

Quad Cities 1

Initiating Events

G**Significance:** Aug 15, 2000

Identified By: NRC

Item Type: FIN Finding

Electrical ring bus caused electrical circuit breakers 1-3 and 3-4 to open.

On July 18 a fault on one of the offsite power feeds to the Quad Cities electrical ring bus caused electrical circuit breakers 1-3 and 3-4 to open. This action isolated the fault and resulted in a Unit 2 turbine generator and reactor trip. The response by the switchyard resulted in a loss of power on the Unit 1 reserve auxiliary transformer. The response to the reactor scram on Unit 2 was as designed. Operator performance during this event was determined to have been acceptable. The inspectors reviewed the risk significance of this initiating event for both units using the Significance Determination Process. All mitigating equipment was available for Unit 2 following the uncomplicated trip, and this event was screened as having very low risk significance (GREEN.) One of two auxiliary transformers for Unit 1 was de-energized during the event, but the unit did not trip and all mitigating equipment was available. Therefore, this event was also screened as GREEN for Unit 1.

Inspection Report# : [2000011\(pdf\)](#)G**Significance:** Dec 29, 2001

Identified By: NRC

Item Type: FIN Finding

DEGRADED AND INADEQUATELY TESTED TRANSFORMER AND PROTECTIVE RELAYING RESULTS IN INCREASE IN TRANSIENT AND LOSS OF OFFSITE POWER INITIATING EVENT FREQUENCIES

On August 2, 2001, Unit 2 experienced a transformer failure, reactor scram, and loss of offsite power. The inspectors determined that a lightning strike in conjunction with age related degradation and inadequate testing of the Unit 2 main power transformer and switchyard protective relaying contributed to the event and resulted in an increase in the initiating event frequency for plant transients and a loss of offsite power. The inspectors determined the risk significance of this issue to be very low since all remaining mitigating systems were available to mitigate the transformer rupture, reactor scram, and loss of offsite power.

Inspection Report# : [2001017\(pdf\)](#)G**Significance:** Feb 29, 2000

Identified By: NRC

Item Type: FIN Finding

Ice Melt Valve Failure

Failure of the ice melt valve on January 22, 2000, resulted in some ice formation in the intake area. Operator detection and compensatory measures prevented the ice from affecting the water level in the intake. The valve gate had become detached from the stem. The failure of the ice melt valve was of very low risk significance because it did not result in an increased initiating event frequency for loss of both normal and ultimate heat sinks. The inspectors compared an estimated valve failure rate to the licensee's evaluation. The licensee's evaluation excluded this initiating event from the probabilistic risk assessment because no precursor event had occurred in the history of the station.

Inspection Report# : [2000001\(pdf\)](#)G**Significance:** Jul 20, 1999

Identified By: NRC

Item Type: FIN Finding

a 3-inch increase in reactor water level

On Unit 2, a 3-inch increase in reactor water level occurred and required operators to take manual control of the system. Various failures in the level control systems have resulted in about ten similar events since January 1, 1999, in which operators were required to intervene to prevent level transients that could have resulted in a reactor trip. Since the plant effect of the failures is limited to an uncomplicated reactor trip, the failures were considered to be of low risk significance using the significance determination process (Section 1R03).

Inspection Report# : [1999011\(pdf\)](#)

Mitigating Systems

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Significance: May 16, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to meet requirement of 10 CFR 50.59.

On June 15, 2000, station personnel removed two of the three rainbow pumps from the site. Quad Cities Updated Final Safety Analysis Report, Section 9.2.5, specifies that portable pumps (called rainbow pumps) of sufficient capacity (5100 gallons per minute) are onsite to provide makeup water to the ultimate heat sink in the event of a Lock and Dam 14 failure on the Mississippi River. The inspectors determined that the licensee had made a change to the facility as described in the Quad Cities Updated Final Safety Analysis Report without first determining if the change required a license amendment, contrary to the requirements of 10 CFR 50.59. The failure to meet the requirements of 10 CFR 50.59 was considered a Non-Cited Violation. The risk significance of this event was determined to be very low due to the very small initiating event frequency of the lock and dam failure, the slow rate of event progression once the initiating event occurs, and the availability of other onsite sources of water not credited in the event analysis.

Inspection Report# : [2001008\(pdf\)](#)

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Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Surveillance testing involving timing of the Unit 1 and Unit 2 emergency diesel generators shortly after the engines had been shut down from previous runs

Inspectors identified that on two occasions, March 9 and March 27, the licensee performed technical specification required surveillance testing involving timing of the Unit 1 and Unit 2 emergency diesel generators shortly after the engines had been shut down from previous runs. Station procedures were inadequate in prescribing the conditions for performance of the tests. Procedures did not prevent preconditioning of the air start systems, fuel systems, and other engine and electrical components. Inadequate procedures for testing was considered a Non-Cited Violation of 10 CFR Appendix B, Criterion V, "Instruction Procedures and Drawings." The risk significance was very low (Green) because inspectors determined that testing practices had not led to declining performance of the diesel generators (Section 1R22).

Inspection Report# : [2001005\(pdf\)](#)

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Significance: Dec 15, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Seal Tops of Electrical Cabinets

The team identified that electrical cabinets in the auxiliary electric equipment room were not sealed at the top to protect equipment from water damage. The failure to seal the top of the cabinets was considered a Non-Cited Violation (NCV 50-254/00-16-01; NCV 50-265/00-16-01) of Operating Licenses DPR-29 and DPR-30, Section h.3.F (Section 1R05.2.b.1). The failure to seal the cabinets, a fire protection feature, involved very low risk (Green) because a fire protection defense-in-depth element, as described by MC 0609, Appendix F, Fire Protection Significance Determination Process, was not affected.

Inspection Report# : [2000016\(pdf\)](#)

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Significance: Dec 15, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Fire Stops in Cable Trays

The team identified that fire stops were not installed in divisional cable trays for which specified separation had not been maintained. The failure to install fire stops was considered a Non-Cited Violation (NCV 50-254/00-16-02; NCV 50-265/00-16-02) of Operating Licenses DPR-29 and DPR-30, Section H.3.F (Section 1R05.2.b.2). The failure to install fire stops, a fire protection feature, involved very low risk (Green) because a fire protection defense-in-depth element, as described by MC 0609, Appendix F, Fire Protection Significance Determination Process, was not affected.

Inspection Report# : [2000016\(pdf\)](#)

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Significance: Nov 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Surveillance testing for torus temperature instrumentation components required by Technical Specification 4.2.F.1 had not been performed since installation in 1990 and 1991.

On October 4, 2000, the licensee identified that surveillance testing for torus temperature instrumentation components required by Technical Specification 4.2.F.1 had not been performed since installation in 1990 and 1991. Condition Report Q2000-03512 was written to address the issue. Failure to perform testing of the instrumentation was considered a Non-Cited Violation of Technical Specification 4.2.F.1 (Section 40A3). Failure to check instrument accuracy by this 18-month surveillance for Unit 1 and Unit 2 involved very low risk because when the surveillance was subsequently performed, instrument accuracy of the temperature indication loop was within acceptable tolerance.

Inspection Report# : [2000015\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

Inadequate operability documentation forms for Problem Identification Form Q2000-2372, regarding a design deficiency for Units 1 and 2 high pressure coolant injection motor speed changers

The inspectors found that the July 3 and August 23, 2000 supporting operability documentation forms for Problem Identification Form Q2000-2372, regarding a design deficiency for Units 1 and 2 high pressure coolant injection motor speed changers, did not adequately support the operability of the system. Inspectors reviewed the risk significance of the motor speed changer being inoperable and found the risk to be very low (GREEN) since the change to core damage frequency was less than E-6/year. In addition, operators were briefed on the potential problems with the system, and the licensee installed design changes to correct the problem on both units (Section 1R15).

Inspection Report# : [2000014\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to implement modifications to correct a previously identified design deficiency which could have made the motor speed changer inoperable in accident situations

Inspectors found that the licensee failed to implement modifications to correct a previously identified design deficiency which could have made the motor speed changer inoperable in accident situations. The failure to implement corrective actions for this condition was a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." This violation is being treated as a Non-Cited Violation (50-254/00-14-02; 50-265/00-14-02), consistent with Section VI.A.1 of the May 1, 2000, Enforcement Policy. The inspectors found that the risk significance for internal and external events was very low (GREEN) since unavailability of the high pressure coolant injection system resulted in a change to core damage frequency of less than E-6/year. The licensee implemented modifications on both units to correct the design deficiency (Section 1R15).

Inspection Report# : [2000014\(pdf\)](#)

Significance: N/A Sep 15, 2000

Identified By: NRC

Item Type: FIN Finding

Unit 1 high pressure coolant injection unavailability

The Unit 1 high pressure coolant injection unavailability resulted from a failure of the auxiliary oil pump to remain on during a start of the system, which was discovered on March 21, 2000. The licensee determined that the primary root cause was "inadequate operating margin" between the system header pressure which was controlled by a pressure regulating valve, and the trip setpoint for pressure switch PS-4, which automatically turned the pump off. Contributing causes included by the licensee were: a. leakage through the 1-2399-43 check valve in the high pressure coolant injection oil system, b. variance in control oil header pressures at different locations in the control oil header, and c. emergency oil pump auto-starts which occurred during auxiliary oil pump startups. Licensee corrective actions included checking and adjusting the setpoints for auxiliary oil system operation, and requiring quarterly testing. Corrective actions also included test changes and installation of test instrumentation to ensure proper system pressure until a modification could be performed which would prevent the auxiliary oil pump from tripping off during initial system startup. Design Changes 9900079 and 9900080 incorporated the modification and were scheduled to be completed for both units by the end of October 2000. The inspectors considered the licensee's root cause investigation and proposed corrective actions adequate to correct the problem with the auxiliary oil pump cycling. Once all corrective actions are completed for both units, the YELLOW performance indicator associated with Unit 1 high pressure coolant injection unavailability will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in Inspection Manual Chapter 0305 "Operating Reactor Assessment Program" and appropriate performance indicator guidelines. However, some weaknesses were noted in the licensee's actions regarding contributing causes and extent of condition. The root cause evaluation for the March 21, 2000, high pressure coolant injection auxiliary oil pump cycling failed to address previous poor corrective actions as a contributing cause to the event. The inspectors also found that the extent of condition reviews performed by the licensee, while thorough in some areas, were weak in others. Weak areas included: setpoint operating margin on the reactor core isolation cooling system, depth of the extent of condition review for some components, and failure to recognize some previously identified system design problems such as missing seal-in logic for the high pressure coolant injection system. However, the inspectors considered the overall assessment to be acceptable. Licensee efforts to correct these issues will be reviewed during the problem identification and resolution inspection in August 2001.

Inspection Report# : [2000013\(pdf\)](#)

Significance: N/A Sep 15, 2000

Identified By: NRC

Item Type: FIN Finding

WHITE Performance Indicators for Units 1 and 2 Safety System Functional Failures

The licensee's August 14, 2000, root cause report for the high number of safety system functional failures on both units listed three root causes: inadequate knowledge of complex systems, a system vice functional focus, and inadequate integration of the new NRC inspection program into the station's processes. Corrective actions listed by the licensee included: Maintenance department clarification of expectations for troubleshooting, Engineering department revision of a troubleshooting procedure to require formal troubleshooting plans, Regulatory Affairs requirement for root cause evaluation of any performance indicator which is "threatened" (less than 50 percent margin to the WHITE threshold), Regulatory Affairs requirement for root cause evaluations to include a section on cumulative effects of the system failure on a "threatened" performance indicator, Regulatory Assurance modification of corrective action program to implement root cause requirements for a "threatened" performance indicator, Plant Health Committee requirement for monthly review of performance indicators, development or revision of process to address a cumulative focus on NRC Mitigating Systems Cornerstone and functional health, Engineering action to expand use of formal troubleshooting techniques and enhance troubleshooting skills and troubleshooting procedure. The inspectors found no current concerns with the individual root cause reports for these issues. Inspectors validated the licensee assertion that poor troubleshooting and poor root causes were an issue at Quad Cities. Two of the ten events from the individual root cause evaluations were repeats of earlier events, and the root cause efforts were not effective initially. Inspectors found weaknesses in the overall root cause report for the multiple safety system functional failures as follows: • The overall root cause evaluation failed to incorporate one of two February 2000 events. Human performance events did not get full coverage in the overall root cause, some events for the safety system functional failures involving human performance were not included. • The evaluation was focused on problems which would cause an NRC performance indicator change, and to a lesser amount on why such a large number of failures were occurring at Quad Cities. The report listed actions to review another method for trending cumulative impact of failures, but another method was not ready for review at the end of the inspection. The inspectors determined that the licensee's search for similar failures focused on the recently instituted category of "performance indicator" and thereby eliminated a number of previous safety system functional failures that occurred in 1997 and 1998. • The corrective action for troubleshooting failed to incorporate the operations department, and only focused on maintenance and engineering. Although the licensee did not entirely agree with all of the weaknesses identified by the inspectors, nevertheless, the licensee revised several of the root cause evaluations to ensure appropriate actions were developed to address the inspector's concerns.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Sep 15, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

One corrective action problem was found on August 16, 2000, and involved a previously identified design deficiency with the high pressure coolant injection system

One corrective action problem was found on August 16, 2000, and involved a previously identified design deficiency with the high pressure coolant injection system. Problem Identification Form Q1997-04485 documented that the auto initiation signal for high pressure coolant injection did not electrically seal in as described in the updated final safety analysis. However, the tracking item for correcting this problem was closed without corrective action being completed. Condition Report Q2000-02954 was written to again track corrective actions to this problem. This was considered a Non-Cited Violation (NCV) of Criterion XVI, "Corrective Action," of 10 CFR 50, Appendix B. Inspectors considered this problem to be of very low risk significance (GREEN) since it would not have prevented the system from starting automatically or being initiated manually.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Aug 15, 2000

Identified By: NRC

Item Type: FIN Finding

Contribution of fire risk to core damage frequency associated with the safe shutdown makeup pump discharge valve being in a degraded condition.

On July 19 during a regulatory conference, the licensee discussed the contribution of fire risk to core damage frequency associated with the safe shutdown makeup pump discharge valve being in a degraded condition. Based on the information presented during the conference, the NRC concluded that this condition was of very low safety significance due to the short duration (2 days) the condition existed.

Inspection Report# : [2000011\(pdf\)](#)



Significance: Aug 15, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of 50.59 for stripping of 125 Vdc loads.

The inspectors found that the 10 CFR 50.59 safety evaluations for procedure changes which required load stripping of the 125 and 250 Vdc busses under certain circumstances were not sufficient to justify that an unreviewed safety question did not exist. The inspectors identified the procedure inadequacies on March 16, 2000. The procedure changes involving stripping loads could have removed important loads from service during certain accident scenarios or could have affected system performance due to operator errors. By August 15, 2000, a new safety evaluation for these procedures had not been approved. These were considered as two non-cited violations of 10 CFR 50.59. Inspectors evaluated the risk associated with these procedure changes using the Significance Determination Process and found them to be of very low risk significance due to the low initiating event frequency.

Inspection Report# : [2000011\(pdf\)](#)

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Significance: Aug 15, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of 50.59 for stripping of 250 Vdc loads.

The inspectors found that the 10 CFR 50.59 safety evaluations for procedure changes which required load stripping of the 125 and 250 Vdc busses under certain circumstances were not sufficient to justify that an unreviewed safety question did not exist. The inspectors identified the procedure inadequacies on March 16, 2000. The procedure changes involving stripping loads could have removed important loads from service during certain accident scenarios or could have affected system performance due to operator errors. By August 15, 2000, a new safety evaluation for these procedures had not been approved. These were considered as two non-cited violations of 10 CFR 50.59. Inspectors evaluated the risk associated with these procedure changes using the Significance Determination Process and found them to be of very low risk significance due to the low initiating event frequency.

Inspection Report# : [2000011\(pdf\)](#)

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Significance: Feb 01, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately address the erosion of the RHRSW room coolers' supply piping

Green. The inspectors identified a failure to promptly identify and correct conditions adverse to quality involving the erosion of safety-related residual heat removal service water piping. The licensee's corrective actions for the piping leak included replacing the affected piping and performing ultrasonic testing on similar piping for the other trains. During this inspection, NRC inspectors identified that the corrective actions were inadequate in that the ultrasonic testing was not able to examine the area of the piping affected by the erosion as evidenced by the subsequent failure. This finding was determined to be of very low safety significance because the equipment was still capable of performing its intended safety function. A Non-Cited Violation of 10CFR 50 Appendix B, Criterion XVI was identified.

Inspection Report# : [2001015\(pdf\)](#)**Significance:** N/A Nov 15, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW OPERATOR REQUALIFICATION PROGRAM PROCEDURAL REQUIREMENTS

No color. The inspectors identified a Non-Cited Violation wherein the facility licensee had failed to follow procedural requirements to evaluate a senior reactor operator (SRO) licensed individual in an SRO licensed position during the year 2001 annual licensed operator requalification examination (10 CFR 55.59). The finding was of very low safety significance because the SRO licensed individual held an "inactive" SRO license (i.e., would not be assigned to licensed duties unless his license was restored to an active status in accordance with 10 CFR 55.53).

Inspection Report# : [2001016\(pdf\)](#)

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Significance: Nov 15, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET 10 CFR 50.65 REQUIREMENTS

On October 24, 2001, the inspectors determined that the licensee failed to count Unit 1 and Unit 2 battery room ventilation system air handling unit drive belt failures as maintenance preventable functional failures and repeat maintenance preventable functional failures where appropriate. The licensee's incorrect assessment of these equipment failures resulted in a failure to develop and implement appropriate action plans for the battery room ventilation systems on Units 1 and 2, assess the Unit 2 battery room ventilation system for (a)(1)classification, and monitor the performance of the systems against licensee-established goals. The failure to properly implement maintenance rule requirements was considered a Non-Cited Violation of 10 CFR 50.65. The risk significance of the issue was determined to be of very low safety significance because the batteries supported by the battery room ventilation systems did not experience an actual loss of safety function.

Inspection Report# : [2001016\(pdf\)](#)

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Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO VERIFY ADEQUATE FILL OF THE HIGH PRESSURE COOLANT INJECTION SYSTEM AS REQUIRED BY TECHNICAL SPECIFICATIONS

On December 27, 2000, the licensee discovered that the high pressure coolant injection system was not filled with water from the pump discharge valve to the system isolation valve following maintenance activities. Technical Specification Surveillance Requirement 4.5.A.1.a.1 required the licensee to verify that the high pressure coolant injection system was filled with water every 31 days. The inspectors determined that greater than 31 days had elapsed since the licensee had verified that the high pressure coolant injection system was properly filled. The failure to perform the

surveillance requirement within 31 days also resulted in the high pressure coolant injection system being inoperable for greater than the Technical Specification 3.5.A.3.a.3 allowed outage time of 14 days. The failure to meet the requirements of Technical Specification 3.5.A.3.a.3 and Surveillance Requirement 4.5.A.1.a.1 was considered a Non-Cited Violation. The risk significance of this event was determined to be very low since all remaining mitigation systems were available to provide water to the reactor during an event.

Inspection Report# : [2001014\(pdf\)](#)



Significance: Jun 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

1992 modification failed to implement procedure changes

On June 27, 2000, inspectors found that licensee implementation of a 1992 modification failed to implement procedure changes for the high pressure coolant injection system. This was considered an NCV of 10 CFR Part 50, Appendix B, "Design Control." Risk was considered very low since the information missing from the procedure should not have prevented operators from accomplishing key steps in the procedure (Section 1R04).

Inspection Report# : [2000007\(pdf\)](#)



Significance: Jun 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

Remove the Unit 1 emergency diesel generator from service for maintenance and testing, but failed to comply with a Technical Specification action

On May 23, the licensee removed the Unit 1 emergency diesel generator from service for maintenance and testing, but failed to comply with a Technical Specification action within the time requirement. Operator failure to comply with the Technical Specifications was considered an NCV. This issue was of very low safety significance since the surveillance was later completed satisfactorily (Section 1R22.1).

Inspection Report# : [2000007\(pdf\)](#)



Significance: Jun 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

control room operators failed to close two drain valves during a pre-start check of the Unit 1 high pressure coolant injection system.

On June 14, control room operators failed to close two drain valves during a pre-start check of the Unit 1 high pressure coolant injection system. The room filled with steam which caused low level contamination of the room and resulted in operators isolating the system. Failure to close the valves in accordance with the procedure was considered an NCV of Technical Specifications. The inspectors considered the Unit 1 high pressure coolant injection system to have been available in this condition since the drain valves were designed to automatically close during an automatic system start signal. Since all other mitigating systems were available at the time, this issue was considered to be of very low risk significance (Section 1R22.2).

Inspection Report# : [2000007\(pdf\)](#)

Significance: N/A May 16, 2000

Identified By: NRC

Item Type: FIN Finding

Surveillance Testing

During logic testing on March 21, 2000, the Unit 1 high pressure coolant injection auxiliary oil pump failed to properly operate. This condition rendered the system inoperable for automatic initiation for approximately one year. The risk from internal events for this condition was determined to be very low (GREEN) in Inspection Report 50-254/2000003; 50-265/2000003. The effect on risk due to external events, specifically fires, was determined to be potentially significant during a preliminary Significance Determination Process review. However, this issue was also the substantial contributor to a YELLOW high pressure coolant injection unavailability performance indicator, which represents performance that minimally reduces safety margin and requires NRC oversight. Therefore, the NRC considers the inspection findings and the performance indicator to be a single issue and agency action will be determined based on application of the Action Matrix for the YELLOW performance indicator.

Inspection Report# : [2000005\(pdf\)](#)



Significance: May 16, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Operability Evaluations

The licensee discovered that maintenance technicians had installed unqualified parts in the Unit 1 average power range monitoring system on January 12, 2000. Subsequent to the installation, operators placed the average power range monitor into service, as an input to the reactor

protection system. This was considered a non-cited violation (NCV) of 10 CFR 50, Appendix B requirements. The risk significance of this issue was determined to be very low because other average power range monitors could have provided redundant reactor protection system signals, if needed.

Inspection Report# : [2000005\(pdf\)](#)

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Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

March 21, 2000, the Unit 1 high pressure coolant injection auxiliary oil pump failed to properly operate

During logic testing on March 21, 2000, the Unit 1 high pressure coolant injection auxiliary oil pump failed to properly operate. This condition rendered the system inoperable for automatic initiation from approximately April 30, 1999, until March 21, 2000. Inspectors determined that sufficient information was not available in the operability evaluation to conclude that the system was operable following the March 21 maintenance. After reviewing supplemental information gathered and provided by the licensee upon inspector request, the inspectors determined that adequate justification was available to consider the system operable. Inspectors used Phase 2 of the Significance Determination Process for internal events, and found the risk of high pressure coolant injection being inoperable for automatic starts for approximately 1 year was very low. However the risk due to external events, specifically fires, was still being evaluated at the end of the period (Section 1R15).

Inspection Report# : [2000003\(pdf\)](#)

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Significance: Feb 29, 2000

Identified By: NRC

Item Type: FIN Finding

Safe Shutdown Makeup Pump Valve Failure

On January 19, 2000, during planned maintenance activities, maintenance workers determined that the safe shutdown makeup pump system was inoperable due to a Unit 2 safe shutdown makeup pump injection valve failure to operate. The valve failure was evaluated using the Significance Determination Process and was found to be of very low risk significance because all other mitigating systems were available.

Inspection Report# : [2000001\(pdf\)](#)

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Significance: Feb 29, 2000

Identified By: NRC

Item Type: FIN Finding

Unit 2 Automatic Depressurization System Valves Taken Out-Of-Service in Mode 3

On January 22, 2000, operators did not recognize entry into a Technical Specification action statement when relief valves were removed from service with the reactor in Mode 3. Upon discovery, about 4-1/2 hours later, the valves were returned to service. The Technical Specification action statement was not exceeded. The unavailability of the relief valves was evaluated by the NRC's Senior Reactor Analyst as part of the Significance Determination Process for shutdown issues. This issue was determined to be of very low risk significance because the reactor was in hot shutdown with vessel pressure at approximately 50 psig.

Inspection Report# : [2000001\(pdf\)](#)

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Significance: Jan 19, 2000

Identified By: NRC

Item Type: FIN Finding

Corrective Action Deficiencies Related to Heaters in the Contaminated Condensate Storage Tanks Allowed Degradation of the Heaters

The inspectors found that corrective action deficiencies related to heaters in the contaminated condensate storage tanks allowed degradation of the heaters to the extent that high pressure injection systems could have been adversely affected. The risk significance for the loss of heaters in the contaminated condensate storage tanks was low, partially because both units were shut down during times when the high pressure injection sources could have been rendered inoperable due to lack of sufficient tank heating.

Inspection Report# : [1999025\(pdf\)](#)

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Significance: Jan 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Contaminated Condensate Storage Tank Heaters Inoperable

The inspectors found that design control deficiencies related to heaters in the contaminated condensate storage tanks allowed degradation of the heaters to the extent that high pressure injection systems could have been adversely affected. Modifications to the system did not evaluate the facility change as required by 10 CFR 50.59. This was considered to be a non-cited violation of 10 CFR 50.59. This issue was first documented by

the licensee in August 1999 and addressed in Inspection Report 50-254/99020; 50-265/99020. The risk significance for the loss of heaters in the contaminated condensate storage tanks was low, partially because both units were shut down during times when the high pressure injection sources could have been rendered inoperable due to lack of sufficient tank heating.

Inspection Report# : [1999025\(pdf\)](#)

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Significance: Dec 03, 1999

Identified By: NRC

Item Type: FIN Finding

Corrective Actions for a Design Control Problem with Software Backups were not Timely or Complete

The inspectors found that two failures of a high pressure coolant injection valve to close in September and October 1999 were not properly classified in the maintenance rule program. Licensee engineers initially failed to consider the second failure of the 1-2301-5 valve to close on October 4, 1999, as a repetitive maintenance preventable functional failure, and failed to monitor the system under (a)(1) of the maintenance rule. This is considered an unresolved item. The valve failure was found to be of low risk significance because the inboard isolation valve was available.

Inspection Report# : [1999023\(pdf\)](#)

G

Significance: Nov 19, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure ADS Valves Qualified for Minimum Possible Voltage

Four of the five Unit 1 automatic depressurization system relief valves were not initially qualified for the degraded voltage conditions that would be seen under accident conditions. The licensee had not originally accounted for the voltage drop that would occur between the station batteries and the valve solenoids when specifying the minimum voltage for which the valves needed to be qualified. The licensee subsequently identified a test report, done for another nuclear station, which qualified the valves to a lower voltage. The inspectors, in conjunction with the Office of Nuclear Reactor Regulations, reviewed the test and accepted it under condition that a ten volt penalty be applied to account for some test deficiencies. The licensee also performed calculations to show that the actual available voltage to the valves, under degraded conditions, was above the accepted minimum voltage. A non-cited violation was identified.

Inspection Report# : [1999021\(pdf\)](#)

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Significance: Oct 20, 1999

Identified By: NRC

Item Type: FIN Finding

The high pressure coolant injection system outboard steam isolation valve failed to close on October 4, 1999, for the third time in 1 year.

The Unit 1 high pressure coolant injection system outboard steam isolation valve failed to close on October 4, 1999, for the third time in 1 year. The three failures indicated poor corrective action to address problems with the valve, including poor root cause efforts, cancellation of a work request without action taken, and disruption of "as-found" evidence which prevented further root cause efforts. The risk significance of this problem was low because the inboard isolation valve was available to close if called upon to mitigate the consequences of a line break (Section 1R03).

Inspection Report# : [1999020\(pdf\)](#)

G

Significance: Oct 20, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Correct Control Room Emergency Ventilation System Deficiency

The inspectors identified two examples of inadequate corrective action regarding the Units 1 and 2 safety-related control room emergency ventilation system. In 1995 the licensee identified emergency diesel generator overloading concerns and degraded voltage concerns. This degraded and nonconforming condition was not corrected, and the design basis for the emergency diesel generator system and control room emergency ventilation system were not changed to reflect the condition. Also, safety-related electrical drawing discrepancies with the control room emergency ventilation system were identified in 1997 and never corrected. A non-cited violation for 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action" with two examples was identified. In utilizing the Significance Determination Process, this issue was determined to have low risk significance because control room habitability was assumed to be maintained for the 1 hour to start control room cooling and, therefore, there was no impact on the ability of control room operators to operate the required mitigating systems. Also, the design basis event was estimated to have a very low initiating event frequency (Section 1R16).

Inspection Report# : [1999020\(pdf\)](#)

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Significance: Sep 08, 1999

Identified By: NRC

Item Type: FIN Finding

Motor-operated valve dynamic testing

During motor-operated valve dynamic testing on August 4, 1999, the Unit 1 residual heat removal cross-tie valve (19A) failed to fully close. However, approximately one month after the failure occurred, the licensee's corrective action program did not include a plan to determine the cause of the failure or to address any potential generic considerations for other valves (Section 1R22.1). No safety functions were affected and no risk increase resulted from this particular valve failure.

Inspection Report# : [1999018\(pdf\)](#)

Significance: N/A Sep 08, 1999

Identified By: NRC

Item Type: FIN Finding

Removal of a high pressure injection pump in parallel with testing on an emergency diesel generator

On two occasions, the licensee's work authorization process allowed removal of a high pressure injection pump in parallel with testing on an emergency diesel generator. The inspectors identified that on one occasion, planned conditional core damage probability was increased to greater than that allowed by licensee administrative procedures. The actual risk was lower because the licensee did not perform the work on both systems together. The significance of this finding was not assessed by the significance determination process due to the instantaneous risk involved and the fact that the work was not performed as planned following NRC discussions with plant management (Section 1R13).

Inspection Report# : [1999018\(pdf\)](#)

G

Significance: G Sep 03, 1999

Identified By: NRC

Item Type: FIN Finding

Copy of post-modification test not retained

The inspectors identified that the Unit 1 post modification test for a design change package on the fuel transfer pump was not retained by the licensee. This item had very low risk significance. The licensee had retained the Unit 2 test and had signature evidence that the Unit 1 test was performed.

Inspection Report# : [1999017\(pdf\)](#)

G

Significance: G Jul 20, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Corrective Action for Flooding Procedures.

Corrective actions were not implemented for an inadequate flood protection procedure originally identified by the licensee in 1997. The procedures did not provide adequate instructions to protect the plant structurally under the forces of severe flood waters. This issue was inappropriately closed in the corrective action program without resolution. This was a non-cited violation for inadequate corrective action. A qualitative risk assessment of the impact of the procedure deficiencies concluded that the issues were of low risk significance since adequate time would be available to make procedure changes and take action during a flooding event. (Section 1R06).

Inspection Report# : [1999011\(pdf\)](#)

G

Significance: G Jul 16, 1999

Identified By: NRC

Item Type: FIN Finding

Corrective actions to address a Unit 1 emergency diesel generator failure

Corrective actions to address a January 1998 Unit 1 emergency diesel generator (EDG) failure to start were postponed in some cases and in others only partially completed. (Reference Report Section 4OA1.3, page 5) This item was categorized by the significance determination process as being of low risk significance based on occasional EDG start failures, redundant EDGs and available off site power.

Inspection Report# : [1999012\(pdf\)](#)

G

Significance: G Jul 16, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Excessive thrust conditions, found during testing of motor operated valves

Excessive thrust conditions, found during testing of motor operated valves (MOVs) from March 1997 through July 2, 1999, were not identified to management and did not receive appropriate corrective action to preclude recurrence. As a result, the cause of the problem was not identified and appropriate corrective action was not taken. This is a non-cited violation. This item was categorized by the significance determination process as being of low risk significance. (Reference Report Section 4OA1.4) Since nine of the ten valves found outside the acceptable thrust windows functioned as required during testing, the issue was determined to be of low risk significance and was categorized as "Green."

Inspection Report# : [1999012\(pdf\)](#)



Significance: Jul 15, 1999

Identified By: NRC

Item Type: FIN Finding

The surveillance procedure for evaluating thermal performance of the residual heat removal heat exchangers

The surveillance procedure for evaluating thermal performance of the residual heat removal heat exchangers contained errors which resulted in the licensee overestimating the heat removal capability of the 1A heat exchanger. This item had very low risk significance, since the heat exchanger was still capable of removing its design heat load.

Inspection Report# : [1999014\(pdf\)](#)



Significance: Jul 15, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Three Examples of Design Control Relating to Original Plant Design

A non-cited design control violation with multiple examples was identified during close out of two unresolved items from the architect-engineer inspection (50-254/265-98201). The issues dealt with ensuring adequate net positive suction head for the emergency core cooling system pumps, ensuring the residual heat removal service water piping was analyzed for its design condition, and determining the adequacy of a thermal relief valve. All the examples in the Non-Cited Violation resulted from original design deficiencies. The licensee's analyses showed that the pumps were operable. Therefore, this issue screened out of the significance determination process as having very low risk significance

Inspection Report# : [1999014\(pdf\)](#)

Barrier Integrity



Significance: Nov 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Three examples of failure to follow procedures.

On November 3, 2000, the 1B channel of the reactor protective system flow biased neutron flux trip was found to be inoperable during reactor startup from the Unit 1 refueling outage 16. The licensee determined that poor wiring practices, poor second verification practices, and inadequate post maintenance testing of nuclear instrumentation wiring led to the malfunction. Maintenance workers failed to follow the wiring requirements in the work request, did not use lift and land sheets when removing and re-terminating the wires, and failed to label the wires which were lifted during the maintenance activity. Failure to follow the procedure (work request) for wiring was considered an example of a Non-Cited Violation. The risk significance of this event was very low because of the short amount of time that the unit was in Mode 1, because the "A" channel of flow biased trip setpoints was still operable, and because the wiring error actually caused the flow biased neutron flux trip to be more conservative (Example A). On October 14, 2000, during disassembly of the Unit 1 reactor for refueling outage 16, reactor service technicians opened a flanged connection of the reactor head vent piping with approximately 5 to 8 psig steam pressure still in the reactor vessel and initiated a steam release to the refueling floor area which lasted for several hours. Numerous procedural, process, and communication problems contributed to the event. Personnel safety, procedure adherence, procedure adequacy, and lack of control of reactor vessel disassembly activities were all concerns brought out by this event. The failure to follow procedures during vessel disassembly was considered an example of a Non-Cited Violation. The risk significance was evaluated as very low because the amount of reactor vessel inventory released to secondary containment was very low, and secondary containment integrity requirements were met (Example B). On October 22, 2000, workers attempting to replace a local power range monitor inadvertently lifted the local power range monitor tube off its seat in the reactor vessel bottom head. This caused highly contaminated radioactive water from the bottom of the reactor vessel to drain directly onto the workers. The draining stopped immediately after the local power range monitor tube was released and resealed back into the vessel. One worker was contaminated such that a meter held to his body read 5 rem per hour on contact. Extraordinary actions by radiation protection workers resulted in the removal of the majority of the highly contaminated material quickly, such that the overall external shallow dose equivalent for the individual was estimated at 2.784 rem, and the internal dose received by the worker was estimated at 45 millirem. Problems involved in this event included workers not adhering to the instructions by radiation protection technicians, workers not having procedures with them and performing steps of two different procedures concurrently, and workers not informing operators or radiation protection technicians that they were taking actions that could allow water to be drained from the reactor vessel. In addition, the procedures were not adequate to control the work. The failure to follow procedures during local power range monitor replacement was considered an example of a Non-Cited Violation. The safety significance of this event was very low because sufficient makeup capacity to fill the vessel was available even if the local power range monitor failed to reseal, the local power range monitor tube was reseated quickly and the reactor vessel drainage stopped, and the contamination was mostly external and was removed quickly (Example C).

Inspection Report# : [2000015\(pdf\)](#)

G

Significance: Nov 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate procedures for vessel disassembly and local power range monitor replacement.

Inadequate procedure for vessel disassembly. The risk significance was evaluated as very low (GREEN) because the amount of reactor vessel inventory released to secondary containment was very low, and secondary containment integrity requirements were met (Example A). Inadequate procedure for local power range monitor replacement. The safety significance of this event was very low (GREEN) because sufficient makeup capacity to fill the vessel was available even if the local power range monitor failed to reseal, the local power range monitor tube was resealed quickly and the reactor vessel drainage stopped, and the contamination was mostly external and was removed quickly (Example B).

Inspection Report# : [2000015\(pdf\)](#)

G

Significance: Jun 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Corrective Action for Delinquent ASME Code Work Packages

The inspectors identified a failure of the corrective action program where ASME Code Class 1, 2 and 3 Replacement and Repair program requirements for work package reviews were not met. On four occasions the licensee did not realize that the Code work packages were not meeting 10 CFR 50.55a ASME Code requirements. In each case, corrective actions were not taken to correct the situation. Failure to promptly identify and correct the failure to meet ASME code requirements for work packages was considered a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI. The safety significance of this issue was considered very low based on the absence of adverse consequences and the fact that no technical problems were identified.

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Jan 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Overthrust of Motor-Operated Valve 2-1001-34A

During surveillance testing on December 12, 1999, residual heat removal torus spray/test return valve 2-1001-34A closed with 116,831 pounds of thrust which was almost double the previous as-left thrust setting of the valve. This value also exceeded the seismic thrust limit for the valve. Corrective actions recommended to determine extent of condition after failure of a similar valve in 1998 were not taken. This was considered to be a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI. The excessive thrust problem was considered to have low risk significance because the valve remained operable.

Inspection Report# : [1999025\(pdf\)](#)

G

Significance: Jan 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Maintenance Rule repetitive failure

High pressure coolant injection system steam supply valve (1-2301-5) failures on September 20, 1999, and October 4, 1999, were not properly classified as repetitive functional failures under the maintenance rule program. As a result, the system was not adequately monitored under 10 CFR 50.65(a)(1). This was considered to be a non-cited violation of 10 CFR 50.65. These equipment failures were considered to have low risk significance using the Significance Determination Process because the redundant containment isolation valve was fully functional.

Inspection Report# : [1999025\(pdf\)](#)

G

Significance: Sep 08, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to promptly correct a design deficiency with the standby gas treatment system.

The licensee discovered during surveillance testing on August 23, 1999, that both standby gas treatment trains may not have functioned as designed during a postulated loss of Bus 19. The item had been previously identified in 1992 but not adequately corrected. No design change or design evaluation justifying the degraded condition had been performed. Failure to take corrective action for this design problem was a Non-cited Violation of Criterion XVI of 10 CFR Part 50, Appendix B. This problem resolution violation could not be classified with a risk significance due to its programmatic nature. However, since 1992 the inspectors were not aware of any failures of the administrative controls that would have jeopardized standby gas treatment operability. Therefore, from an equipment standpoint, this finding has a very low risk significance (Section 40A1).

Inspection Report# : [1999018\(pdf\)](#)

G

Significance: Jul 20, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Secondary Containment Penetration.

Secondary containment integrity did not exist from 1981 until May 1997 due to an unsealed 1 inch diameter penetration. This was a non-cited violation of Technical Specification 3.7 (Section 4OA3). This issue had very low risk significance. Test results showed that the standby gas treatment system could still maintain negative pressure in secondary containment with leak pathways up to 4 inches in diameter.

Inspection Report# : [1999011\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

W

Significance: Nov 27, 2000

Identified By: NRC

Item Type: FIN Finding

Radiological dose for the Safety Relief Valve (SRV) replacement work results in a determination of a White Finding.

Planning problems caused the dose for the Safety Relief Valve (SRV) replacement work completed during refueling outage Q1R16 to exceed its projected dose by more than 50 percent. Elevated dose rates were encountered in the drywell as a result of cobalt 60 plate-out. The drywell cooling/ventilation system was out of service for maintenance and testing, significantly elevating temperatures in the drywell. Also, less experienced workers performed the SRV job NRC Supplemental Inspection (Report 50-254/01-13, 50-265/01-13): During this supplemental inspection, performed in accordance with Inspection Procedure 95001, the inspector concluded that the licensee performed a comprehensive evaluation of the radiological planning weaknesses. The licensee's evaluation attributed the planning weaknesses to ineffective job management by the radiation protection and construction staffs (root cause). In determining the root cause, the licensee identified contributing factors which included ineffective management of work force changes and drywell temperature control, inadequate monitoring of job duration and identification of changes in duration, and inadequate consideration of work location dose rates and contamination levels when developing revised job dose estimates. The inspector reviewed the licensee's corrective actions, both completed and planned, and concluded that the corrective actions appeared to address the identified root cause and contributing causes. In particular, the licensee implemented an ALARA job standard to provide additional guidance to the staff for identifying and managing changes in radiological work. The purpose of the job standard was to fully identify the changes (both prior to the work and based on the as-found conditions) and to communicate the changes to the station ALARA committee so that the planning could be adequately evaluated to determine if replanning was necessary. Initial implementation of the standard during the Spring 2001 Unit 1 recirculation pump seal replacement was adequate; however, the inspector observed weaknesses in the understanding of staff concerning when the standard was to be applied. Due to the licensee's acceptable performance in assessing the radiological planning problems, the White finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in NRC Manual Chapter 0305, "Operating Reactor Assessment Program." Implementation of the licensee's corrective actions will be reviewed during a future inspection.

Inspection Report# : [2000018\(pdf\)](#)Inspection Report# : [2001013\(pdf\)](#)**Significance:** N/A Jul 13, 2001

Identified By: NRC

Item Type: FIN Finding

A supplemental inspection was performed by the NRC to assess the licensee's evaluation associated with the failure to provide adequate radiological planning to maintain radiological doses as-low-as

This supplemental inspection was performed by the NRC to assess the licensee's evaluation associated with the failure to provide adequate radiological planning to maintain radiological doses as-low-as-is-reasonably-achievable (ALARA) during the Fall 2000 Unit 1 outage. This performance issue was previously characterized as having low to moderate risk significance (White) in NRC Inspection Report No. 50-254/00-18 (DRS) and 50-265/00-18(DRS). During this supplemental inspection, performed in accordance with Inspection Procedure 95001, the inspector concluded that the licensee performed a comprehensive evaluation of the radiological planning weaknesses. The licensee's evaluation attributed the planning weaknesses to ineffective job management by the radiation protection and construction staffs (root cause). In determining the root cause, the licensee identified contributing factors which included ineffective management of work force changes and drywell temperature control, inadequate monitoring of job duration and identification of changes in duration, and inadequate consideration of work location dose rates and contamination levels when developing revised job dose estimates. The inspector reviewed the licensee's corrective actions, both completed and planned, and concluded that the corrective actions appeared to address the identified root cause and contributing causes. In particular, the licensee implemented an ALARA job standard to provide additional guidance to the staff for identifying and managing changes in radiological work. The purpose of the job standard was to fully identify the changes (both prior to the work and based on the as-found conditions) and to communicate the

changes to the station ALARA committee so that the planning could be adequately evaluated to determine if replanning was necessary. Initial implementation of the standard during the Spring 2001 Unit 1 recirculation pump seal replacement was adequate; however, the inspector observed weaknesses in the understanding of staff concerning when the standard was to be applied. Due to the licensee's acceptable performance in assessing the radiological planning problems, the White finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in NRC Manual Chapter 0305, "Operating Reactor Assessment Program." Implementation of the licensee's corrective actions will be reviewed during a future inspection.
Inspection Report# : [2001013\(pdf\)](#)

Public Radiation Safety



Significance: Jul 02, 1999

Identified By: NRC

Item Type: FIN Finding

Lack of Documentation for Offsite Dose Calculation Manual Revisions

The inspectors identified a lack of documentation for the licensee's review of changes to the Offsite Dose Calculation Manual. Although an independent technical review determined that the changes maintained a sufficient level of effluent control, the licensee did not maintain documentation to support this determination. (Section 2PS3.3) This item had very low risk significance based on the results of the independent technical review.

Inspection Report# : [1999013\(pdf\)](#)

Physical Protection

Significance: N/A Jun 14, 2001

Identified By: NRC

Item Type: FIN Finding

A supplemental inspection was performed to assess the licensee's root cause evaluation related to exercise failures during two of four force-on-force contingency exercises.

This supplemental inspection was performed to assess the licensee's root cause evaluation related to exercise failures during two of four force-on-force contingency exercises. This performance issue was characterized as a White finding having a low to moderate risk significance in NRC Inspection Report No. 50-254; 265/00-201. This supplemental inspection determined that the licensee had performed a comprehensive evaluation which identified the root cause and contributing factors associated with the exercise failures noted above. The licensee's evaluation identified that the root cause of the exercise finding was a failure to effectively accomplish exercise control activities. Contributing factors were human performance errors by some security force response personnel and controllers, a lack of effective controller training, vulnerabilities in some defensive positions, and command and control activities. Licensee corrective actions were implemented to address the root cause and each contributing factor. Those actions appeared effective in correcting the identified deficiencies. Therefore, the White performance finding associated with the exercise failures was closed.

Inspection Report# : [2001011\(pdf\)](#)



Significance: Nov 17, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

An unattended security storage container containing Safeguards Information was found unlocked and open for approximately two hours.

An unattended security storage container containing Safeguards Information was found unlocked and open for approximately two hours (Section 40A3). The inspector reviewed the risk significance of this finding and determined the risk to be very low since no Safeguards Information was compromised and there have not been greater than two similar findings in four quarters.

Inspection Report# : [2000019\(pdf\)](#)



Significance: Jun 23, 2000

Identified By: NRC

Item Type: FIN Finding

Contingency Response Performance Deficiencies

Deficiencies were noted in the licensee's performance in the contingency response element of the Physical Protection Cornerstone. (The details of

this finding are Safeguards Information and are required to be withheld from public disclosure.)

Inspection Report# : [2000201\(pdf\)](#)

Miscellaneous

Significance: N/A May 25, 2001

Identified By: NRC

Item Type: FIN Finding

Adverse performance trend.

The corrective actions to prevent recurrence for an event that resulted in an inadvertent steam release during a breach of the reactor pressure boundary proved to be ineffective to prevent a similar event that occurred six months later. Additionally, corrective actions for the second event were narrow in scope and did not address the aspects in common with the first event. Condition report Q2001-01976 was issued to address the potential common issues. The inspectors concluded that the issue was more than minor since the failure to fully identify and correct deficiencies could be reasonably viewed as a precursor to a significant event. The inspectors reviewed the applicability of the issue with respect to program cornerstones and determined that the issue did not impact a cornerstone. However, this issue contained extenuating circumstances in that the full extent of condition for the October event was not completely identified and corrected, allowing a similar event in April. The combination of these two events indicates an adverse performance trend.

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A May 25, 2001

Identified By: NRC

Item Type: FIN Finding

Corrective action program problems.

The inspectors concluded that in general the corrective action program was a complete program containing all the necessary attributes to successfully identify and correct issues at Quad Cities. However, over the past year there were several instances of difficulties with problem identification, evaluation and resolution. Most of these were documented in previous findings and violations in inspection reports. In general, these issues have been recognized, and actions have been taken to address them. For most of the issues it is too soon to fully evaluate the effectiveness of these actions so effectiveness is still to be determined. During this inspection, three areas of corrective action program problems were identified. These were the failure to properly implement the M&TE program, several instances when condition reports should have been written and they were not, and, failure to address common causes for similar steam release events on the reactor vessel during the October refueling outage, and in the April maintenance outage.

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A May 25, 2001

Identified By: NRC

Item Type: FIN Finding

Test problems on condition reports not identified.

In May of 2001, an inspector observing a surveillance noted that instrument maintenance technicians had difficulty conducting calibrations of differential transmitters on the Unit 2 station blackout diesel air intake filter differential pressure detectors. The results were not repeatable and indicated some out-of-tolerance readings on both instruments. No condition reports were generated for either the difficulty with the tests or the apparent out-of-tolerance results until inspectors intervened. Condition Report Q2001-1549 was issued 12 days later and subsequently, Condition Reports Q2001-1474 and Q2001-1475 were written for the out-of-tolerance readings. The inspectors reviewed the significance of not identifying test problems on condition reports and concluded that the issue was more than a minor issue because if left uncorrected, the issue could become a more significant safety concern. The actual effect on the station blackout diesel was minimal since it did not directly impact operation of the equipment and another diesel was available. However, this corrective action finding is a cross-cutting issue for corrective action process performance and is assigned No Color.

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A May 25, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to assure that measuring and test equipment was properly calibrated.

In April of 2001, the station Nuclear Oversight staff identified that measurement and test equipment which was found to be out-of-calibration during post-use verifications was not evaluated as required by plant procedure. Also, condition reports on these out-of-tolerance conditions were not written when required by procedures. The licensee initiated a review which identified 159 items of out-of-tolerance equipment which had not been evaluated appropriately. The use of these items was evaluated and appropriate recovery actions taken. Failure to assure that measuring and test equipment used in 2000 and 2001 was properly calibrated was a Non-Cited Violation of 10 CFR 50, Appendix B. The inspectors reviewed the significance of not evaluating out-of-tolerance equipment and determined that the issue was more than a minor issue because if left uncorrected, the issue could become a more significant safety concern. However, since this is a corrective action concern, and no specific cornerstone was impacted, this item is assigned No Color.

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Dec 15, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Technical Errors in Appendix R Safe Shutdown Procedures

The inspectors identified a number of technical errors in safe shutdown procedure QCARP 0050-02. The procedure errors were considered a Non-Cited Violation (NCV 50-254/00-16-03; NCV 50-265/00-16-03) of 10 CFR 50, Appendix R, Section III.L.5 (Section 40A4.1). The technical errors were determined to have no appreciable risk significance (No Color) because the errors would not have impacted safe shutdown. However, the errors were another example of a previously identified adverse trend in human performance.

Inspection Report# : [2000016\(pdf\)](#)

Significance: N/A Nov 20, 2000

Identified By: NRC

Item Type: FIN Finding

The inspectors found that a number of human performance errors during the Q1R16 refueling outage period resulted in undesirable consequences and constituted an adverse trend.

The inspectors found that a number of human performance errors during the Q1R16 refueling outage period, October 14 to November 3, resulted in undesirable consequences and constituted an adverse trend in human performance. These errors resulted from problems with procedure adherence, control of work activities, communications, and procedure quality. Resulting problems included venting the pressurized reactor to containment near maintenance workers who were not adequately prepared for the subsequent release of steam and contamination, inadvertently draining from the reactor vessel bottom head area resulting in significant personnel contamination, and a number of wiring and second verification errors during electrical modifications and maintenance. Although most of these wiring errors were caught and corrected during testing, one error was not caught and resulted in the inoperability of one of two channels of the reactor protective system flow biased trips. While none of these events resulted in equipment performance outside the licensee response band (GREEN), the overall trend indicated problems with adhering to procedures, proper performance of second verification techniques, and the communication and coordination of activities (Section 40A4).

Inspection Report# : [2000015\(pdf\)](#)

Significance: N/A Jun 30, 2000

Identified By: NRC

Item Type: FIN Finding

Cross-Cutting Issues: Human Performance

Inspectors found that several recent events which affected plant operations and/or had the potential to adversely affect personnel safety involved elements of human performance deficiencies. An apparent adverse trend in human performance during the period May 5, 2000 to June 30, 2000, was evidenced by the following incidents. A senior reactor operator failed to implement a Technical Specification surveillance requirement for removing an emergency diesel generator from service. Control room operators experienced problems controlling reactor vessel water level during post-scrum recovery efforts and failed to close a pair of drain valves during a pre-start of the Unit 1 high pressure coolant injection system. Maintenance personnel errors were involved in a reactor trip on May 5, and spread of contamination in the 2B reactor water cleanup room when a fitting was disconnected under 1000 psig pressure on June 10 (Section 40A.4).

Inspection Report# : [2000007\(pdf\)](#)

Significance: N/A Jun 30, 2000

Identified By: NRC

Item Type: FIN Finding

Weakness in Corrective Action Program.

The corrective action program was fully functional and typically identified and corrected conditions adverse to quality. In general, station personnel effectively identified and entered problems into the corrective action program using problem identification forms (PIFs). The significance threshold for entering issues into the program appeared appropriate. However, over the past year issues were identified at Quad Cities where the corrective action process was not vigorously implemented to address the issues. In addition, the licensee's corrective action process had lost over two items a month since January 2000. Although none of these lost items were considered safety significant, and thousands of other action items were opened and closed in that time frame, this represented a weakness in the licensee's program.

Inspection Report# : [2000008\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

On September 10, 1999, the control room emergency ventilation system was inoperable

On September 10, 1999, the licensee identified that the control room emergency ventilation system was inoperable. Flow rates were out-of-specification due to repositioning of a ventilation damper 9 days previously. The action statement for Technical Specification 3.8.D allowed the system to be inoperable for 7 days. Failing to comply with the allowed outage time requirements was considered a non-cited violation of Technical Specification 3.8.D. This issue was screened as GREEN (very low risk significance) after a Phase 1 Significance Determination Process review (Section 40A3).

Inspection Report# : [2000003\(pdf\)](#)

Significance: N/A Feb 29, 2000

Identified By: NRC

Item Type: FIN Finding

Human Performance Problems

Inspectors found that errors in review, coordination, and implementation of maintenance activities during or near Unit 2 refueling outage number 16 (January and February 2000) led to inoperable safety systems. Operators were unaware that Technical Specification or administrative limiting condition for operation action statements were entered or exceeded. Required nuclear instruments and emergency diesel generators were not operable during some fuel moves (Sections 1R04 and 1R20.4), automatic depressurization system valves were taken out of service while required (Section 1R20.2), the high pressure coolant injection system was inoperable due to incomplete maintenance (Section 1R19.1), and safe shutdown requirements were not properly addressed (Section 1R20.5). Other events included technician errors in which electrical jumpers were installed in incorrect locations for logic used by the reactor protective system and by the emergency core cooling system. While the risk of the individual events was very low, an increase in maintenance activity problems was evident.

Inspection Report# : [2000001\(pdf\)](#)

Significance: N/A Dec 03, 1999

Identified By: NRC

Item Type: FIN Finding

reactor coolant system leakage performance indicator

The inspectors completed verification inspection of the reactor coolant system leakage performance indicator and found very minor discrepancies which did not affect the validity of the reported performance indicator (Section 4OA2.2).

Inspection Report# : [1999023\(pdf\)](#)

Significance: N/A Dec 03, 1999

Identified By: NRC

Item Type: FIN Finding

the public radiation safety performance indicator

The inspectors verified that the licensee had properly evaluated and reported the public radiation safety performance indicator (Section 4OA2.7).

Inspection Report# : [1999023\(pdf\)](#)

Significance: N/A Dec 03, 1999

Identified By: NRC

Item Type: FIN Finding

verification inspection for the residual heat removal unavailability performance indicator.

The inspectors completed the verification inspection for the residual heat removal unavailability performance indicator. The inspectors identified that the licensee had not included 12.5 hours of residual heat removal system unavailability during system logic testing in January 1999. The licensee explained that the rules for system availability, at that time, did not require documenting the safety system unavailability. The licensee elected to report these hours in a future submittal. The extra hours would not cause the residual heat removal system unavailability to cross a color threshold (Section 4OA2.1).

Inspection Report# : [1999023\(pdf\)](#)

Significance: N/A Dec 03, 1999

Identified By: NRC

Item Type: FIN Finding

verification inspection of the licensee's performance indicators

The inspectors completed verification inspection of the licensee's performance indicators for scrams, scrams with loss of normal decay heat removal, reactor coolant specific activity, and primary containment leakage. No findings were identified (Section 4OA2).

Inspection Report# : [1999023\(pdf\)](#)

Significance: N/A Oct 20, 1999

Identified By: NRC

Item Type: FIN Finding

The licensee corrected discrepancies with the safety system functional failure indicator.

The licensee corrected discrepancies with the safety system functional failure indicator previously identified by the NRC in the September report of performance indicator data. The NRC exercised enforcement discretion and did not issue a Notice of Violation (Section 4OA3).

Inspection Report# : [1999020\(pdf\)](#)

Significance: N/A Oct 20, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

Notification Failure Under 50.72

The inspectors identified two violations of NRC reporting requirements. The licensee failed to notify the NRC within 1 hour of identifying a condition in which the control room emergency ventilation system was found outside the design basis. The licensee also failed to notify the NRC within 4 hours of an event in which the reactor core isolation cooling system was unable to perform a required safety function. The licensee made late notifications, submitted a licensee event report for the control room emergency ventilation system, and planned to submit a licensee event report for the reactor core isolation cooling system failure. These were considered two non-cited violations (Plant Status).

Inspection Report# : [1999020\(pdf\)](#)



Significance: Oct 08, 1999

Identified By: Licensee

Item Type: FIN Finding

The licensee identified errors in the PI Occupational Radiation Safety Performance Indicator (PI)

Occupational Radiation Safety Performance Indicator (PI). The licensee identified errors in the PI reported to the NRC. Originally, the licensee reported six technical specification high radiation area incidents, which resulted in a white PI. After identifying a missed occurrence and a misinterpretation of the PI criteria, the licensee determined that only two incidents were applicable to the PI, which resulted in the PI indicating that performance was in the licensee response band (green).

Inspection Report# : [1999022\(pdf\)](#)



Significance: Jul 16, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

the repetitive problem of excessive use of overtime.

The root cause report and the corrective actions, approved by the Plant Operations Review Committee and the Corrective Action Review Board, did not fully address the repetitive problem of excessive use of overtime. There were 177 instances between February 1 and 28, 1999, where station procedures were not followed to control overtime of plant workers. Further corrective actions were being developed to ensure that overtime violations did not continue. There were no known incidents where the excessive use of overtime directly impacted or affected the safety of the plant; however, the repetitive failure to follow procedures to control overtime is a non-cited violation. (Reference Report Section 4OA1.4, page 8)

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