

Quad Cities 2

1Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2008

Identified By: NRC

Item Type: FIN Finding

EXPLOSION OF THE FDSgT VESTIBULE.

A self-revealed finding of very low safety significance was identified for inadequate procedures that resulted in an onsite explosion on October 27, 2008. Specifically, operating procedures for the floor drain surge tank did not include appropriate warnings, cautions, or notes to alert operators to potentially hazardous conditions or operating sequences that could result in localized elevated concentrations of methane gas. As a result, waste water transfer activities resulted in an accumulation of methane gas in the floor drain surge tank building vestibule that subsequently ignited, damaging the onsite structure and putting the station in an emergency plan Unusual Event. Corrective actions for the affected tank included purging the tank with nitrogen, repairing the installed tank ventilation, monitoring for methane gas buildup until the tank is cleaned, and processing the waste water stored in the tank. Restrictions on system operation are in place pending final procedure revisions.

The finding is more than minor because if left uncorrected this finding would become a more significant safety concern. In addition, it affected the Reactor Safety: Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the Reactor Safety: Initiating Events Cornerstone attribute of protection against external factors relating to production and control of hazardous gasses. The finding is of very low safety significance (Green) because the finding does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Additionally, the finding does not increase the likelihood of a fire affecting mitigating systems or a fire of significant duration. Inspectors determined that the finding had a cross-cutting aspect in the area of Problem Identification and Resolution. Specifically, the inspectors determined that the licensee was aware of industry events involving the anaerobic production of methane gas in radwaste systems and had opportunities to incorporate relevant industry operating experience into recent revisions of radwaste operating procedures, but failed to implement this operating experience into station processes, procedures, and training programs for radwaste operations (P.2 (b)). The failure to establish and implement effective radwaste operating procedures to prevent the production of combustible gasses is not an activity affecting quality subject to 10 CFR Part 50, Appendix B, Criterion V. Therefore, while a performance deficiency was identified, no violation of NRC regulatory requirements occurred.

Inspection Report# : [2008005](#) (*pdf*)

Mitigating Systems

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

BROKEN LATCH ON FIRE DOOR 145

Inspectors identified a Non-Cited Violation of License Condition 3.F, having very low safety significance for failure to ensure that Fire Door 145 could be positively latched. Section 2-8.4.4 of the National Fire Protection Association (NFPA) 80-1975, "Fire Doors and Windows," required that closing mechanisms be adjusted to overcome the resistance of the latch mechanism so that positive latching is achieved on each door operation. As a result of the

discovery of the broken latch, that prevented the fire door from positively latching, the licensee initiated an action request report (AR 864090), and established the immediate actions to return Fire Door 145 to service. The licensee declared the fire door inoperable, issued fire impairment No. 1612 and established an hourly watch. Repairs to the door were completed and the fire door was declared operable the same day.

The finding was determined to be more than minor because a lack of positive latching could result in the door opening during a fire, thereby allowing a fire to affect additional equipment important to safety in the exposed fire zone. Based on screening under IMC 0609, Appendix F, "Fire Protection Significance Determination Process," the inspectors determined that a Phase 2 analysis was required. The inspectors determined that the change in core damage frequency associated with the finding was significantly less than 1×10^{-6} per year. As such, the finding was determined to be of very low safety significance (i.e., Green). This finding has a cross-cutting aspect in the area of Human Performance for the Resources component because the licensee did not provide adequate training to personnel. Specifically, as noted in the licensee's corrective action document, annual training on fire barriers was inadequate in that equipment operators (EOs) did not consistently challenge fire doors in accordance with training (H.2(b)).

Inspection Report# : [2009002](#) (pdf)

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW WORK INSTRUCTIONS FOR 2A CORE SPRAY CHECK VALVE

A self-revealed finding of very low safety significance (Green) and Non-Cited Violation of Technical Specification 5.4.1.a was identified by inspectors on January 15, 2009, when the 2A core spray pump discharge check valve, 2-1402-8A, failed to close. Specifically, the valve failed to close because mechanics did not follow work instructions and ensure the valve was assembled as required. Corrective actions for this event included repair of the valve, briefings with the licensee staff, reinforcement with the operating staff on the differences between operability and post-maintenance testing requirements, and revision of the steps in the "model" work order and the operation's department surveillance procedure to more clearly delineate the acceptance criteria.

The inspectors determined that the failure to follow the work instructions for the 2A core spray pump discharge check valve was more than minor because the non-conforming valve impacted the Mitigating Systems Cornerstone attribute of Equipment Performance to ensure the reliability and capability of the core spray system to respond to initiating events when returned to service. The inspectors concluded that the issue was of very low safety significance (Green) because the plant operators were able to manually perform the required function and thus maintain both functionality and operability of the system until the valve was repaired. The inspectors determined that failure to provide enough detail in the post-maintenance test acceptance criteria to ensure that the valve was able to perform as designed without operator assistance was a significant contributor to the valve's subsequent return to service in a degraded condition, and the inspectors concluded that this event is cross-cutting in Human Performance, Resources for failure to provide accurate procedures (H.2(c)).

Inspection Report# : [2009002](#) (pdf)

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE OF THE UNIT 2 EMERGENCY DIESEL GENERATOR COOLING WATER PUMP

A self-revealed finding of very low safety significance (Green) and NCV of 10 CFR 50, Appendix B, Criterion III, Design Control was identified by inspectors when the Unit 2 diesel generator cooling water pump failed on November 12, 2008, due to damage caused by inter-granular stress corrosion cracking (IGSCC). The licensee's staff failed to apply appropriate rigor during the design and procurement process for pump replacement parts resulting in installation of vendor-supplied components that were not suited to the application and operating methodology for the emergency diesel generator cooling water system. The pump was repaired and returned to service the next day. Additionally, the remaining pumps were started to demonstrate that they were functional at the time of Unit 2 pump failure.

The inspectors concluded that the failure to implement measures that assured the equipment was suitable for the process environment was of very low safety significance (Green) because only one pump of three subsystems was degraded to the point where operability and function was affected. Additionally, the licensee process did not validate the vendor's compliance with all procurement specifications, instead assuming that the vendor's communications

were complete even though details of wear ring material changes were not included. Inspectors have determined that this behavior is cross-cutting in Human Performance, Decisionmaking, for failure to use conservative assumptions in communications with the vendor and ensuring all of the vendor supplied parts were appropriate to support the pump function (H.1(b)).

Inspection Report# : [2009002](#) (pdf)

Significance:  Oct 24, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Use of Non-Conservative Inputs and Methodologies in Calculating Terminal Voltages to Safety-Related MOV Motors During Design Basis Events

A finding of very low safety significance (Green) involving a NCV of 10 CFR Part 50, Appendix B, Criterion III, Design Control, was identified by the inspectors for the failure to evaluate the effect of lower transient voltages that would exist for safety injection actuated motor-operated valves (MOVs) prior to voltage recovery on the upstream 4Kv buses. Specifically, the licensee used non-conservative inputs and methodologies in calculating terminal voltages to safety-related MOV motors. The licensee entered the issue into their corrective action program and performed an operability review of all safety injection actuated valves to verify they had sufficient margin to operate when considering transient voltage conditions.

The finding was more than minor because it was similar to IMC 0612, Appendix E, Example 3.j, in that there was a reasonable doubt on the operability of several low pressure coolant injection valves that would have to operate at voltages as low as 60 percent of rating. The inspectors determined the finding was of very low safety significance because it was a design deficiency that did not result in actual loss of safety function. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Operating Experience because the licensee did not adequately evaluate a similar issue in an NRC Information Notice. (P.2(a)).

Inspection Report# : [2008007](#) (pdf)

Significance:  Oct 24, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Calculations/Analyses and Testing for Thermal Overload Relays (TOLs) on Safety-Related MOVs

A finding of very low safety significance (Green) and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the failure to assure that thermal overload relays (TOLs) on safety-related motor-operated valve (MOV) circuits were sized properly and periodically tested. The licensee entered this issue into its corrective action program and was able to demonstrate operability, in that the TOLs would not prevent any MOVs from performing their safety function.

The finding was more than minor because it was similar to IMC 0612, Appendix E, Example 3.j, in that failing to assure that TOLs on safety-related MOV circuits were sized properly and periodically tested led to there being a reasonable doubt as to the operability of the affected safety-related MOVs. The issue was of very low safety significance because the inspectors determined it was a design deficiency that did not result in actual loss of safety function. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Self-Assessment because the licensee incorrectly evaluated this issue as not being a concern during a self-assessment. (P.3(a)).

Inspection Report# : [2008007](#) (pdf)

Significance:  Oct 24, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Seismic Qualification of 250 VDC Batteries

A finding of very low safety significance (Green) and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the failure to assure that 250VDC safety-related batteries were

installed in accordance with their seismic qualification. The licensee entered this nonconformance into its corrective action program and initiated work orders to replace the intercell spacers with properly sized material. To establish a reasonable assurance of operability, the licensee reviewed seismic experience database reports from the Seismic Qualification Utility Group.

The finding was determined to be more than minor because the finding was conceptually similar to IMC 0612, Appendix E, Example 3a, in that rework (spacer replacement) was required to restore seismic qualification. The issue was of very low safety significance because the inspectors determined it was a qualification deficiency that did not result in actual loss of safety function. The inspectors determined there was no cross-cutting aspect associated with this finding.

Inspection Report# : [2008007](#) (*pdf*)

Significance:  Oct 24, 2008

Identified By: NRC

Item Type: FIN Finding

Inaccurate RCIC Instrument Setpoints

A finding of very low safety significance was identified by the inspectors for failure to accurately implement the design setpoint for reactor core isolation cooling turbine exhaust pressure switches 1(2)-1360-26A/B. The licensee entered this issue into its corrective action program and was able to demonstrate operability by determining that the setpoints would not be challenged for scenarios where reactor core isolation cooling was credited.

The finding was determined to be more than minor because the finding was conceptually similar to IMC 0612, Appendix E, Example 3a, in that rework (instrument recalibration) was required to restore conformance with the design. The issue was of very low safety significance because the inspectors determined it was a design deficiency that did not result in actual loss of safety function. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program because the licensee did not adequately evaluate the issue in 2004 such that it was properly classified and prioritized. (P.1(c))

Inspection Report# : [2008007](#) (*pdf*)

Significance:  Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

2D Vault Door Work Order Instructions Not Followed

A self-revealing finding of very low safety significance and associated NCV of TS 5.4.1 was identified for failure to follow written work instructions resulting in a non-functional main control room alarm and degraded flood protection measures. Specifically, a contract electrician did not perform work instructions as written and lifted energized leads for the 2D residual heat removal service water (RHRSW) vault door limit switch without the appropriate work package documents as required by station procedures. This action resulted in an inoperable control room alarm that was not corrected for approximately three months. Further investigation revealed the licensee was performing a surveillance to verify the RHRSW vault doors closed once per day, contrary to the surveillance periodicity of once per shift credited in the licensee's flood protection analysis. The failure to follow the credited once-per-shift surveillance in combination with the non-functional supplemental control room alarm resulted in degraded flood protection measures associated with the 2D RHRSW vault. This finding has a cross-cutting aspect in the area of Human Performance, Resources Component, Documentation Aspect because the licensee failed to provide enough detail in the work package to ensure that the control room alarm was verified as functional during the post-maintenance testing following completion of the work activity (H.2(c)). Corrective actions included repair of the limit switch and correction of the operator rounds to verify the vault doors closed each shift.

The finding is determined to be more than minor because it is associated with the Mitigating Systems Cornerstone attribute of external factors, flood hazard, and affects the cornerstone objective of ensuring the availability and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of findings," Table 4a for the Mitigating Systems cornerstone because the finding is associated with the operability and availability of the 2D train of the

RHRSW mitigating system. The finding is of very low safety significance, Green, because the degraded flood protection measures did not result in the loss of operability or functionality of the 2D RHRSW system

Inspection Report# : [2008004](#) (*pdf*)

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Significance: Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Assess and Manage Risk Associated with Work on U1 SBO.

NRC inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR 50.65(a) (4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," when the licensee failed to effectively evaluate the risk associated with work on the Unit 1 station blackout (SBO) diesel generator, which resulted in an unplanned risk condition for Unit 1 and Unit 2 without the appropriate risk management actions. Specifically, the Unit 2 SBO diesel generator was determined to be unavailable after inspectors found the oil level in the governor below the indicating sight glass level due to leakage from a loose connection. Concurrently, the Unit 1 SBO diesel generator was unavailable due to planned maintenance. When unavailability of the Unit 2 SBO diesel generator was factored into the on-line risk model with the Unit 1 SBO diesel generator unavailable, the risk profile changed from Green to Yellow. Since the Unit 2 SBO diesel generator was assumed to be available in the original risk evaluation, the underestimation of risk resulted in the station having no risk management actions in place as would have been required by procedure. Those actions include protecting pathways of safety-related equipment that could have a significant impact on the increase in risk, if unavailable. The inspectors also determined that the finding has a cross-cutting aspect in the area of Human Performance, Resources Component, Documentation Aspect because the licensee failed to provide timely and up-to-date procedures to check the engine governor oil sight glass level following the permanent modification to a different governor model that has an oil level sight glass (H.2(c)). Corrective actions included protecting the appropriate equipment and contacting mechanical maintenance to have the fitting tightened and the governor oil sump refilled to the proper level. The Operations Department initiated a process requiring a walkthrough verification of redundant equipment areas before removing equipment from service. Additionally, procedure revisions to operator rounds were made to include verification of sight glass level.

The finding is determined to be more than minor because the finding is based on incorrect assumptions that changed the outcome of the risk assessment and therefore crossed the risk threshold requiring additional actions to manage the risk. The inspectors evaluated this finding using the Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," worksheets of IMC 0609 because the finding is a maintenance risk assessment issue. Flowchart 1, "Assessment of Risk Deficit," requires the inspectors to determine the risk deficit associated with this issue. This finding was determined to be of very low safety significance because the incremental core damage probability deficit was less than 1E 6.

Inspection Report# : [2008004](#) (*pdf*)

Barrier Integrity

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Significance: Jun 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Exceeded 50 Degree Differential Temperature Limit of TS 3.4.9 when starting Recirculation Pump

A Non-Cited violation of Technical Specification 3.4.9, "RCS Pressure and Temperature (P/T) Limits," was identified on March 31, 2008 when operators did not establish effective controls to ensure compliance with the Technical specification when they started the 2A reactor coolant recirculation pump with temperature in the 2A loop more than 50°F below the bulk temperature in the reactor vessel represented by the 2B loop temperature. The failure to implement effective controls to prevent exceeding the Technical Specification limit was more than minor because it was associated with the Barrier Integrity Cornerstone attribute of Human Performance and affected the cornerstone objective by challenging the physical design barriers intended to maintain the functionality of the Reactor Coolant System. This finding was determined to be of very low safety significance because the plant conditions were

determined to be within the bounds of the existing analysis and therefore the issue did not result in degrading the reactor coolant system boundary. This finding has a cross-cutting aspect in the area of Human Performance for the Decision-Making component because the licensee failed to communicate the decisions and the basis for decisions to personnel who have a need to know the information in order to perform work safely, in a timely manner (H.1(c)). Specifically, planning decisions such as the compensatory actions for prompt restoration made during the dayshift for this repair were not effectively communicated to those individuals that were called upon to implement the plan in a safe and timely manner.

This finding was determined to be of very low safety significance because the plant conditions were determined to be within the bounds of the existing analysis and therefore the issue did not result in degrading the reactor coolant system boundary, in exceeding the Technical Specification Limit for any Reactor Coolant System Leakage, nor could it have likely affected other mitigation systems to result in a loss of their safety functions. This finding has a cross-cutting aspect in the area of Human Performance for the Decision-Making component because the licensee failed to communicate the decisions and the basis for decisions to personnel who have a need to know the information in order to perform work safely, in a timely manner (H.1(c)). Specifically, planning decisions such as the compensatory actions for prompt restoration made during the dayshift for this repair were not effectively communicated to those individuals that were called upon to implement the plan in a safe and timely manner.

Inspection Report# : [2008003](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH TECHNICAL SPECIFICATION AND RADIATION WORK PERMIT REQUIREMENTS DURING WORK IN A LOCKED HIGH RADIATION AREA

A self-revealed finding of very low safety significance and an associated Non Cited Violation (NCV) of Technical Specification 5.7.1 was identified by inspectors for the failure to comply with the requirements of the radiation work permit during work activities in the radwaste basement, an area controlled as a locked high radiation area. Specifically, on January 13, 2009, an equipment operator failed to inform the radiation protection staff prior to access into overhead areas above 7 feet. Consequently, the worker entered areas which had not been surveyed, and, therefore, the radiological conditions were unknown. As a result, the worker encountered radiation levels greater than those anticipated for the work activity. The licensee's corrective actions included counseling of the involved individual and conducting a standdown with the operations department to reinforce radiological requirements along with communication expectations. The licensee was also in the process of completing an apparent cause evaluation to formulate additional actions to prevent recurrence.

The finding was more than minor because it impacted the program and process attribute of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation, in that, access into high radiation areas whose radiological conditions were unknown placed the worker at risk for unnecessary radiation exposure. The finding was determined to be of very low safety significance because it was not an as-low-as-is-reasonably-achievable (ALARA) planning issue, there was no overexposure or substantial potential for an overexposure, and the licensee's ability to assess worker dose was not compromised. The finding involved a cross-cutting aspect in the area of Human Performance related to Work Practices, in that, radiation work permit (RWP) compliance for access into overhead areas was not effectively communicated to the worker and the worker failed to follow the RWPs (H.4(b)).

Inspection Report# : [2009002](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Aug 08, 2008

Identified By: NRC

Item Type: FIN Finding

PI&R Assessment

On the basis of the sample selected for review, the team concluded that implementation of the CAP was generally good. The licensee had a low threshold for identifying problems and entering them in the CAP. Items entered into the CAP were screened and prioritized in a timely manner using established criteria; were properly evaluated commensurate with their safety significance; and corrective actions were generally implemented in a timely manner, commensurate with the safety significance. The team noted that the licensee reviewed operating experience for applicability to station activities. Audits and self assessments were determined to be performed at an appropriate level to identify deficiencies. On the basis of licensee self-assessments and interviews conducted during the inspection, workers at the site expressed freedom to raise safety concerns. The team observed that some significant adverse trends in human performance and equipment clearances and tagging were not initially identified and aggressively addressed for effective results. Subsequent efforts were more effective.

Inspection Report# : [2008008](#) (*pdf*)

Last modified : May 28, 2009