

## Dresden 3

### 2Q/2016 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:** G Mar 31, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

### **Failure to Maintain Design Control of the 2/3 Emergency Diesel Generator**

A finding of very low safety significance and an associated NCV of Title 10 of the Code of Federal Regulations Part 50, Appendix B, Criterion III, "Design Control," was self-revealed associated with the licensee's failure to assure that the applicable design basis for applicable structures, systems, and components were correctly translated into specifications, procedures, and instructions. Specifically, since initial plant construction the licensee failed to correctly identify the effect a loss of non-safety 2/3 emergency diesel generator (EDG) room ventilation could have on maintaining operability of the 2/3 EDG. On November 6, 2015, during a planned maintenance outage of the normal non-safety related instrument air pneumatic supply and a failure resulting in the depressurization of the back-up non-safety related nitrogen system, the 2/3 EDG ventilation intake and exhaust dampers failed closed making the 2/3 EDG inoperable for approximately 20 minutes on two occasions from the time of discovery of the condition. The licensee incorrectly believed that a loss of the non-safety related instrument air system and its non-safety related back-up nitrogen system would cause the dampers to fail in the conservative open position. This feature was never tested; and therefore the licensee incorrectly believed the non-safety related control systems for the room ventilation system would not adversely affect the safety-related EDG's operability.

The performance deficiency was determined to be more than minor, and thus a finding, in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because it was associated with the Design Control attribute of the Mitigating Systems Cornerstone and affected the associated cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and if left uncorrected could lead to a more significant safety concern. The finding screened as very low safety significance (Green) because the inspectors answered "no" to questions A.1. through A.4. of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, dated June 19, 2012. This finding has a cross-cutting aspect in the area of Human Performance, Training, because the licensee did not ensure licensed operations and engineering personnel properly understood the operation and configuration of the 2/3 diesel generator ventilation system under accident conditions and its impact on the safety-related 2/3 EDGs ability to accomplish its design function. Specifically, the licensee incorrectly believed that the 2/3 EDG room ventilation system failed in a conservative manner with a loss of its non-safety related pneumatic supply systems. Corrective Action Program documents and other engineering products up until September 2015 incorrectly state that the 2/3 EDG's operability was not adversely affected by a loss of damper control pneumatics as the dampers were expected to fail open. [H.9]

Inspection Report# : [2016001](#) (*pdf*)

**Significance:** G Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Evaluate the Available Net Positive Suction Head for the Diesel Generator Cooling Water Pumps Following a Dam Failure**

The inspectors identified a finding of very low safety significance, and an associated NCV of Title 10, Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion III, "Design Control," for the failure to verify the adequacy of the diesel generator cooling water (DGCW) pumps' design. Specifically, the licensee failed to evaluate the net positive suction head (NPSH) available to the DGCW pumps at the most limiting ultimate heat sink (UHS) level after a postulated dam failure where they are expected to perform a safety function. The licensee entered this finding into their Corrective Action Program (CAP) and, after a review of their DGCW pump NPSH calculation and an evaluation, concluded that the DGCW pumps had adequate NPSH available to them at the most limiting UHS level after a postulated dam failure, and therefore remained operable.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attribute of equipment performance, and adversely affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding screened as very low safety significance (Green) because although it affected the design or qualification of the DGCW pumps, it did not result in the loss of operability or functionality of the pumps. The inspectors did not identify a cross-cutting aspect associated with this finding because it was not confirmed to reflect current performance due to the age of the performance deficiency.

Inspection Report# : [2015003](#) (*pdf*)

**Significance:**  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Perform Ultimate Heat Sink Surveys in Accordance With Quality Assurance Program**

The inspectors identified a finding of very low safety significance, and an associated NCV of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," for the failure to perform surveys of the UHS in accordance with the Quality Assurance Program. Specifically, the licensee failed to ensure that: (1) the requirements and acceptance limits in the Updated Final Safety Analysis Report (UFSAR) and other applicable design documents for the high points of the intake and discharge canals were incorporated into the UHS test; (2) the evaluation of the bathymetric survey results accounted for the instrument uncertainty of the test equipment; and (3) the UHS

bathymetric survey results were evaluated in accordance with the Quality Assurance Program to assure that the UFSAR required UHS volume was satisfied. The licensee entered this finding into their CAP and, after a review of past bathymetric surveys and other information, determined that: (1) the discharge canal high point had not degraded and was not expected to significantly degrade; and (2) the UHS remained operable because the available UHS water volume still remained above the UFSAR required volume.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attribute of procedure quality, and adversely affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding screened as very low safety significance (Green) because although it affected the design or qualification of the UHS, it did not result in the loss of operability or functionality of the UHS. The inspectors determined this finding had an associated cross-cutting aspect in the area of Human Performance, Design Margins, because the licensee did not pay special attention to maintaining the safety-related UHS. Specifically, special attention was not placed on guarding the design margin of the UHS, and a test program that did not meet all the quality assurance requirements was accepted to demonstrate the adequacy of the UHS.

Inspection Report# : [2015003](#) (*pdf*)

**Significance:**  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Post Protected Pathway Signs**

The inspectors identified a finding of very low safety significance, and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to implement all necessary prescribed risk management actions as required by licensee procedure OP-AA-108-117, "Protected Equipment Program," during a Unit 3 low pressure coolant injection (LPCI) logic system functional test (LSFT) maintenance window. Specifically, the licensee failed to post protected equipment signs for the Unit 3 2203-28 instrument rack whose unavailability impacts the high pressure coolant injection (HPCI) system and would have taken the unit into a licensee-defined Orange risk condition and Technical Specification (TS) Limiting Condition for Operations (LCO) 3.0.3.

The performance deficiency was determined to be more than minor because the licensee failed to implement prescribed risk management actions which if left uncorrected could have become a more significant safety concern. Specifically, operators inadvertently removed the protected equipment postings on instrument rack 2203-28 which could have significantly degraded the key safety function of reactor coolant inventory control if both the HPCI and LPCI systems became unavailable simultaneously and were required to mitigate the consequences of an accident that could result in potential offsite exposure comparable to the 10 CFR Part 100 guidelines. The finding screened as very low safety significance (Green) because the inspectors answered "No" to all of the Mitigating Systems Screening Questions. The inspectors determined this finding had a cross-cutting aspect in the area of Human Performance, Work Management, because the licensee failed to implement risk management actions in accordance with procedure OP-AA-108-117. Specifically, the licensee inappropriately removed protected equipment postings prior to commencing maintenance activities which required the risk management activity to be in place.

Inspection Report# : [2015003](#) (pdf)

## **Barrier Integrity**

**Significance:**  Dec 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

### **Failure to Maintain Design Control of Secondary Containment Interlock Doors**

A finding of very low safety significance (Green) and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was self-revealed on September 4, 2015, when the integrity of the Secondary Containment for Units 2 and 3 was not maintained for 39 minutes when interlock features designed to prevent both doors of a Secondary Containment interlock from being simultaneously open prevented the closure of Reactor Building to Turbine Building doors 47 and 48 following simultaneous operation during routine access of the interlock by plant personnel.

The performance deficiency was determined to be more than minor because it was associated with the Barrier Integrity cornerstone attribute of design control, and adversely affected the associated cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The finding screened as very low safety significance (Green) because the inspectors answered yes to the Barrier Integrity Screening Question C.1, Exhibit 3 of IMC 0609, Appendix A. This finding has a cross cutting aspect in the area of Human Performance, Conservative Bias, because the licensee did not use decision making-practices that emphasize prudent choices over those that are simply allowable. Specifically, the licensee failed to implement a modification which addressed a known design deficiency in the 570 foot elevation Secondary Containment interlock in 2013. The licensee reasoned that the interlock was a low traffic area and that it would be unlikely that the doors would be open simultaneously. [H.14]

Inspection Report# : [2015004](#) (pdf)

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## Emergency Preparedness

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## Occupational Radiation Safety

**Significance:**  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Implement and Maintain Written Procedures Regarding Breathing Air Quality Testing**

A finding of very-low safety significance and an associated NCV of Title 10 of the Code of Federal Regulations (CFR), Part 20.1703, was an NRC-identified finding for failure to implement and maintain written procedures regarding breathing air quality that resulted in the failure to perform a continuous in-line breathing air quality test during filling of self-contained breathing apparatus (SCBA) cylinders since 2009. Specifically, on May 4, 2016, during an inspection of the licensee's air compressor, the inspectors identified that the in-line carbon monoxide (CO) detector located at the compressor high-pressure filling station was inoperable since 2009, the procedure does not specify an alternative method of CO monitoring during the filling of the SCBA cylinders. Without specifying an alternative method of monitoring and only relying on the high-temperature safety shut-off, hazardous CO gas could be introduced into the SCBA cylinders, thus degrading the Grade-D air quality, during a compressor malfunction. The licensee's corrective actions included but were not limited to revising the applicable procedures, servicing or replacing the CO monitor by the manufacturer, and installing a new air compressor at the facility.

The inspectors determined that that the finding was more than minor in accordance with Inspection Manual Chapter (IMC) 0612, in that the finding impacted the program and process attribute of the Occupational Radiation Safety Cornerstone and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation through the use of SCBAs during an emergency response use by maintaining certified air quality. Specifically, the licensee failed to implement and maintain written procedures regarding an alternative method of monitoring air quality testing to maintain the Grade-D air quality during filling of SCBA cylinders. The finding was determined to be of very-low safety significance in accordance with IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," because it was not an as low as reasonably-achievable planning issue, there was no overexposure nor substantial potential for an overexposure, and the licensee's ability to assess dose was not compromised.

The inspectors concluded that the cause of the issue involved a cross-cutting component in the area of human performance, resources, in that, the license did not ensure the adequacy of the procedure describing the alternate methods of CO monitoring during filling of Grade D air into the SCBA cylinders. [H.1]

Inspection Report# : [2016002](#) (pdf)

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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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