

Dresden 2

3Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: FIN Finding

Failure to Identify and Replace CR120A Relays as Recommended by GE SIL 229 Supplement 1

A finding of very low safety significance was identified by NRC Inspectors for the licensee's failure to identify and replace several CR120A relays as recommended by GE SIL 229 Supplement 1. Specifically, the licensee failed to replace several CR120A relays associated with primary containment valve isolation logic which eventually resulted in a partial Group 2 logic isolation event. The licensee entered this issue into the corrective action program (CAP) as Issue Report 923691. The licensee plans to replace these CR120A relays. There was no enforcement action associated with this finding.

This finding was determined to be more than minor because it was associated with the Equipment Performance attribute of the Initiating Events Cornerstone and affected the cornerstone's objective to limit the frequency of those events that upset plant stability and challenge critical safety functions during power operations. The relay failure caused an unplanned partial Group II primary containment isolation that impacted plant operations for several days. This issue was determined to be of very low safety significance since it did not contribute to both a reactor scram and loss of a mitigating function when evaluated as a Transient Initiator.

Inspection Report# : [2009004](#) (pdf)

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Instrument Air Isolation Valve Mispositioning on April 26, 2009

A finding of very low safety significance and associated Non Cited Violation of Technical Specification Section 5.4.1 was self revealed when the Unit 2 instrument air system had a significant pressure drop because a non licensed operator failed to follow procedure DOP 4700 01, "Instrument Air System Startup," Revision 46. The violation was placed into the licensee's corrective action program (CAP) in Issue Reports 911794 and 893376. The non licensed operator was relieved from duty. Both the non licensed operator and the unit supervisor were counseled for the failure to perform expected work practices. The licensee also found that this event was similar to other problems discussed in the licensee's Root Cause Report 893376, "Operations Cyclic Performance." Multiple corrective actions were assigned in Root Cause Report 893376 to address a lack of operations supervision enforcing department standards. Using the guidance contained in IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening," dated December 4, 2008, the inspectors determined that the finding was more than minor because the finding could be reasonably viewed as a precursor to a significant event. Specifically, the failure to follow procedure resulted in an instrument air (IA) transient that could have resulted in a unit scram if the IA system had not been recovered in a timely manner. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 Initial Screening and Characterization of findings," Table 4a, for the Initiating Event Cornerstone. The inspectors determined that the finding represented an increase in the likelihood of a reactor trip and the likelihood that mitigation equipment would be unavailable because the finding increased the likelihood of a loss of instrument air (LOIA) event. Therefore, the finding required a phase 2 SDP evaluation. The duration of the condition was less than three days. Using the SDP usage rules from IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At Power Situations", the inspectors increased the initiating event frequency for the LOIA event by one order of magnitude for the three day exposure period. The result was an estimated change in core damage frequency of less than 1.0E 6/yr. As a result, the finding was determined to be of very low safety significance (Green) based on the phase 2 SDP evaluation. This finding had a cross cutting aspect in the area of Human Performance, Work Practices because the operator did not use the expected human performance techniques.

Inspection Report# : [2009003](#) (pdf)

Significance: **G** Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure the Control of the Design Basis Was Correctly Translated Into Station Procedures

The inspectors identified a NCV of 10 CFR 50, Appendix B, Criterion III, "Design Control", of very low safety significance, for the failure to ensure that the control of the design basis was correctly translated into station procedures. The procedures used to control the temporary placement of 480V heaters in safety-related areas did not meet the station procedural requirements for a temporary configuration change. The violation was placed into the licensee's corrective action program (CAP) in Issue Report (IR) 876126. The licensee's corrective actions included planning to change all the station procedures that control the installation and removal of temporary heaters.

Using the guidance contained in IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening," dated December 4, 2008, the inspectors determined that the finding was more than minor because, if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. The inspectors evaluated the finding using IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria," dated December 22, 2006. Per IMC 0609, Appendix M, a bounding quantitative and/or qualitative (i.e., worst case analysis) was performed. The resultant risk significance of the inspection finding was determined to be of very low safety significance and is determined to be Green. The inspectors determined that this issue also affected the cross cutting area of Problem Identification and Resolution because the licensee failed to take corrective actions to address a safety issue in a timely manner.

Inspection Report# : [2009002](#) (*pdf*)

Mitigating Systems

Significance: **G** May 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Diesel-Driven Fire Pump Discharge Valve Found Out of Position

A finding of very low safety significance and associated non-cited violation of license conditions 2.E and 3.G for Units 2 and 3, respectively, was identified by the inspectors for the failure to restore the Unit 1 diesel-driven fire pump to an operable condition within 7 days as required by Technical Requirements Manual (TRM) 3.7.i.A.1. Specifically, the Unit 1 fire pump discharge valve was found closed rendering the pump inoperable for greater than 7 days. Upon discovery of the valve in the closed position the licensee repositioned the valve in the correct locked open position and initiated Action Requests (AR) 922581 and 922585.

This finding is more than minor because the failure to provide the two required fire pumps could have resulted in a failure of the station's water based fire protection system should the Unit 2/3 fire pump have been out of service at the same time. The finding screened as very low safety significance because the performance of the system was not affected by the closed valve as the Unit 2/3 diesel-driven fire pump remained operable to provide water to the station's fire protection system, if required. This finding has a cross-cutting aspect in the area of human performance, work control because the licensee did not properly plan and coordinate activities consistent with nuclear safety. Specifically, the licensee failed to restore the Unit 1 diesel-driven fire pump to an operable condition within 7 days as required by TRM 3.7.i.A.1 as a result of ineffective communications between licensee personnel to verify that valve 1-4199-109 was in its correct locked open position prior to declaring the pump operable [H.3(b)].

Inspection Report# : [2009006](#) (*pdf*)

Significance: **G** Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Develop a Pre Fire Plan for Fire Zone 18.6

The inspectors identified an NCV of the Dresden Nuclear Power Station Renewed Facility Operating License having very low safety significance for the licensee's failure to develop a pre fire plan for Fire Zone 18.6. This issue was entered into the licensee's CAP as issue reports 873977 and 875688. The licensee's corrective actions included the

development of a pre fire plan for Fire Zone 18.6.

The finding was more than minor because it involved the Mitigating Systems attribute of protection against external factors (i.e., fire), where the failure to develop a pre fire plan for Fire Zone 18.6 could have adversely impacted the fire brigade's ability to fight a fire. The inspectors completed a Phase 1 significance determination of this issue using IMC 0609, "Significance Determination Process," Appendix A, Attachment 0609.04. However, as discussed by Attachment 0609.04, issues related to performance of the fire brigade are not included in IMC 0609, Appendix F, "Fire Protection SDP," and require management review. The finding was reviewed by NRC management, and was determined to be a finding of very low safety significance because no safe shutdown equipment was located in this fire zone. The inspectors determined that this issue also affected the cross cutting area of Problem Identification and Resolution (e.g., corrective action program) because the licensee failed to thoroughly evaluate the problem addressed in NCV 05000237/2008008 02; 05000249/2008008 02, "Failure to Develop a Pre fire Plan for Fire Zone 18.6," such that appropriate corrective actions to address safety issues and adverse trends were not taken in a timely manner, commensurate with their safety significance and complexity.

Inspection Report# : [2009002](#) (pdf)

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Implement and Maintain in Effect All Provision of the Approved Fire Protection Program as described in the UFSAR

A self revealed NCV of the Dresden Nuclear Power Station Renewed Facility Operating License having very low safety significance was identified for the licensee's failure to implement and maintain in effect all provisions of the approved Fire Protection Program as described in the Updated Final Safety Analysis Report (UFSAR). Specifically, the licensee failed to ensure that the floor penetrations to Fire Zone 2.0 were sealed as described in the Fire Hazards Analysis. Licensee corrective actions included revising the Fire Hazard Analysis and sealing the floor penetrations.

The finding was more than minor because it involved the Mitigating Systems attribute of protection against external factors (i.e., flood hazard, fire) and impacted the Mitigating Systems objective to ensure availability, reliability, and capability of systems that respond to initiating events (i.e., flood hazard, fire) to prevent undesirable consequences. The inspectors performed a Phase 1 qualitative screening and the finding screened to very low safety significance. The inspectors determined that because the modifications took place in the 1985 to 1986 timeframe, the performance deficiency is not reflective of current licensee performance and therefore no cross cutting area was affected.

Inspection Report# : [2009002](#) (pdf)

Significance: SL-IV Jan 15, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Complete and Accurate Information to the NRC Associated with Verifying No Operating Test Item Duplication with the Audit Test

The inspectors identified a Severity Level IV Non-Cited Violation (NCV) of 10 CFR 55.40, "Implementation," 10 CFR 50.9, "Completeness and accuracy of information," and 10 CFR 55.49, "Integrity of examinations and tests." For the Dresden Station March 2009 NRC Initial Operator License Examination, the inspectors identified that the examination author and the facility reviewer had initialed Step 2.b and Step 3.a.(3) of Form ES-201-2, "Examination Outline Quality Checklist," on August 15, 2008, and August 19, 2008, respectively, and Step 1.c of Form ES-301-3 "Operating Test Quality Checklist," on January 15, 2009, and January 20, 2009, respectively, which indicated that the operating test did not duplicate items from the applicants' audit test, when, upon NRC review, it was determined that six of the 23 dynamic simulator scenario events, and one of the 15 Job Performance Measures (JPMs) for the Reactor Operator (RO) candidates were duplicated from the applicants' audit test.

The finding was determined to be more than minor, because the integrity of the NRC initial operator licensing examination could have been compromised if, but for detection by the NRC examiners, the NRC examination had been administered with the duplication of the operating test items from the applicants' audit test. The finding was determined to be of very low safety significance because the duplication of operating test items was discovered by the NRC examiners prior to administration of the NRC examination, the duplicate test items were either removed from the audit test or the NRC exam changed to remove the duplication, and the facility implemented examination security

requirements for the audit test similar to that which was required for the NRC examination. The inspectors concluded that this finding had a cross-cutting aspect in the area of Human Performance, Work Practices, because the licensee did not define and effectively communicate expectations regarding procedural compliance and for personnel to follow procedures (i.e., in the development of the NRC initial operator license examination).

Inspection Report# : [2009301](#) (pdf)

Significance:  Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

LPCI Heat Exchangers' Design Calculation Deficiencies and Discrepancies

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance involving the low pressure coolant injection (LPCI) heat exchangers cooling capability during a design basis loss of coolant accident (LOCA). Specifically, the licensee failed to evaluate the effects of higher containment pressure post power up-rate on the LPCI heat exchangers' differential pressure set-point calculation. In response to the issue, the licensee implemented compensatory actions including updating various calculations and performing several operability evaluations.

This finding was more than minor because there was reasonable doubt on the operability of the LPCI heat exchangers and if left uncorrected, these heat exchangers had the potential to be inoperable during the summer months. This finding was of very low safety significance because the inspectors determined that the LPCI heat exchangers were in a non-conforming but operable condition and the issue screened as Green using the SDP Phase 1 screening worksheet.

Inspection Report# : [2008005](#) (pdf)

Barrier Integrity

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Technical Specification 5.5.2 Implementing Procedures

The inspectors identified several examples of failure to follow the procedures that implemented Technical Specification (TS) 5.5.2, "Primary Coolant Sources Outside Containment." These failures were determined to represent a Green finding and a non cited violation. Planned corrective actions associated with this violation included, but were not limited to: a revision to DTP 09, "Leak Detection and Reduction Program," to restore commitments made to the NRC; changes to the work control program to ensure that leaks identified by the Leakage Reduction Program are given a high priority; assignment of a program owner; revising operating surveillances to ensure they meet the requirements of TS 5.5.2; initiating a training program for operations and engineering personnel on TS 5.5.2; and developing an administrative limit on emergency core cooling system leakage outside the primary containment.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, the failure to track, trend, and repair leakage outside primary containment could lead to exceeding radiation exposure limits in the event of an accident. This finding was determined to have very low safety significance because the actual emergency core cooling system leakage outside the primary containment was low. This finding had a cross cutting aspect in the area of Human Performance, Work Practices because the licensee did not effectively communicate expectations regarding procedural compliance with regard to TS 5.5.2, "Primary Coolant Sources Outside Containment." Specifically, licensee personnel failed to follow several procedural requirements because they were unaware of the requirements.

Inspection Report# : [2009004](#) (pdf)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Corrective Actions to Replace a Degraded Valve in a Timely Manner

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action", for the failure to

correct degraded safety related equipment in a timely manner. A degraded 4 way solenoid valve for the reactor building ventilation damper 2 5741B actuator was not replaced during the work window that started on January 5, 2009. The solenoid valve failed on January 13, 2009, when it was called upon during a reactor building ventilation isolation. The violation was placed into the licensee's corrective action program in IR 877591. The licensee's corrective action included replacing all the 4 way solenoid valves in the actuators for all the Unit 2 and Unit 3 reactor building ventilation secondary containment isolation boundary dampers.

Using the guidance contained in IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening," dated December 4, 2008, the inspectors determined that the finding was more than minor because it was associated with the Reactor Safety Barrier Integrity Cornerstone objective of maintaining the functionality of the secondary containment. The inspectors evaluated the finding using IMC 0609, Attachment 0609.04, dated January 10, 2008. Per Table 4a, under Containment Barrier, question 1, "Does the finding only represent a degradation of the radiological barrier function provided for the ... Standby Gas Treatment System," the inspectors answered, YES. The secondary containment isolation valves isolate the secondary containment to ensure the effectiveness of the Standby Gas Treatment System. Therefore the finding was determined to be Green. The inspectors determined that this issue also affected the cross cutting area of Problem Identification and Resolution

Inspection Report# : [2009002](#) (*pdf*)

Significance: G Mar 31, 2009

Identified By: Self-Revealing

Item Type: FIN Finding

Operator Performed an Incorrect Response to an Unexpected Alarm in the Control Room

On January 13, 2009, a Finding with no violation of regulatory requirements was self revealed when an operator performed an incorrect response to an unexpected alarm in the control room that resulted in a reactor building ventilation isolation and a standby gas treatment system actuation. This action required entry into TS 3.6.4.1 Limiting Condition of Operation, Action A for reactor building low differential pressure.

The finding was more than minor because it impacted the structures, systems, and components attribute of the Barrier Integrity Cornerstone objective. The finding was of very low safety significance because it impacted the reactor building differential pressure for a time period of less than one hour. The finding was placed into the licensee's CAP as IR 866445. As an immediate corrective action, the individual was temporarily removed from licensed shift duties and no manipulation of any equipment in the plant or the control room was allowed without a peer check until January 18, 2009. The inspectors also concluded that this finding affected the cross cutting issue of Human Performance (Personnel) because the operator failed to utilize human performance error prevention techniques

Inspection Report# : [2009002](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings

pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : December 10, 2009