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Quad Cities 1 – Quarterly Plant Inspection Findings

2Q/2017 – Plant Inspection Findings

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Initiating Events

Mitigating Systems

Significance: G Mar 31, 2017

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

FAILURE TO ENSURE HARDWARE SECURE FOR BREAKER MOC SWITCH LINKAGE

A finding of very low safety significance and an associated NCV of 10 CFR 50, Appendix B, Criterion V was self revealed on January 27, 2017, when the Unit 1C residual heat removal service water (RHRSW) pump was started for a routine surveillance evolution and all expected annunciators and equipment failed to operate properly, which led to the licensee declaring the Unit 1C RHRSW pump inoperable. Specifically, the licensee failed to establish a procedure for the mechanism operated contact (MOC) switch linkage arm that was appropriate to the circumstances to ensure the component would continue to perform its function. Immediate corrective actions included reconnecting the MOC switch linkage arm assembly and testing it by starting the 1C RHRSW pump prior to declaring the pump operable. In addition, the licensee planned procedure revisions to QCEPM 0200-11 that would specify a torque value to ensure the MOC switch linkage arm was adequately secured and could perform its function. This issue was entered into the licensee's corrective action program as Issue Report 3967424.

The finding was determined to be more than minor because the finding was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to ensure the MOC switch linkage arm was adequately fastened led to the failure of the component and its associated Unit 1C RHRSW pump during breaker operation on January 27, 2017. The finding was determined to be of very low safety significance (Green), because the inspectors answered "No" to all of the questions in IMC 0609, Appendix A, "The Significance Determination Process for Findings at Power," Exhibit 2, "Mitigating Systems Screening Questions," Section A, "Mitigating SSCs and Functionality." The inspectors determined this finding affected the cross-cutting area of human performance, in the aspect of avoid complacency, which states, "Individuals recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes."

Specifically, the licensee failed to recognize a potential risk and inherent latent issue for a condition identified in 2015 at Quad Cities, when a MOC switch failed to perform its function due to a missing nut in a different breaker's linkage assembly. The licensee identified and corrected the condition but failed to evaluate the cause of the missing nut because it did not impact the operability of the component. In the 2015 instance, the MOC switch issue only affected indications for the component and had no adverse impact on the ability of the component to perform its function [H.12].

Inspection Report# : 2017001 (*pdf*)

Significance:  Dec 31, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

FAILURE TO IMPLEMENT FOREIGN MATERIAL EXCLUSION CONTROLS

A finding of very low safety significance and an associated non-cited violation of Title 10 of the Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self revealed for the licensee's failure to implement foreign material exclusion (FME) controls during the implementation of modification Work Order 1649339, "Modify the Target Rock to Increase the Volume per Engineering Change 394119," and was contrary to MA-AA-716-008, "Foreign Material Exclusion Program," Revision 9. The failure to implement FME controls during maintenance led to the failure of the Unit 2 Target Rock safety relief valve solenoid valve during surveillance testing on April 5, 2016. The licensee's corrective actions included replacing the Target Rock safety relief valve solenoid valve. In addition, the licensee made procedure revisions to the standard template for welding activities to ensure that a FME plan is developed when performing butt welds or weld repairs. The licensee entered this issue into their corrective action program as Issue Report 2703233.

The finding was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of Equipment Performance. The inspectors determined the finding represented a potential loss of the valve function and, therefore, a detailed risk evaluation was required. A regional senior risk analyst performed a detailed risk evaluation and determined the finding was of very low safety significance. This finding had a cross-cutting aspect in the area of Human Performance, Work Management, because the licensee did not implement a process of planning, controlling, and executing work activities such that nuclear safety was an overriding priority. Specifically, during the implementation of Work Order 1649339 and subsequent revisions, the licensee failed to control and execute the work while following FME processes and procedures [H.5].

Inspection Report# : 2016004 (*pdf*)

Significance:  Aug 26, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Provide Appropriate Operating Instructions for Aligning a Battery Charger to the Station Black-Out Diesel Generator (Section 1R17.1.b.)

Green. A finding of very-low safety significance (Green) and an associated NCV of Technical Specification 5.4.1.a, "Procedures," was self-revealed on December 2, 2014 when procedural guidance failed to be implemented as written. Specifically, Procedure QCOA 6100-17, Revision 12, "Loss of SBO [Station Black-Out Normal 13.8kV Transformer T42R-6 Feed to 4kV Bus 61 and 71]," included inappropriate guidance to cross-tie Bus 61 and Bus 71. The licensee's procedural guidance as written were technically infeasible and could not be implemented due to breaker interlocks caused by the digital control system interface that precluded the 4kV buses 61 and 71 from being cross-tied. The licensee entered this finding into their Corrective Action Program as Issue Report 2487426 and Issue Report 2706435 and removed the guidance to cross-tie the 4KV buses from the procedure.

The performance deficiency was determined to be more-than-minor because it was associated with the Mitigating System cornerstone attribute of design control and adversely affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences

(i.e., core damage). The finding screened as of very-low safety significance (Green) because it did not result in the loss of operability or functionality of any structure, system, or component. Specifically, using other procedural guidance, operators were able to start both station black-out diesels within the hour. The inspectors did not assign a cross-cutting aspect associated with this finding because it was not confirmed to reflect current performance. (Section 1R17.1.b.)

Inspection Report# : 2016008 (*pdf*)

Significance:  Aug 26, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Evaluate the Target Rock Relief Valve Accumulator per ASME Code (Section 1R17.2.b.)

Green. The inspectors identified a finding of very-low safety significance (Green) and an associated NCV of Title 10 of the Code of Federal Regulations, Part 50, Appendix B, Criterion III, "Design Control," for licensee's failure to assure that quality standards for the Target Rock Relief valve accumulator were specified and included in the design documents and that deviations were identified and controlled. Specifically, Engineering Change (EC 394119) fabricated the replacement Unit 2 Target Rock valve accumulator to American National Standard B31.1 Power Piping code requirements instead of the applicable American Society of Mechanical Engineers Boiler and Pressure Vessel Code, Section VIII requirements, without adequate justifications. The licensee captured this issue in their Corrective Action Program as IR 02708406 to evaluate the appropriate corrective actions and revise documentation as required. The performance deficiency was determined to be more-than-minor because it was associated with the Mitigating System cornerstone attribute of design control and adversely affected the cornerstone objective to ensure the availability, and reliability of systems that respond to initiating events to prevent undesirable consequences. The finding screened as of very-low safety significance (Green) because it did not result in the loss of operability or functionality of any affected structure, system, or components. This finding has a cross-cutting aspect in the area of Human Performance in the area of Design Margin because the licensee failed to maintain equipment within its design margins. (Section 1R17.2.b.) [H.6]

Inspection Report# : 2016008 (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Current data as of : August 03, 2017

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