

**From:** "Mike Mulligan" <steamshovel@adelphia.net>  
**To:** "Mindy Landau" <MSL@nrc.gov>  
**Date:** Sun, Mar 30, 2003 10:27 PM  
**Subject:** I request a 2.206 on Quad Cities 2.

Mr. William D Travers

Executive Director for Operations

United States Nuclear Regulatory Commission

Washington, DC 20555-0001

March 30, 2003

Dear Mr. Travers:

I request a 2.206 against Quad Cities 2. LER 265/03-001 speaks of a failure to detect and reset the RHR LPCI containment logic due to a 1999 procedural update failure. The corrective action of this problem is grossly inadequate, and further, the characterization of the LER is inadequate.

1. I request that the plant be given six months to fully front panel annunciate all primary containment and RHR silent relays that can prevent the operation of safety equipment without the immediate direct observation of the shift. That energize relay should have been immediately self revealing to the control room.
2. I request an investigation in other Quad Cities safety systems that may have the same the potential of similar issues and if there are generic issues in the industry. Are there other core cooling component relays or circuits that are not announced or discoverable by surveillance?
3. I request an investigation on the region III on if this was properly accessed -and if region III has adequate resources, which to pick up safety problems. Why wasn't this caught by the NRC in the beginning?
4. I request a reevaluation of the effectiveness of the ROP, as we know this plant is in a lot more troubled than what is reflected in your documents and future inspection activities.

WE observe that Quad Cities 2 is a typical very busy Exelon plant; engineering, maintenance and incident, confusion wise. WE think that the plant ROP assessment (4/3) of only future base-line inspections is ridiculous. This assessment seems to be related how the agency distributes limited regulatory resources and not reflective of the

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condition of the plant -with this future NRC focus. WE are very concerned that the relicensing of Quad Cities had -will- severely divert facility services (engineering/maintenance/ budgets) away from the maintenance of safety system and component reliable.

To explain it in terms of understanding; it's like you caught a manager falsifying a document. As far as the initial typical assessment process of this falsification, the first question you would ask in your investigation is if the specific incident is risk significant. Then, if it's not risk significant, it could never be a falsification no matter what the manager did.

I am not implying that there is falsification of documents here. I am saying that the selective and limited tools of quantifying risk doesn't engage the NRC significantly enough in the beginning, in which to turn a facility's and corporation's behavior away from their continued degradation. You and the industry imply that the NRC involvement is always punitive. That speaks volumes to the industry, with them always politicking that the NRC activity is always punitive.

Your application of risk insights has become a corrupt tool that diverts accountability (creates extraordinary benefits) from your elites. This prevents the possibility of early correction until after the multi 100 million dollar accident that threatens the credibility of the whole industry. You protect your elites at the cost of destroying the whole industry, witness Indian Point. Your response to Davis Besse to date has been to protect your elite NRC officials from accountability.

Just what initiates the tipping point -a risk "insignificant" accident that uncovers to the sleeping public, of a prolonged waste pit of negligent generic NRC issues and plant activity that ends up challenging the continued operation of the facility? You elite maniacs need to keep patting your backs and congratulating yourselves about what an extraordinary job you are doing - as you lose credibility to the local politicians and increase the hostility to the local anti's. Don't you get it; these highly educated and paid executives will always define themselves as doing an extraordinary job, surely worthy of a bonus, as the media and politicians lose confidence of your individual plants. They will turn you dwindling jobs and increasing responsibilities into a cesspool of mindless rules, infractions, and internal conflicts, as they continue to have faith in a disproven philosophy, as they make the isolated elite happy. It not a meltdown that you have to worry about it seems.

The more you think about it, just where is there a utility analysis indicating that the NRC's harsh activity had opened eyes at a facility

and saved the utility(s) an enormous amount of money from going down the costly road as Davis Besse, Cook, Indian Point, Millstone, Main Yankee.? You wouldn't expect the NRC themselves to do this type of analysis themselves; the right wing politician's would order the military to bunker bomb the NRC head quarters. There is no evaluation of this type because these guys are a check valve. You know it had occurred many times in the past.

That's what I have been saying across the board. The elites; the CEO'S, the executives, senior management of the NRC, have come up with a vast check valve: business, management, safety and regulatory philosophy. This house of cards is based on the selective collection of facts that justifies beneficial corrupt activity of the elites. Regulatory economic damage from so called over regulation is massively exaggerated by the industry and the NRC. The regulatory economic benefits of the agency on preventing a plant from stepping off the cliff is never counted. I am telling you its Harvard, MIT, Yale, and Keene State (NH) stealing!

Where it does come dam close to falsification though, is in the LER 03-01 F's "previous occurrence" section. I find that Quad Cities response utterly confusing with the inclusion of the vent and fill of an unrelated system (HPCI LER 1-00-007). I can't believe LER 03-02 didn't mention the burnt out light bulb and mysterious dandling wire that obscured an eight month INOP of RHR toward the end in Oct 02. How can anyone connect the dots about the maintenance of core cooling reliability if your engineering and public safety documents don't? I wonder if you are trying to obscure these connections to the public.

My guess is that because you have so many poor maintenance events (pipes, pumps relays and wires), plant transients and component failures, that your analytical ability of these events is inadequate and shallow. This is why you are missing things. The dangling wire of LER 02-05 with the multiple missed opportunities beginning in early March 02 raises extremely poor analytical issues with your ability to prioritize the maintenance request system. Frankly your facility is overwhelmed with management, engineering and operational system preventable issues. The inappropriate prioritizing of LER 02-05 worries me about a large backlog of engineering and maintenance issues.

I say the NRC increased activity is much needed early help. We recognize that Quad Cities is in region III. There are serious issues coming from the NRC itself that Davis Besse region III oversight had resource issues leading to the poor regulatory characterization of Davis Besse prior to their unexpected head degradation. There are legitimate question about if poor oversight is continuing on throughout Region III now. Why can't the NRC keep these guys out of trouble?

Factually at Quad Cities both sides of RHR LPCI were not functional for 20 days, which wasn't mentioned correctly in the LER 03-01. I hope this redundant system unavailability was correctly entered into maintenance program and included in the plant assessment. Generally, because of the silent energized relays in an accident, there would have been a high likelihood that this problem would have remained hidden in the confusion of an accident and this would have limited cooling water to the core. The unavailability of easily available indication for the shift to correctly diagnose the serious degradation of RHR and the ability of this to increase shift turmoil during an accident demand that the utility pay a price, such that the RHR is declared INOP anytime the relay was inappropriately energized.

With LER 003-01, Quad Cities discloses that they created a fault in a procedural update in 1999 that led to this. We have no idea what was the cumulative time since 1999 that the RHR system became INOP after the logic testing. Did other shifts have the injection valves go close, hit the reset buttons without disclosing if the relays were inappropriately energized? Why did some I&C employees seemly depress the reset button not according to procedure and the I&C employee of LER 03-01 correctly follow the procedure leading to the discovery? Do you have procedure adherence problems since 1999? How widespread is it? We have no idea if unit 1 had the same problem and what was their cumulative time that LPCI RHR was unavailable. I request a historic comprehensive Quad City investigation about why this wasn't discovered earlier.

The issue to me is; did catching this finally uncover a long term plant design defect? Is the silent relay modeled in the simulator, training, and the emergency procedures? Relays are notoriously difficult to visually detect if they are energized or not. Did you need relays of a type that are easy to visually detect what state they are in. Are the critical relays as this easily visually differentiated from not so important relays? How come the control room didn't pick this up on rounds? How come the relays aren't a part of the plant computer and alarmed? I find it hard to believe that there was only one injection valve surveillance during the eight months -what happened during those? Does this conform to human factors? Are there other potential silent failures of primary containment and not detectable during surveillances. It looks like you are turning this into a simple human error correctable by ink on a paper, with it actually being a human factors defect needing a design change.

As always, an event like this has to be evaluated with the recent historical record of problems. I include the following for your analysis. I think this indicates that the NRC is in a lot more serious situation than what has been admitted to date. I am astonished that you can't maintain core cooling reliability. I worry that with the rationale of, well we got Core Spray, a kind of risk justification, that the game becomes that you always come to the conclusion that its an isolated

event, and that never look for the big picture until its much to late.

- **ANNUAL ASSESSMENT LETTER February 11, 2003** -Additionally, the staff has identified a substantive cross-cutting issue in the area of human performance involving a number of findings. Examples include the catastrophic failure of the 2B control rod drive pump due to improper setting of a constant level oiler, starting up Unit 2 with the reactor head vent isolation valves open, failure to recognize that the Unit 2 residual heat removal system was inoperable for several months, and inadvertent isolation of the Unit 1 reactor water cleanup system while being used for decay heat removal. Notably, most of the examples occurred during plant outage periods.
  
- **NRC INTEGRATED INSPECTION REPORT 50-254/03-02; 50-265/03-02** excerpts -Identification and Resolution of Problems- Although issues were generally entered into the corrective action process at an appropriate level, there were times when opportunities to identify issues were missed due to a narrow focus. This led to issues either being self-revealing or being identified by outside organizations. Several of these issues resulted in plant shutdowns. Minor issues were generally properly categorized and evaluated. However, there were a number of examples where it appeared that the initial evaluation was limited and narrowly focused. These examples tended to be non-routine and involved multiple organizations and layers of management.
  
- **Extinguished Panel Light:** As discussed in Inspection Report 02-08, the licensee failed to fully understand the significance of an extinguished light during multiple performances of an instrument maintenance surveillance procedure which resulted in the failure to identify the 2B RHR system was inoperable and unable to start automatically for approximately seven months. This condition also would have resulted in water from the 2A RHR system being diverted through the 2B system if an automatic start signal was received while the 2B RHR system was in torus cooling. Although actions were taken to document the extinguished light on the surveillance procedure and in the corrective maintenance process, the rigor applied in trying to understand the significance of the extinguished light was less than adequate since the licensee believed, without verifying, that the light was for indication only and the cause of the light failure was not thoroughly evaluated for potential impact on equipment operability until a different surveillance test failed in October 2002.

I request only a written reply from the NRC unless you have questions.

Sincerely,

mike mulligan

PO Box 161

Hinsdale, NH

16033367179

steamshovel@adelphia.net