition requiring an operability determination. The licensee's corrective actions for this deficient condition were inadequate because the licensee initially performed an inadequate operability determination which was not recognized by the condition review group or the management review committee. In addition, engineering personnel performed an untimely informal operability determination. An NCV for this issue is discussed in Section 1R04.

4OA6 Meeting

Exit Meeting

The inspectors presented the inspection results to Mr. Bowman and other members of licensee management on June 28, 2001. The licensee acknowledged the findings presented. No proprietary information was identified.

KEY POINTS OF CONTACT

Licensee

R. Riley, NRC Coordinator
V. Castle, Training Operations Manager
R. Fisher, Plant Manager
T. Fisk, Chemistry Manager
V. Gengler, Security Manager
T. Luke, Engineering Manager
J. Nalewajka, Acting Nuclear Oversight Manager
B. Norris, RP Engineering Supervisor
R. Peak, Design Engineering Manager
B. Rybak, Regulatory Assurance
D. Schupp, Operations Manager
W. Stoffels, Maintenance Manager
R. Whalen, System Engineering Manager

NRC

M. Ring, Branch Chief
D. Smith, Dresden Senior Resident Inspector

IDNS

R. Zuffa, Illinois Department of Nuclear Safety

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-237/01-13-01	NCV	Failure to ensure proper clearance between stored equipment and safety related equipment
50-237/01-13-02	NCV	Inadequate corrective action for nonseismic equipment storage
50-237/01-13-03	URI	Inadequate surveillance acceptance criteria
50-237/01-13-04	URI	Improper crediting of manual operator during surveillance

Closed

50-237/01-13-01	NCV	Failure to ensure proper clearance between stored equipment and safety related equipment
50-237/01-13-02	NCV	Inadequate corrective action for nonseismic equipment storage

LIST OF ACRONYMS AND INITIALISMS USED

CR	Condition Report
DAP	Dresden Administrative Procedure
DOS	Dresden Operating Surveillance Procedures
gpm	gallons per minute
HPCI	High Pressure Coolant Injection System
IDNS	Illinois Department of Nuclear Safety
LOCA	Loss of Cooling Accident
NCV	Non-Cited Violation
rpm	revolutions per minute
SDP	Significance Determent Process
UFSAR	Updated Final Safety Analysis Report
URI	Unresolved Item
WO	Work Order

LIST OF DOCUMENTS REVIEWED

1R01 Adverse Weather

DOP 0010-02	Tornado Warning/Severe Winds	Revision 4

1R04 Equipment Alignment

CR D2001-02557	Fire Doors Rendered Inoperable After Fire Door Surveillance Completed	May 10, 2001
CR D2001-03344	NRC Concerns During Plant Walkdown	June 21, 2001
CR D2001-03411	Potential Seismic Operability Issue Not Addressed in Timely Manner	June 27, 2001
CR D2001-03438	Potential Maintenance Performance Trend in Restraint of Portable Equipment	June 28, 2001
CR D2001-03439	Improper Restraint of Portable Equipment	June 28, 2001
CR D2001-03447	Retired Piping Evaluation by Engineering - NRC Issue Response	June 29, 2001
DOP 2300-M1/E1	Unit 2 High Pressure Coolant Injection System	Revision 26
P&ID M-33	Diagram of Standby Liquid Control	
P&ID M-51	Diagram of High Pressure Coolant Injection Piping	

1R05 Fire Protection

CR D2001-03236	Contaminated Condensate Storage Tank Level Indication Not Available for an Appendix R Zone 8.2.4.A Fire	June 18, 2001
CR D2001-03318	Missing Self Contained Breathing Apparatus	June 22, 2001

1R12 Maintenance Rule Implementation

CR D2001-02604	Intermediate Range Monitor 14 Spiking High Intermittently	May 12, 2001
CR D 2001-02602	Unit 2 Refuel Floor High Range Area Rad Monitor Intermittently Downscale	May 12, 2001
CR D2001-02831	Unplanned Shutdown of Unit 2 Reactor Water Cleanup	May 26, 2001

UFSAR	Condensate and Feedwater Systems	Section 10.4.7
UFSAR	Combustible Gas Control in Containment	Section 6.2.5
UFSAR	Pumpback System	Section 9.3.1.4
UFSAR	Drywell Pneumatic Supply System	Section 9.3.1.5
CR D2001-03291	Design of Station Blackout Diesel Maintenance Charger Results in Loss of Uninterruptible Power Supply and Delay in Station Blackout Diesel Fragnet	June 21, 2001

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

CR D2001-03309	Design change package #9900616 Prefilter Modification Revisions	June 21, 2001
WO 991427717-02, 03, and 04	2B1 Reactor Recirculation Motor Generator Set Oil Pump Vent and Fill	
WO 990022215	50C Suction Valve	
WO 99023054-01	Performing of 4-Year Planned Maintenance, Inspection, Cleaning and Calibration of 2C Shutdown Cooling Pump Discharge Pressure Transmitter Indication Loop	
WO 990259850-01	Quarterly Scram Discharge Volume Hi Level Scram Level Scram Functional Test	
WO 990222015-01	Lift/Land Leads and Place Jumpers on Shutdown Cooling Suction Valve (2-1001-2C)	

1R15 Operability Evaluations

CR D2001-02748	Unit 3 Intermediate Range Monitor 15 Erratic Indication Causing Main Control Room Alarms	May 22, 2001
CR D2001-06752	2B Recirculation Loop Temperature Indication Failed High	December 17, 2000
00-63	2B Recirculation Pump Suction Temperature Element	
DOA 1000-01	Residual Heat Removal Alternatives	Revision 13
FSAR	Shutdown Cooling System	Section 5.4.7
12E-2508	Primary Containment Isolation System, Shutdown Cooling Isolation Logic	Sheet 8

TS 3.4.7	Shutdown Cooling System - Hot Shutdown	
TS 3.4.8	Shutdown Cooling System - Cold Shutdown	
TS 3.3.6.1	Primary Containment Isolation Instrumentation	
01-024	Contaminated Condensate Storage Tank Inventory Preservation during Appendix R Fire	
UFSAR	4160-V System	Section 8.3.1.2
00-44	Incorrect Tap Setting for Bus 24 Undervoltage Relay	Revision 0
12E-2343	4160V Bus 24 Main and Reserve Feed	
00-031	Air Filtration Unit Booster Fan Damper	

1R19 Post Maintenance Testing

CR D2001-02711	Incorrect Post Maintenance Test Surveillance Listed on Work Order 99111348-03 (control rod drive K-8, WO-1)	May 20, 2001
CR D2001-02773	Scheduled Work Cannot be Performed: Inadequate Post Maintenance Testing Assigned	May 21, 2001
CR D2001-02736	Unexpected Response From Surveillance - Potential Rework	May 21, 2001
WO 99063179-05	Replaced Check Valve for Pumpback Air Compressor Suction Valve	
DOS 1600-28	Air Operated Valve Fail Safe and Accumulator Integrity Test	Revision 00
TS 3.6.1.3	Primary Containment Isolation Valves	
UFSAR	Pump back System	Section 9.3.1.4
WO 00329075-01	U2 Core Spray Flow Transmitter Channel Calibration	
WO 9910196902	Stem Lubrication of Isolation Condenser Outlet Valve, 2-1301-3	
WO 00329075-01	Unit 2 Core Spray Minimum Flow Valve Flow Transmitter Channel Calibration	
WO 99143216-04	Unit 3 Core Spray Control Switch Replacement for Valve 1301-3, Isolation Condenser Outlet Valve	

1R22 Surveillance Testing

CR D2001-02702	Unit 2/3 Isolation Condenser Makeup Pump Failed to Start	May 18, 2001
CR D2001-02763	Failure to Perform Calculations necessary to Compare Leak Test Results to Acceptance Criteria	May 21, 2001
CR D2001-03259	Station Blackout Diesel Switchgear Room Intake Actuators fail Preventive Maintenance Surveillance	June 19, 2001
CR D2001-03262	Unit 2 125 Alt Battery Float Volt. Found High Outside Accept. Surveillance Criteria	June 19, 1001
DIS 500-05	U2 Scram Discharge Volume Hi Level Scram Functions	
WO 00318006-01	Dresden Technical Surveillance 8236, U2 Whole Core Local Power Range Monitors Calibration	
WO 99195501-01	Dresden Instrument Surveillance 2300-15, Unit 2 High Pressure Coolant Injection Gland Seal Leakoff Condenser Level Controller/Alarm Switch Inspection and Functional Test	
WO 99265263-01	Dresden Operations Surveillance 2300-03, Unit 2 Quarterly High Pressure Coolant Injection Test, In-Service Testing Surveillance	
CR D2001-03053	Slow Raise Mode of High Pressure Coolant Injection System Speed Controller Not Working	June 7, 2001
CR D2001-02969	NRC Resident Question Operability of Unit 2 High Pressure Coolant System	June 4, 2001
DOS 2300-03	High Pressure Coolant Injection System Operability Verification Surveillance	Revision 67
UFSAR Section 6.3.2.3.2	Emergency Core Cooling Subsystem Characteristics	Revision 3
UFSAR Section 6.3.3.1.3.1	High Pressure Coolant Injection Subsystem Availability	Revision 3
UFSAR 6.3.3.1.3.2	Evaluation of High Pressure Coolant Injection Subsystem Performance	Revision 2
UFSAR Section 14.2.4.1.33	High Pressure Coolant Injection System	Revision 0