

Quad Cities 1

3Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

UNEXPECTED HALF SCRAM OCCURRED DUE TO FAILURE TO EVALUATE CHANGE IN EQUIPMENT CONFIGURATION VIA THE PROCEDURE CHANGE PROCESS PRIOR TO INSTALLATION

A self-revealing half scram occurred on July 10, 2003, due to the failure to fully evaluate a change to the test equipment configuration specified in surveillance procedure QCIS 0500-01, "Unit 1 Division 1 Low Condenser Vacuum Scram Calibration and Functional Test." The failure to properly evaluate the configuration change was considered a human performance issue and a Non-Cited Violation of Technical Specification 5.4.1.

This finding was more than minor because it impacted the procedure quality, configuration control, and design control attributes of the initiating events cornerstone, and affected the cornerstone objective of limiting the likelihood of events that upset plant stability. The inspectors determined that the finding was of very low safety significance because the exposure time was short, all other mitigating systems were available, and the condenser could have been recovered if needed. The licensee's immediate corrective actions included removing the test equipment, restoring the low condenser vacuum circuitry, and properly determining an alternate means to perform the surveillance test.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

INADEQUATE PROCEDURE AND SELF CHECKING RESULTS IN CONNECTING AIR POWERED VACUUM TO INSTRUMENT AIR SYSTEM AND TWO AIR TRANSIENTS

The failure to identify the proper plant air supply prior to installing moisture separator decontamination equipment (air powered vacuum) resulted in two unexpected instrument air system transients on October 14 and 15, 2002. The work package did not contain equipment identification numbers to aid in identifying the proper air supply. In addition, the individual instructed to identify the air supply failed to perform self-checking activities that could have identified the inappropriate selection of instrument air for the equipment installation rather than service air.

This finding was more than minor because it affected the loss of instrument air initiating event frequency. The finding was of very low safety significance because the exposure time was short and all mitigating systems needed to address a loss of instrument air were available. No violation of NRC requirements occurred due to the instrument air system being non-safety-related.

Inspection Report# : [2002008\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

WEAKNESSES IN PROBLEM IDENTIFICATION AND RESOLUTION LEADS TO 1B REACTOR RECIRCULATION PUMP TRIP

The failure to adequately correct deficiencies in the 1B reactor recirculation motor generator voltage regulator resulted in a pump trip and power transient on December 6, 2002. On November 29 and December 3, the licensee initiated two condition reports due to the motor generator voltage regulator failing to meet acceptance criteria during tuning activities. The inspectors determined that the licensee had not adequately considered changes made to the voltage regulator during the outage and power ascension which resulted in inappropriately concluding that the failure to meet the acceptance criteria was acceptable.

This finding was determined to be more than minor because the reactor recirculation pump trip was a precursor to a significant transient. This finding was considered to be of very low safety significance since it did not: contribute to the likelihood of both a reactor trip and that mitigating equipment would not be available, contribute to the likelihood of a loss of coolant accident, increase the likelihood of a fire or flood, or increase the frequency of core damage scenarios using other plant specific analyses.

Inspection Report# : [2002008\(pdf\)](#)



Significance: Dec 20, 2002

Identified By: NRC

Item Type: FIN Finding

Failure to Recognize and Address High Vibration Indications on Plant Equipment

Green. The inspectors identified a Green finding due to the licensee's failure to recognize and address high vibration indications on plant equipment. On April 2, 2002, a Unit 2 main steam drain line broke due to high vibrations. The pipe break occurred down stream of the main steam isolation valves in a non-safety-related portion of the main steam piping.

The issue was more than minor, in that if the vibrations were not corrected (on both units) they could become a more significant safety concern. However, due to the location of the actual break, the issue was determined to be of very low safety significance. This issue was not subject to NRC enforcement since the break occurred in a non-safety-related portion of the main steam line and did not impact the operation of safety-related equipment (Section 40A2.1.b1).

Inspection Report# : [2003002\(pdf\)](#)

Mitigating Systems



Significance: Jun 30, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROVIDE A CORRECT PROCEDURE FOR VENTING EMERGENCY CORE COOLING SYSTEM TO DEMONSTRATE THE PIPING FULL OF WATER

The inspectors identified a Non-Cited Violation of Technical Specification Paragraph 5.4.1 for the licensee's failure to provide a correct procedure for venting emergency core cooling systems to ensure continued operability. As a result, 1B core spray operability was not properly evaluated after a large volume of gas was vented from the system.

This finding was greater than minor because it prevented a proper operability evaluation of the 1B core spray system after operators vented a large volume of gas from the system. It adversely affected the procedure quality attribute of the

mitigating systems cornerstone. If left uncorrected, the finding could become a more significant safety concern. The finding was of very low safety significance because the failure to address the as-left operability of the 1B core spray system did not result in the actual loss of the 1B core spray safety function.

Inspection Report# : [2003005\(pdf\)](#)



Significance: Jun 30, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT ADEQUATE CORRECTIVE ACTION FOR A PREVIOUSLY IDENTIFIED EMERGENCY DIESEL GENERATOR PRECONDITIONING CONCERN

The inspectors identified a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI for the licensee's failure to implement adequate corrective action for a previously identified emergency diesel generator preconditioning concern. The inadequate corrective action contributed to the preconditioning of two emergency diesel generators and prevented proper preconditioning evaluations.

This finding was greater than minor because it contributed to the preconditioning of two emergency diesel generators and prevented a proper preconditioning evaluation. It adversely affected the procedure quality attribute of the mitigating systems cornerstone. If left uncorrected, the finding could become a more significant safety concern. The finding was of very low safety significance because it did not result in the actual loss of the emergency diesel generator safety function.

Inspection Report# : [2003005\(pdf\)](#)



Significance: Mar 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN ADEQUATE SPATIAL SEPARATION OF FLAMMABLES FROM THE DIESEL DRIVEN FIRE PUMPS

The inspectors identified a finding involving a Non-Cited Violation for the licensee's failure to maintain 80 feet of spatial separation between a flammable liquids storage cabinet and the furthest diesel fire pump as required by the Quad Cities Operating Licenses and the Fire Protection Program.

The inspectors concluded that this finding was more than minor because the improper cabinet placement and potential storage of a large amount of flammable materials could lead to a fire which could engulf both fire pumps and cause a loss of the non safety-related service water system and the circulating water system. In addition, this finding was associated with the initiating events cornerstone attribute of protecting the plant against external factors and impacted the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions. The finding was of very low safety significance based on the determination that the actual stored flammable liquids, if inadvertently ignited, would not produce sufficient radiative heat flux to damage both fire pumps at the same time.

Inspection Report# : [2003003\(pdf\)](#)



Significance: Mar 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY LATCH FUSE DRAWERS CAUSING AUTOMATIC INITIATION AND LOADING OF EMERGENCY DIESEL GENERATOR

The inspectors identified a finding involving a Non-Cited Violation on Unit 1 for the failure to properly latch the

potential transformer fuse drawers for bus 14 and bus 14-1. This resulted in the fuse drawers dropping open and causing the automatic initiation and loading of the emergency diesel generator due to loss of voltage on the emergency bus. Multiple operations department procedures failed to contain instructions to ensure that the potential transformer fuse drawers for the safety-related busses were properly latched. Unit 1 was unknowingly vulnerable to a loss of voltage condition on two safety-related busses during a seismic event.

The finding was more than minor because it was associated with attributes in both the mitigating systems and initiating events cornerstones and also affected each cornerstone objective. For example, a seismic event could cause both drawers to open resulting in a loss of both busses; a scram, and the loss of two residual heat removal service water pumps. The finding was of very low safety significance primarily due to the low initiating event frequency associated with a seismically induced loss of offsite power.

Inspection Report# : [2003003\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

INADEQUATE DESIGN LEADS TO DELAY IN DISCOVERING SAFE SHUTDOWN MAKEUP PUMP WAS INOPERABLE DUE TO STRAINER CLOGGING

A self-revealing failure occurred on October 16, 2002, when the safe shutdown makeup pump room cooler strainer became clogged with duck weed. The inspectors determined that twice per shift rounds to verify strainer operability and multiple strainer cleanings were not effective in ensuring continued operability of this equipment. In addition, control room personnel were not immediately notified of the clogged strainer via a control room alarm or a local alarm due to a system design deficiency.

This finding was more than minor because the strainer clogging impacted the operability of the safe shutdown makeup pump which can be used when responding to initiating events. In addition, the system design issues created a situation where operations personnel were unaware of equipment operability issues. This finding was of very low safety significance because the total exposure time was short, all other mitigating systems were available, and the safe shutdown makeup pump could have been recovered if needed. No violation of NRC requirements occurred due to the safe shutdown makeup only being of augmented quality per the licensee's Quality Assurance Report.

Inspection Report# : [2002008\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

MULTIPLE EXAMPLES OF SCAFFOLDING IN CONTACT WITH SAFETY-RELATED EQUIPMENT

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, due to the failure to adhere to procedural requirements regarding the erection of scaffolding near safety-related equipment. On November 6, 2002, the inspectors identified numerous examples where scaffolding was in contact with residual heat removal system piping and valves.

This finding was more than minor since multiple examples of scaffolding erection deficiencies were identified which indicated that workers routinely failed to follow scaffolding erection procedural requirements. This finding was determined to be of very low safety significance since the scaffolding did not result in an actual loss of safety function of any system.

Inspection Report# : [2002008\(pdf\)](#)

Significance:  Dec 20, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," Related to the Quality of Design Basis Engineering Calculations

Green. The inspectors identified a Green Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," related to the quality of design basis engineering calculations. Specifically, the inspectors identified that instrument and test uncertainty was not considered in a number of design calculations, such that the calculation acceptance limits could not be validated. The diesel generator cooling water (DGCW), high pressure coolant injection (HPCI), and reactor core isolation cooling (RCIC) system design bases were not being adequately controlled by existing calculations.

This finding was considered greater than minor because a loss of design control could affect the reliability of the DGCW, HPCI and RCIC systems to perform their safety functions. Because no operability concerns were identified, the issue was determined to be of very low safety significance (Section).

Inspection Report# : [2003002\(pdf\)](#)

Barrier Integrity

Significance:  Sep 30, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATION OF UNIT 1 WITH REACTOR COOLANT PRESSURE BOUNDARY LEAKAGE WHICH EXCEEDED TECHNICAL SPECIFICATION REQUIREMENTS

The inspectors identified a Green finding and a Non-Cited Violation due to the discovery of a reactor coolant pressure boundary leak on the Unit 1 reactor pressure vessel head vent piping in May 2003.

The inspectors determined that the presence of a reactor coolant system pressure boundary leak was more than minor because it impacted the equipment performance attribute and the objective of the initiating events cornerstone and the reactor coolant system and barrier performance attribute and objectives of the barrier integrity cornerstone. The inspectors determined that this finding was of very low safety significance because additional equipment not credited in the Probabilistic Risk Assessment was available to mitigate the leak and the contribution of this type of event to the baseline core damage frequency was small. Corrective actions included cutting out the weld defect which caused the leak and repairing the pipe.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURE AND WEAK CONTROL BOARD MONITORING LEADS TO INADVERTENT REACTOR WATER CLEANUP ISOLATION

The failure to adhere to procedure precautions and perform timely control room panel monitoring resulted in the inadvertent isolation of the reactor water cleanup system while the system was being used to remove decay heat from the Unit 1 reactor vessel. A Non-Cited Violation of Technical Specification 5.4.1 was identified.

This finding was determined to be more than minor because the isolation impacted the reactor water cleanup system's continued ability to provide cooling of the reactor fuel and fuel cladding while the Unit 1 reactor was in a shutdown condition. The finding was of very low safety significance since the isolation did not significantly degrade the licensee's ability to recover decay heat removal through the use of the reactor water cleanup or residual heat removal systems once the isolation occurred.

Inspection Report# : [2002008\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Dec 20, 2002

Identified By: NRC

Item Type: FIN Finding

Corrective Action Program Generally Effective in Ensuring that Conditions Adverse to Quality were Being Adequately Addressed

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. In general, the licensee effectively corrected plant problems. On the positive side, the inspectors noted that Nuclear Oversight appeared to be an effective source for identifying performance issues and that plant employees, in general, indicated a strong willingness to report problems "to the highest levels." The inspectors concluded that corrective action program was generally effective in ensuring that conditions adverse to quality were being adequately addressed

Inspection Report# : [2003002\(pdf\)](#)

Last modified : December 01, 2003