

## Dresden 3

### 2Q/2014 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:** G May 23, 2014

Identified By: NRC

Item Type: FIN Finding

### **Inadequate Applicability Reviews of Configuration Changes for De-Energizing Safety-Related Valves**

The inspectors identified a finding of very low safety significance (Green) related to inadequate applicability reviews of operational configuration changes that were implemented as a result of the licensee's Multiple Spurious Operation (MSO) evaluations. Specifically, the licensee failed to follow procedural requirements for determining the applicability for performing 10 CFR 50.59 screening and evaluations for changes made to the facility which de-energized several safety-related motor operated valves (MOVs). The procedural action required that the configuration changes be screened for applicability for a specific 10 CFR Part 50.59 evaluation since aspects of the changes were not completely controlled under the licensee's Fire Protection Program. The licensee entered this issue into their Corrective Action Program to perform a 10 CFR 50.59 screening of changes for each affected system to ensure that all aspects of component design were evaluated.

The performance deficiency was determined to be more than minor because the issue, if left uncorrected, would have become a more significant safety concern. Specifically, by not individually evaluating the scope and applicability of plant configuration changes, the licensee lost the ability to ensure that all aspects of component design were appropriately evaluated against the plant's design and licensing basis. Such changes have the potential to adversely affect design or operation of systems. Failure to evaluate such aspects allows the potential for adverse changes to go undetected. This finding has a cross-cutting aspect in the area of Human Performance because the licensee became complacent during the conduct of performing applicability reviews that were related to the facility's Fire Protection Program, and failed to recognize changes that included elements outside of the scope of fire protection.

Inspection Report# : [2014008](#) (*pdf*)

**Significance:** G May 23, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Seismically Secure Nitrogen Bottles**

The inspectors identified a finding of very low safety significance (Green) and associated Non-Cited Violation of Technical Specifications (TS) Section 5.4.1.a, for the licensee's failure to seismically restrain nitrogen bottles located near safety-related motor control centers (MCCs). Specifically, the licensee failed to seismically restrain a cart with two nitrogen bottles located near safety-related MCCs per their procedures for the handling and storage of compressed gas cylinders and restraint of portable equipment. The licensee entered this issue into their corrective action program, moved the cart with the nitrogen bottles away from the MCCs, and secured it to a column nearby.

The inspectors determined that the finding was more than minor because during a seismic event the bottles could have tipped over and impacted the MCCs, thereby causing a loss of safety-related equipment, such as the Unit 2/3

emergency diesel generator. The finding was determined to be of very low safety significance based on a detailed risk-evaluation. The finding has a cross-cutting aspect in the area of Human performance because maintenance and operations personnel did not coordinate during a change out of nitrogen bottles which resulted in the bottles being left unsecured. (Section 4OA5.2)

Inspection Report# : [2014008](#) (pdf)

**Significance:**  Mar 15, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Adequately Incorporate GE Operating Experience into Vendor Manual**

The inspectors identified a finding of very low safety significance and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to ensure that operating experience provided via a vendor Service Information Letter (SIL) was properly evaluated and incorporated into the vendor manual contrary to the requirements of procedure

RS-AA-115, "Operating Experience." The failure to properly assess operating experience for alternating current (AC) Motors resulted in a condition where specific deficiencies could go unrealized under the licensee's condition based monitoring program. The licensee initiated action request (AR) 1633528 and 1635766 to document and develop corrective actions for the issue.

The finding was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of design control and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to adequately evaluate and document the basis for the use or rejection of 9 out of 10 experiences presented in General Electric (GE) SIL 484, Supplement 6, could cause a reduction in reliability for safety related systems that use AC motors. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." The finding was screened against the Mitigating Systems Cornerstone, Exhibit 2 of Appendix A, and determined to be of very low safety significance because the answer was "no" to all of the screening questions. This finding has a cross-cutting aspect in the area of Human Performance, Avoid Complacency (H.12), because individuals failed to recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes.

Inspection Report# : [2014007](#) (pdf)

**Significance:**  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Update the UFSAR for Reactor Water Cleanup Design Changes**

A Severity Level IV NCV of 10 CFR 50.71(e), "Periodic Update of the Final Safety Analysis Report" (USFAR) and an accompanying Green finding were identified by the inspectors for the licensee's failure to update the Updated Final Safety Analysis Report (UFSAR) for a design modification performed on the Unit 3 reactor water cleanup (RWCU) system. Specifically, the licensee did not update Dresden UFSAR Section 5.4.8, "Reactor Water Cleanup System," to reflect changes made during a design modification installed on Unit 3 in 1997. The design changes included reducing the pipe dimension of RWCU piping outside of the primary containment and eliminating a string of regenerative and non-regenerative heat exchangers. The licensee also identified several high energy line break (HELB) calculations which did not include the design modification when determining the impact on environmentally qualified components affected by a failure of the RWCU system piping outside of the primary containment structure. Corrective actions included submitting a UFSAR change request to include the appropriate operating characteristics and specifications under the present design. In addition, the licensee reviewed all affected calculations to ensure no non-conservative outcomes resulted based on the design modifications installed.

This finding was determined to be more than minor using IMC 0612, "Power Reactor Inspection Reports," Appendix

B, "Issue Screening," dated September 7, 2012 because, if left uncorrected, the performance deficiency could have led to a more significant safety concern. Specifically, failure to update the UFSAR with the actual RWCUC system configuration prevented the inspectors from readily concluding that the design change would not require additional calculational analyses for HELB. The inspectors completed a Phase 1 significance determination of this issue using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated July 1, 2012 and IMC 0609, Appendix A, "The Significance Determination Process (SDP) For Findings At-Power," dated July 1, 2012. The inspectors answered NO to all questions in Exhibit 2, Section A, "Mitigating SSCs and Functionality," therefore the finding screened as Green (very low safety significance). In accordance with Section 6.1.d.3 of the NRC Enforcement Policy, this violation is categorized as Severity Level IV because the information was not used to make an unacceptable change to the facility or procedures since the design changes did not result in a reduction of the previous margin to the 10 CFR 100 guidelines nor did they challenge the environmental quality rating of safety related components in the vicinity of the RWCUC system during a HELB event outside of containment. The inspectors determined that this finding did not reflect present performance because it is a legacy issue with changes made to the facility more than 16 years previously; therefore, there was no cross cutting aspect associated with this finding.

Inspection Report# : [2013004](#) (*pdf*)

**Significance:** G Dec 31, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Inadvertent Lo-Lo Reactor Water Level Indication Received During Maintenance Resulting in Unavailability of the 2/3 Emergency Diesel Generator to Unit 3**

A finding of very low safety significance and associated non-cited violation of Technical Specification (TS) 5.4.1, "Procedures", was self-revealed on November 17, 2013, when the 2/3 Emergency Diesel Generator (EDG) was inoperable to Unit 3 with an Emergency Core Cooling Systems (ECCS) signal present on Unit 2 due to sensing a low reactor water level condition. Specifically, while the licensee performed procedure DIS 0263-07, Revision 20, "Unit 2 ATWS RPT/ARI and ECCS Level Transmitters Channel Calibration Test and EQ Maintenance Inspection", in conjunction with Anticipated Transient Without a Scram (ATWS) level transmitter replacements, a failure to remove trip relays in addition to performing all transmitter replacements at the same time resulted in an unexpected Lo-Lo reactor water level trip signal, subsequently resulting in the auto initiation of the Unit 2 EDG and the 2/3 EDG, causing the 2/3 EDG to be inoperable to Unit 3. The licensee immediately restored the ATWS trip relay circuitry, clearing the Lo-Lo reactor water level signal. This enabled the EDGs to be returned to a standby condition and, thereby, restored 2/3 EDG availability to Unit 3.

The licensee's failure to properly implement the steps in the procedure was a performance deficiency that was determined to be more than minor, and thus a finding, because it was associated with the Mitigating Systems Cornerstone attribute of Configuration Control and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance. The finding was of very low safety significance because each of the questions provided in IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," were answered "no." The finding has a cross-cutting aspect in the area of human performance, work control, for failing to appropriately coordinate work activities by incorporating actions to address the impact of changes to the work activity on the plant. Specifically, the licensee committed a human performance error by failing to adequately address the impact of work activity changes on the plant and implement the required prerequisites.

Inspection Report# : [2013005](#) (*pdf*)

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## Barrier Integrity

**Significance:** G Mar 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to Maintain Secondary Containment Integrity During Outage Demobilization Activities**

A finding of very low safety significance and associated non-cited violation of Technical Specification (TS) 5.4.1, “Procedures”, was self-revealed on November 28, 2013, when the integrity of the secondary containment for Unit 3 was not maintained when plant personnel bypassed interlock features, designed for preventing both doors of a secondary containment interlock from being simultaneously open, in order to remove equipment from a work area. Specifically, during demobilization activities from Unit 2 refueling outage D2R23, a radiation protection technician (RPT) and station laborers were dispatched to the Unit 2 main steam tunnel area, known as the Unit 2 X-Area, to remove lead blanket shielding which had been used to support maintenance work during the outage. Upon arriving at the Unit 2 X-Area the RPT and laborers opened and held open the outer containment door and attempted to simultaneously open the inner containment door. The installed door interlock prevented the RPT from unlocking the inner door. Not understanding the significance of this, the RPT pressed the emergency open push button which is normally reserved for personnel emergencies and bypassed the secondary containment interlock, opening both doors simultaneously. With both doors open, the team began removing the lead shielding blankets from the X-Area to the adjacent turbine building. Main control room operators, receiving the X-Area interlock door trouble alarm, dispatched an Equipment Operator (EO) to investigate. Upon arriving at the X-Area, the EO directed the doors to be shut restoring secondary containment integrity to Unit 3.

The simultaneous opening of the Unit 2 X-Area secondary containment interlock doors for 15 minutes was contrary to step 3.6 of licensee procedure CC-AA-201, “Plant Barrier Control Program,” and was a performance deficiency warranting further review. The performance deficiency was determined to be more than minor, and thus a finding, because it was associated with the Barrier Integrity Cornerstone Attribute of Configuration Control and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance because the inspectors answered “yes” to question C.1 in IMC 0609, Appendix A, Exhibit 3, “Barrier Integrity Screening Questions.” The finding has a cross-cutting aspect of Challenge the Unknown (H.11), in the area of human performance, for failing to appropriately challenge an unexpected condition when the RPT and laborers determined that the containment interlock doors were closed with the interlock in operation. Specifically, the individuals did not request further guidance from their supervision or the operations watch team with regards to the status of secondary containment. This information would have revealed to them that their task of demobilizing lead shielding in the Unit 2 X-Area would have to be completed while maintaining the integrity of the secondary containment interlock barrier.

See LER 249/2013-001-00

Inspection Report# : [2014002](#) (*pdf*)

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

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