April 23, 2001

Mr. Oliver D. Kingsley, President
Exelon Nuclear
Exelon Generation Company, LLC
1400 Opus Place, Suite 500
Downers Grove, IL 60515

SUBJECT: DRESDEN NUCLEAR POWER STATION
NRC INSPECTION REPORT 50-237/01-08(DRP); 50-249/01-08(DRP)

Dear Mr. Kingsley:

On March 31, 2001, the NRC completed an inspection at your Dresden Units 2 and 3. The enclosed report documents the inspection findings which were discussed on April 3, 2001, with Mr. Swafford and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to safety and 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.

On March 31, 2001, the local International Brotherhood of Electrical Workers (IBEW) union contract with ComEd expired. Because negotiations between the union and Exelon (ComEd) management indicated that an agreement was not likely prior to expiration of the contract, the NRC conducted an inspection to evaluate the licensee's strike contingency plans. This inspection, conducted prior to the expiration of the contract at Dresden, verified that the licensee's plan met all requirements of the Technical Specifications and Federal Regulations in the event that a strike were to occur.

Based on the results of this inspection, the inspectors identified one issue of very low safety significance (GREEN). This issue concerned the failure to follow a surveillance procedure which resulted in an unexpected half scram. This issue was determined to involve a violation of NRC requirements. However, because the issue is of very low safety significance and was entered into your corrective action program, the NRC is treating this issue as a Non-Cited Violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this Non-Cited Violation, 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 Inspector at the Dresden facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (The Public Electronic Reading Room).

Sincerely,

/RA/

Mark Ring, Chief
Projects Branch 1
Division of Reactor Projects

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

Enclosure: Inspection Report 50-237/01-08(DRP);
50-249/01-08(DRP)

cc w/encl: W. Bohlke, Senior Vice President, Nuclear Services
C. Crane, Senior Vice President - Mid-West Regional
J. Cotton, Senior Vice President - Operations Support
J. Benjamin, Vice President - Licensing and Regulatory Affairs
H. Stanley, Operations Vice President
J. Skolds, Chief Operating Officer
R. Krich, Director - Licensing
R. Helfrich, Senior Counsel, Nuclear
DCD - Licensing
P. Swafford, Site Vice President
R. Fisher, Station Manager
D. Ambler, Regulatory Assurance Manager
M. Aguilar, Assistant Attorney General
Illinois Department of Nuclear Safety
State Liaison Officer
Chairman, Illinois Commerce Commission

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J. Skolds, Chief Operating Officer
R. Krich, Director - Licensing
R. Helfrich, Senior Counsel, Nuclear
DCD - Licensing
P. Swafford, Site Vice President
R. Fisher, Station Manager
D. Ambler, Regulatory Assurance Manager
M. Aguilar, Assistant Attorney General
Illinois Department of Nuclear Safety
State Liaison Officer
Chairman, Illinois Commerce Commission

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	50-237; 50-249
License Nos:	DRP-19; DRP-25
Report No:	50-237/01-08(DRP); 50-249/01-08(DRP)
Licensee:	Exelon Generation Company
Facility:	Dresden Nuclear Power Station, Units 2 and 3
Location:	6500 North Dresden Road Morris, IL 60450
Dates:	February 11, 2001, through March 31, 2001
Inspectors:	D. Smith, Senior Resident Inspector B. Dickson, Resident Inspector D. Chyu, Reactor Inspector D. Funk, Physical Security Inspector R. Landsman, Project Engineer P. Pelke, Reactor Engineer R. Zuffa, Illinois Department of Nuclear Safety
Approved by:	Mark Ring, Chief Projects Branch 1 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000237-01-08, IR 05000249-01-08; on 02/11 - 03/31; Exelon Generation Company; Dresden Nuclear Power Plant, Units 2 and 3. Personnel performance during non-routine plant evolutions and events.

The inspection was conducted by resident inspectors, a reactor engineer, and regional specialists. The inspection identified one Green finding which was 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.

Reactor Safety

Initiating Event

- GREEN — 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).

Report Details

Summary of Plant Status

Unit 2 began the period at full power operations. On February 23, 2001, operators reduced power to approximately 25 percent to plug leaking tubes in the main condenser. The licensee replaced 150 old or missing plugs. This work was completed with only the south half of the condenser isolated. The operators returned the unit to full power operations on February 25, 2001.

Unit 3 began the period at full power operations. On March 4, 2001, operators reduced power to 66 percent power to repair the 3A feedwater regulating valve. The operators returned the unit to full power operations on March 5, 2001. On March 11, 2001, operators reduced power to 85 percent to swap reactor feed pumps. The operators started the "A" reactor feed pump and secured the "C" reactor feed pump. The operators returned the unit to full power operations later that day.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity and Emergency Preparedness

1R05 Fire Protection (71111.05)

a. Inspection Scope

The inspectors toured plant areas important to safety to assess the material condition, operational 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 compensatory measures. The tour included:

Initiating Event Cornerstone

Unit 2 Condensate/Condensate Booster Pumps Room Fire Zone 8.2.1.A

In addition, the inspectors reviewed the issues that the licensee entered into its corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports (CR):

CR D2001-01219 Nuclear Oversight Notes Potential Fire Header Leak

CR D2001-01399	Planned Operability Surveillance of the 2/3 Diesel Fire Pump Stopped Due to Smoking Pump Packing
CR D2001-01027	System Engineer Identifies Inoperable Fire Door

b. Issues and 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.

Mitigating System Cornerstone

Unit 3 Reactor Protection System

In addition, the inspectors reviewed the issues that the licensee entered into the corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports:

CR D2001-00302	Maintenance Rule Failure Cause Determinations
CR D2001-00325	2B Reactor Feed Pump Minimum Flow Valve Solenoid Failure Results in Derate and Maintenance Rule Unavailability
CR D2001-01027	Maintenance Rule Failure Cause Determinations not Performed

b. Issues and 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.

The following risk significant activities were evaluated:

Initiating Events Cornerstone

WR 990245804-01	Unit 3 Scram Discharge Volume Level Switch Replacement, Calibration and Functional Check
WR 990135311-01	Unit 2 Calibration and Setpoint Change for Reactor Feed Pump Mini-Flow Valve
WR 990214699-07	Unit 2 Replacement of Off-gas Chimney Isolation Valve, 2-5406

Mitigating Systems Cornerstone

WR 990128925	Unit 2/3 Control Room Emergency Heating, Ventilation and Air Conditioning System Refrigeration Control Unit, Heat Exchanger Leak
WR 990038539-01	Unit 2 'A' Core Spray Pump Breaker and Cubicle Inspection

In addition, the inspectors reviewed the issues that the licensee entered into the corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports:

CR D2001-01210	Unit 2 'C' Low Pressure Coolant Injection Pump Flexible Hoses Leaking
CR D2000-06577	Unit 2 125 VDC Charger Tripped During Load Test

b. Issues and Findings

No findings of significance were identified.

1R14 Personnel Performance During Non-routine Plant Evolutions (71111.14)

a. Inspection Scope

The inspectors reviewed the licensee's performance during non-routine evolutions and events to ensure that the issues 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 in the corrective action program.

The inspectors reviewed operator logs, action tracking items and other documents. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports and follow-up documents:

CR D2001-01242	No Differential Pressure Across 3A and 3B Low Pressure Coolant Injection Heat Exchangers
CR D2000-06577	Unit 2 'A' Motor Generator Set Oil Cooler Divider Plate
Action Request Item 40172	Equipment Apparent Cause Report for Unit 2 'A' Motor Generator Set Oil Cooler
CR D2001-00916	Unexpected Half Scram Cause
Action Request Item 45569	Apparent Cause Report for Unexpected Half Scram

b. Issues and Findings

The inspectors identified one Green finding involving a Non-Cited Violation.

On February 16, 2001, an instrument maintenance technician (technician) performed Dresden Instrument Surveillance 500-08, "EHC Low Oil Pressure Scram Switch Calibration, Revision 15." Procedural Step I.7.a.9 instructed the technician to install a reactor protection system test box on terminals 2 and 4 of relay 2-590-121A (EHC Low Pressure Scram Relay). The procedure also required a second technician to perform a concurrent verification to ensure that the first technician installed the reactor protection system test box to the correct relay. The concurrent verification was performed and the second technician initialed and dated the procedure. Subsequently, during the calibration of the low pressure switch, an unexpected half-scram was received in the control room. The licensee terminated this surveillance and initiated an investigation.

The licensee's investigation discovered that the reactor protection system test box was installed on relay 2-590-100A ('A' Channel Scram Discharge Volume High-level Scram Relay) terminals 2 and 4 instead of relay 2-590-121A. Following this identification, the operators entered the appropriate Technical Specifications (TSs) for loss of this reactor protection system channel. The scram discharge level instrument logic was restored to normal within the time limits of Dresden TSs. The licensee documented this issue in CR D2001-00916.

As part of the licensee's corrective action program, the licensee performed an apparent cause evaluation for this event. This evaluation concluded that the apparent cause was the failure of the technicians to properly use error prevention techniques. The evaluation noted that flagging was used but the flag was not visible from a direct view of the relay. Three-way communication was incorrectly used; the technicians used only the relay terminal numbers instead of the entire relay number.

The inspectors reviewed the evaluation and noted that both issues were contributing factors for this event; however, the inspectors determined that there was an additional contributing cause. The surveillance procedure required concurrent verification. Administrative Procedure AD-AA-104-103, "Verification Practices Procedure," defines concurrent verification as the act of two individuals verifying the correct component position/condition concurrent with the activities related to establishing the condition or the component's position. The procedure states this is an "apart in action" activity.

Section 4.2.1, states that two individuals independently determine that they are indeed on/at the correct component per the following:

> "Do not make determinations based upon observed actions or verbal cues given by the individual. As a minimum, READ the location, component identification and action to be performed . . . . When the action is complete, then the second individual will verify the desired action was performed correctly on the correct component and remove any marking device placed as part of the component identification."

Therefore, the inspectors concluded that the second technician did not perform concurrent verification correctly. The inspectors also concluded that the apparent cause evaluation should have captured this issue. Following discussions with the inspectors, the licensee appropriately changed the apparent cause evaluation to include these issues.

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).

Dresden TS 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 surveillance and calibration tests are typical safety-related activities that should be covered by procedures. Procedural Step I.7.a.9 of Dresden Instrument Surveillance 500-08 required the installation of a reactor protection system test box on terminals 2 and 4 of relay 590-121A. Additionally, Procedural Step I.7.a.12 of the same procedure required a concurrent verifier to ensure the test box is installed on the correct terminal. Contrary to the above, on February 16, 2001, the first technician's failure to install the reactor protection system test box on terminals 2 and 4 of relay 590-121A, and the second technician's failure to perform a concurrent verification that the reactor protection system test box was installed on terminals 2 and 4 of relay 590-121A is a violation of Dresden TS 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 50-237/008-01(DRP)).** This issue was entered into the licensee's corrective action program as CR D2001-00916.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

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

Mitigating Systems Cornerstone

Operability Evaluation 00-035	Unit 3 Containment Cooling Service Water System
Operability Evaluation 01-011	Unit 2 and Unit 3 Drywell Steel Beams-Inadequate Beam Reinforcement Development Lengths

In addition, the inspectors reviewed the issues that the licensee entered into the corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports:

CR D2001-01627	Unit 3 Scram Discharge Volume High Level Switch 3-0302-82C and 82D Failure To Actuate
CR D2001-01473	Unit 2 High Pressure Inlet Drain Pot 2A Trap Downstream Stop Valve Found Closed

b. Issues and Findings

No findings of significance were identified.

1R16 Operator Work-Arounds (71111.16)

a. Inspection Scope

The inspectors reviewed the following operator work-arounds to assess any potential effect on the functionality of mitigating systems.

Mitigating Systems Cornerstone

OWA	99-034	Unit 2/3 Control Room Main Control Room Fire Damper
OWA	2-OB-024	Unit 2/3 Reactor Building Differential Pressure not Reading Accurately

In addition, the inspectors reviewed the issues that the licensee entered into the corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports:

CR D2001-01253	Unit 2 Low Pressure Core Injection Flow Recorder Showing Flow with None in System
CR D2001-01254	Unit 2 Hydrogen Addition System Erratic in Auto, Required Transfer to Manual

b. Issues and Findings

No findings of significance were identified.

1R19 Post Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors reviewed the following 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.

Mitigating Systems Cornerstone

WR 990085577	Unit 2 Low Pressure Coolant Injection Division 1 and 2 Cross Tie Valve
WR 990089755	Unit 3 Core Spray Torque Switch Calibration

In addition, the inspectors reviewed the issues that the licensee entered into the corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports:

CR D2001-00022	Unit 3 Core Spray Torque Switch Calibration
CR D2001-01196	Unclear Post Maintenance Test Results
CR D2001-01198	345 KV Yards 125 Vdc Breakers Maintenance Test

b. Issues and Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors screened an active temporary modification on a system ranked high in risk and assessed the effect of this temporary modification on safety-related systems. The inspectors also determined that the installations were consistent with the system design.

Mitigating System Cornerstone

9900867	Weld Repair on the Turbo Charger Air Intake Box on the Unit 2 Emergency Diesel Generator, Revision 0

In addition, the inspectors reviewed the issues that the licensee entered into the corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports:

CR D2001-01380	Box Material Stuffed in Security Diesel HVAC Unit Doors
CR D2001-01376	Nuclear Regulatory Commission Identifies Concerns with the Reactor Building Crane
CR D2001-01391	Wiring Discrepancy on Control Switch for Control Room HVAC 'A' Train

b. Issues and Findings

No findings of significance were identified.

Emergency Preparedness Cornerstone

1EP1 Drill, Exercise, and Actual Events (71114.06)

a. Inspection Scope

On March 1, 2001, the inspectors assessed the performance of operating crew 4 in providing the proper emergency classifications (Unusual Event and Alert) during a simulator evaluation during a pre-exercise drill. The scenario included a traversing in-core probe system accident, loss of the Unit 2 emergency diesel generator and the loss of the reserve 125 Vdc bus. The inspectors reviewed Emergency Plan Implementing Procedure 0200-T1, "Classification of GSEP Conditions," Revision 5, as part of the inspection.

b. Issues and Findings

No findings of significance were identified.

4. OTHER ACTIVITIES (OA)

4OA1 Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors reviewed a sample of plant records and data against the reported performance indicators in order to determine the accuracy of the indicators.

Mitigating System Cornerstone

Unit 3 Safety System Functional Failures (November 1999 through December 2000).

Unit 2 Safety System Functional Failures (November 1999 through December 2000).

Unit 2/3 Emergency AC Power System Unavailability (November 1999 through December 2000).

In addition, the inspectors reviewed the issues that the licensee entered into the corrective action program to verify that identified problems were being entered into the program with the appropriate characterization and significance. The inspectors also reviewed the licensee's corrective actions for the issues documented in the following condition reports:

CR D2000-06826	Containment Cooling Service Water System Dispositioned to Maintenance Rule (a)(1)
CR D2000-06827	Shutdown Cooling System Dispositioned to Maintenance Rule (a)(1)

b. Issues and Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems

Unresolved Items

(Closed) URI 50-237/249-98029-01: NRC review of additional licensee documentation for demonstrating the basis for not maintaining fire stops and fire retardant coatings as discussed in fire protection safety evaluation reports. On December 2, 1985, the licensee submitted a letter requesting relief from installing and/or maintaining fire stops and fire retardant coatings on cable trays. The Office of Nuclear Reactor Regulation did not take exceptions to the request for not completing the commitments. Therefore, not maintaining the fire stops and fire retardant coatings is not a violation of regulatory requirements. This item is closed.

4OA3 Event Follow-up (71153)

(Closed) LER 50-249/2000-007: Unit 3 High Pressure Coolant Injection (HPCI) System Declared Inoperable due to Faulty HPCI Pressure Switch Resulting in the Loss of Ability to Reset HPCI Turbine. On October 3, 2000, while restoring the HPCI system following successful completion of an Operability surveillance procedure, the turbine trip reset light in the main control room did not illuminate. During troubleshooting, it was determined that the internally sealed contacts of the HPCI Turbine Stop Valve Reset Pressure Switch, 3-2303-PS1, had failed preventing remote reset of the HPCI logic. The degradation of the contacts was accelerated by a switch solenoid valve failure on June 12, 1997, which allowed the maximum inrush current for the switch to be exceeded. Corrective actions included replacing the pressure switch, scheduling removal of the switch in approximately one year for failure analysis testing and adjusting the preventive maintenance frequency based on the results, and adding a requirement to test the switch following failures of the switch's solenoid valve.

4OA5 Other

.1 Licensee Strike Contingency Plans (92709)

a. Inspection Scope

The inspectors evaluated the licensee's strike contingency plan and verified that all TSs and Code of Federal Regulation requirements were met. In particular, the inspectors verified that in the unlikely event of a strike, the licensee's strike contingency plan ensured that personnel were sufficient in number and qualifications to maintain the safe operation of the facility, including implementation of the site emergency plan. Specifically, the inspectors verified that in the areas of plant management, operations, maintenance, security, chemistry, radiation protection, surveillance and calibrations, and administrative controls, strike contingency personnel met all qualification requirements and were proficient.

The inspectors reviewed the licensee's safeguards contingency plan and verified that the equipment and personnel required by the plan were available and sufficient to ensure that reactor operation and facility security would be maintained.

The inspectors verified that support from local agencies was adequate to ensure unimpeded access of strike contingency workers, medical care services, local fire department services, and support goods. Emergency communication equipment and the Emergency Notification System were verified to be available.

b. Observations

During a walkdown of the facility with an individual designated as a chemistry lead in the licensee's contingency plan, the inspectors discovered that this individual met all the ANSI qualification requirements for this position, but lacked detailed familiarity with Dresden's procedures and equipment. The inspectors informed the licensee of this observation and the licensee responded by having this individual perform several panel walkdowns and mock sampling evolutions.

Also, the inspectors questioned the readiness of the licensee's emergency preparedness organization. The inspectors questioned whether the contingency plan had taken into consideration a policy statement contained in a document entitled "Emergency Preparedness Department Training and Reference Material Respirator Qualifications for Emergency Responders." The document was dated September 16, 1999. In this document the licensee stated that 50 percent of the Operational Support Center emergency responders would have adequate respirator qualifications. The licensee's immediate response to this question was that the strike contingency plan did not consider this policy statement. Subsequently, the licensee reviewed the respirator qualifications of each individual listed in the contingency plan as emergency responders, and concluded that the policy statement had been met.

.2 World Association of Nuclear Operators Report Review

The inspectors reviewed the final report for the September 1999 Plant Evaluation performed by an inspection team from the World Association of Nuclear Operators. No further inspection was deemed necessary by NRC inspectors, and no assessment was made of the results of the inspection.

4OA6 Management Meetings

The inspectors presented the inspection results to Mr. Swafford and other members of licensee management on April 3, 2001. The licensee acknowledged the findings presented. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

D. Ambler, Regulatory Assurance Manager
K. Bowman, Operations Manager
S. Butterfield, NRC Coordinator
C. Cerovac, Training Manager
T. Fisk, Chemistry Manager
V. Gengler, Security Manager
B. Grant, Shift Operations Superintendent
B. Hanson, Work Management Manager
M. Karney, Manager, Nuclear Security, Midwest Regional Operating Group
C. Kemper, Nuclear Oversight
L. Licata, Engineering Administration Supervisor
T. Luke, Engineering Manager
J. Moser, Radiation Protection Manager
J. Nalewajka, Acting Nuclear Oversight Manager
B. Speek, Nuclear Oversight
W. Stoffels, Maintenance Manager
P. Swafford, Site Vice President

NRC

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

IDNS

R. Zuffa, Illinois Department of Nuclear Safety

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-237/01-008-01	NCV	Failure to Follow Procedures

Closed

50-237/001-008-01	NCV	Failure to Follow Procedures
50-237/249-98029-01	URI	Review additional documentation for not maintaining fire stops
50-249/2000-007	LER	HPCI system declared inappropriate due to faulty pressure switch

LIST OF BASELINE INSPECTIONS PERFORMED

The following inspectable-area procedures were used to perform inspections during the report period. Documented findings are contained in the body of the report.

Inspection Procedure		Report
Number	Title	Section
71111-05	Fire Protection	1R05
71111-12	Maintenance Rule Implementation	1R12
71111-13	Maintenance Risk and Emergency Work	1R13
71111-14	Nonroutine Evolutions	1R14
71111-15	Operability Evaluations	1R15
71111-16	Operator Workarounds	1R16
71111-19	Post Maintenance Testing	1R19
71111-23	Temporary Modifications	1R23
71114-06	Drill Evaluation	1EP1
4OA2	Identification and Resolution of Problems	4OA2
4OA3	Event Followup	4OA3
(none)	Other	4OA4
(none)	Management Meetings	4OA5

LIST OF ACRONYMS USED

AC	Alternation Current
ANSI	American National Standards Institute
CR	Condition Report
DRP	Division of Reactor Projects
EHC	Electro-hydraulic Control
GSEP	Generating Station Emergency Plan
HPCI	High Pressure Coolant Injection
HVAC	Heating, Ventilation, and Air Conditioning
IDNS	Illinois Department of Nuclear Safety
KV	Kilovolt
LER	Licensee Event Report
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
SDP	Significance Determination Process
URI	Unresolved Item
Vdc	Volts Direct Current
WR	Work Request