



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION III  
801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351

December 22, 1999

Mr. Oliver D. Kingsley  
President, Nuclear Generation Group  
Commonwealth Edison Company  
ATTN: Regulatory Services  
Executive Towers West III  
1400 Opus Place, Suite 500  
Downers Grove, IL 60515

**SUBJECT: INSPECTION PLAN - QUAD CITIES NUCLEAR POWER STATION**

Dear Mr. Kingsley:

On December 1, 1999, the NRC staff reviewed the performance of Quad Cities Nuclear Power Station as reflected in the performance indications and inspection results in order to integrate performance information and to plan for inspection activities at your facility from December 1, 1999, to July 31, 2000. The purpose of this letter is to inform you of our plans for future inspections at your facility so that you will have an opportunity to prepare for these inspections and to inform us of any planned inspections which may conflict with your plant activities.

Based on our review of performance at Quad Cities, we identified that the threshold from Green (licensee response band) to White (increased regulatory response band) was crossed for the Heat Removal System Unavailability performance indicator in the third quarter of 1999. We will review this as a supplemental inspection (IP 95001) by the resident inspector staff in accordance with the action matrix of the new assessment process. Another threshold was crossed from Green to White and back to Green in the plant protection area. This was identified by aggressive action on your part to review and report additional performance indicator information for Perimeter Alarm Security Equipment Performance. We have already completed a supplemental inspection to assess this performance indicator color change.

The NRC staff also has had numerous discussions with ComEd personnel about interpretations and information provided for other performance indicators. We understand that your staff has put significant effort into correctly reporting performance indicator data. Based on your efforts, evolving interpretations and definitions for some performance indicators, and the continuing discussions between us, we plan to perform additional baseline inspection using the Performance Indicator Verification procedure during the next 8 months.

Additionally, the staff has identified a potential adverse trend in the cross-cutting area of Problem Identification and Resolution. Our findings in this area include motor operated valves with test results outside of the acceptance criteria, contaminated condensate storage tanks with fewer operable heaters than designed, and repetitive failures of a high pressure coolant injection valve. While the adverse trend has not yet resulted in performance indicators or inspection findings outside of the licensee response band, our inspection plan includes a

Problem Identification and Resolution inspection in June of 2000. This is early in the next assessment period which runs from April 1, 2000, to March 31, 2001.

Enclosure 1 details the scheduled inspections that will occur from December 1, 1999, to July 31, 2000. Also, we will continue to conduct the resident inspector baseline procedures; although the resident inspections are not listed due to their ongoing and continuous nature. The last 4 months of the inspection plan are tentative and may be revised based on the results of our end-of-cycle review meeting. Enclosure 2 is the Plant Issue Matrix that was used as part of the mid-cycle review. Note that Enclosure 2 contains entries for Inspection Report 1999010 which were considered in our review, but were not part of the Pilot Plant Inspection Program.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room (PDR).

If circumstances arise which cause us to change this inspection plan, we will contact you to discuss the change as soon as possible. Please contact me at 630/829-9703 with any questions you may have regarding this letter or the inspection plan.

Sincerely,



Mark A. Ring, Chief  
Reactor Projects Branch 1  
Division of Reactor Projects

Docket Nos. 50-254; 50-265  
License Nos. DPR-29; DPR-30

Enclosures: 1. Inspection Plan  
2. Plant Issue Matrix

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**SEE PREVIOUS CONCURRENCES**

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NAME	Lerch/tr		Ring		Grobe		Grant <i>MZO for</i>	
DATE	12/ /99		12/ /99		12/ /99		12/22/99	

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O. Kingsley

-2-

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NAME	Lerch/irp/for		Ring ml		Grobe		Grant
DATE	12/21/99		12/21/99		12/21/99		12/ /99

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G. Barnes, Quad Cities Station Manager  
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**QUAD CITIES**  
**Inspection / Activity Plan**  
**12/01/1999 - 07/31/2000**

ENCLOSURE 1

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates		Inspection Type
					Start	End	
	<b>IP 71121 - RADIATION PROTECTION INSP (UNIT 2)</b>		<b>3</b>				
1, 2	IP 71121.02	ALARA Planning and Controls		3	01/24/2000	02/04/2000	Other Routine
	<b>ISI - QUAD ISI INSP (UNIT 2)</b>		<b>1</b>				
1, 2	IP 71111.08	Inservice Inspection Activities (I,B)		1	01/31/2000	02/04/2000	Other Routine
	<b>IP 71114 - ROUTINE EMERGENCY PREPAREDNESS INSP.</b>		<b>2</b>				
1, 2	IP 71114.02	Alert and Notification System Testing		2	02/14/2000	02/18/2000	Other Routine
1, 2	IP 71114.03	Emergency Response Organization Augmentation Testing, Identification, and R		2	02/14/2000	02/18/2000	Other Routine
1, 2	IP 71114.04	Emergency Action Level Changes		2	02/14/2000	02/18/2000	Other Routine
1, 2	IP 71151	Performance Indicator Verification		2	02/14/2000	02/18/2000	Other Routine
	<b>FY 2000 - QUAD CITIES INIT PREP 02/2000</b>		<b>3</b>				
1	W83296	OL EXAMS - QUAD CITIES UNITS 1 & 2 050-254/265		3	03/06/2000	03/10/2000	Not Applicable
	<b>FY 2000 - QUAD CITIES INIT EXAM 03/2000</b>		<b>3</b>				
1	W83296	OL EXAMS - QUAD CITIES UNITS 1 & 2 050-254/265		3	03/27/2000	03/31/2000	Not Applicable
	<b>RP - ACCESS CONTROL, RADWASTE, &amp; TRANSPORT.</b>		<b>1</b>				
1, 2	IP 71121.01	Access Control to Radiologically Significant Areas		1	04/24/2000	04/28/2000	Other Routine
1, 2	IP 71122.02	Radioactive Material Processing and Shipping		1	04/24/2000	04/28/2000	Other Routine
1, 2	IP 71151	Performance Indicator Verification		1	04/24/2000	04/28/2000	Other Routine
	<b>OSRE - OPERATIONS SAFEGUARD RESPONSE EVALUATION</b>		<b>5</b>				
1, 2	IP 81700	Physical Security Program For Power Reactors		1	05/01/2000	05/05/2000	Core
	<b>PI&amp;R - PROBLEM IDENTIFICATION &amp; RESOLUTION</b>		<b>3</b>				
1, 2	IP 71152	Identification and Resolution of Problems		1	06/19/2000	06/23/2000	Other Routine
	<b>IP 71114 - EMERGENCY PREPAREDNESS BIENNIAL EXERCISE</b>		<b>3</b>				
1, 2	IP 71114.01	Drill and Exercise Inspection		3	07/11/2000	07/14/2000	Other Routine
	<b>RP - ACCESS CONTROL &amp; INSTRUMENTATION</b>		<b>1</b>				
1, 2	IP 71121.01	Access Control to Radiologically Significant Areas		1	07/31/2000	08/04/2000	Other Routine
1, 2	IP 71121.03	Radiation Monitoring Instrumentation		1	07/31/2000	08/04/2000	Other Routine

This report does not include INPO and OUTAGE activities.  
This report shows only on-site and announced inspection procedures.

**United States Nuclear Regulatory Commission**  
**Revised Oversight Process PLANT ISSUE MATRIX**

ENCLOSURE 2

By Cornerstone

Region 3

QUAD CITIES

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
07/21/1999	1999010	NRC	MISC	Operations	Identification	<p><b>configuration control as a multi-site issue</b></p> <p>In June 1998, the licensee identified configuration control as a multi-site issue that affected all sites within the Nuclear Generation Group. In response to the continuing configuration control occurrences, the licensee implemented numerous corrective action initiatives to improve performance in this area. While these initiatives have resulted in improved performance, the continuing events at the Braidwood, Byron, and Quad Cities Stations indicated that the corrective actions had not been fully effective. These occurrences were primarily attributable to human performance deficiencies with the largest contributor to these occurrences involving maintenance activities. (Section O7.1)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Normal Operations	<p><b>The licensee's communication method</b></p> <p>The licensee's communication method (e.g., daily station bulletin handouts, departmental briefings, and bulletin boards) for establishing and maintaining a consistent awareness and understanding of plant issues had not been fully effective. (Section O8.1)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Programs and Processes	<p><b>station personnel were not knowledgeable of the abnormal component position process</b></p> <p>The inspectors concluded that with the exception of operators, station personnel were not knowledgeable of the abnormal component position process delineated in Common Work Practice Instruction NSP-OP-1-20, "Operational Configuration Control." (Section O4.2)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	KSA	<p><b>Station personnel generally did not recognize and understand the configuration control and human perfor</b></p> <p>Station personnel generally did not recognize and understand the configuration control and human performance issues that existed at their site. As a result, the licensee had not been fully effective in improving performance in these areas since station personnel did not recognize the need to improve. (Section O4.4)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	KSA	<p><b>management's expectation to spend between 40 and 50 percent of their time in the field</b></p> <p>First line supervision did not meet licensee management's expectation to spend between 40 and 50 percent of their time in the field reinforcing standards and expectations. First line supervision also exhibited an insufficient understanding of the station's performance issues and demonstrated knowledge weaknesses in the areas of verification practices and the abnormal component position process. Consequently, the effectiveness of first line supervision was limited. (Section O4.5)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Identification	<p><b>The licensee did not consistently perform self-assessments regarding operational configuration control</b></p> <p>The licensee did not consistently perform self-assessments regarding operational configuration control and human performance to a standard; and in some cases, these assessments were not self-critical. Consequently, the quality and effectiveness of these self-assessments varied significantly. (Section O7.5)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						



## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 QUAD CITIES

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07/21/1999	1999010	NRC	NEG	Operations	Identification	<p><b>The licensee's evaluation of NRC Information Notice 98-34</b></p> <p>The licensee's evaluation of NRC Information Notice 98-34, "Configuration Control Errors," was incomplete. Specifically, Byron Station focused too narrowly on the specific examples identified in the information notice and did not evaluate the issue generically. In addition, Quad Cities Station addressed the issue broadly, but did not evaluate the specific examples identified in the information notice. (Section O7.6)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Identification	<p><b>The licensee did not fully utilize the intra-lessons learned program</b></p> <p>The licensee did not fully utilize the intra-lessons learned program to ensure that configuration control problems identified at other Commonwealth Edison stations were addressed at each site. Specifically, the licensee frequently focused too narrowly on the details of the issue identified in the nuclear operations notification and did not address the causes of the problem. (Section O7.7)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Analysis	<p><b>Corporate Nuclear Oversight Five Station Configuration Control Assessment</b></p> <p>The licensee implemented corrective actions to address the issues identified during the Corporate Nuclear Oversight Five Station Configuration Control Assessment, which was conducted in June 1998, with the following exception. The licensee had not implemented corrective actions to address the finding that nuclear oversight inconsistently responded to configuration control events and missed opportunities to provide the stations with configuration control event insights. (Section O7.3)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Analysis	<p><b>The licensee did not fully utilize the effectiveness review process</b></p> <p>The licensee did not fully utilize the effectiveness review process to evaluate implemented corrective actions to address recurring configuration control issues. Consequently, the licensee had missed opportunities to proactively identify which corrective action initiatives had not been fully effective in addressing the long-standing configuration control issues at each of these stations. (Section O7.8)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Resolution	<p><b>Configuration Control Action Plan items had not been completed.</b></p> <p>Several of the Nuclear Generation Group Configuration Control Action Plan items had not been completed. In addition, the licensee had not evaluated the effectiveness of the action plan in addressing the long-standing configuration control issue at each of the sites. (Section O7.2)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/21/1999	1999010	NRC	NEG	Operations	Resolution	<p><b>the site nuclear oversight organizations were occasionally not effective</b></p> <p>The inspectors concluded that the site nuclear oversight organizations were occasionally not effective at identifying precursor level issues prior to their manifestation in plant events. In addition, site nuclear oversight organizations were not consistently escalating long-standing issues to ensure that the issues were addressed effectively and in a timely manner. (Section O7.4)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						

## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 QUAD CITIES

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
07/21/1999	1999010	NRC	POS	Operations	Normal Operations	<p><b>Station personnel generally understood who was authorized to operate plant equipment</b></p> <p>Station personnel generally understood who was authorized to operate plant equipment and their understanding was consistent with the station's policies. (Section O4.1)</p> <p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>
07/21/1999	1999010	NRC	POS	Operations	Identification	<p><b>the Nuclear Oversight Monthly Issues Report</b></p> <p>The inspectors concluded that the Nuclear Oversight Monthly Issues Report contained a thorough evaluation of the issues that needed to be resolved at each station. (Section O7.4)</p> <p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>
07/21/1999	1999010	NRC	POS	Operations	Resolution	<p><b>Configuration Control Action Plan represented a comprehensive corrective action initiative.</b></p> <p>The Nuclear Generation Group Configuration Control Action Plan represented a comprehensive corrective action initiative. (Section O7.2)</p> <p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>
07/21/1999	1999010	NRC	WK	Operations	Programs and Processes	<p><b>Standardized processes for operational configuration control and verification practices.</b></p> <p>The licensee did not consistently implement the standardized processes for operational configuration control and verification practices. In addition, the policies and expectations were not proceduralized, and differences existed regarding who was authorized to manipulate plant equipment. The implementation of processes at each site which had not been standardized including aspects of the out-of-service program, the system line-up process, and the locked valve program. These inconsistencies were notable since the licensee frequently shared personnel between sites. These individuals may not be aware of the differences. (Section O3.1)</p> <p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>
07/21/1999	1999010	NRC	WK	Operations	Programs and Processes	<p><b>a large backlog of procedures in the review and approval process.</b></p> <p>The manner in which standardized procedures had been implemented at each of the sites resulted in a large backlog of procedures in the review and approval process. Consequently, some standardized procedures were not implemented in a timely manner. In addition, a lack of rigor in the licensee's implementation of the procedural review and approval process resulted in multiple procedures existing for the same topic and insufficient training on some procedure changes. This contributed to knowledge weaknesses regarding the implementation of verification practices and the abnormal component position process. (Section O3.2)</p> <p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>
07/21/1999	1999010	NRC	WK	Operations	Programs and Processes	<p><b>inconsistent understanding of verification practices</b></p> <p>Station personnel had an inconsistent understanding of verification practices. Specifically, confusion existed regarding the differences between the verification practices, when each was required to be performed, and who was allowed to perform these verification practices. (Section O4.3)</p> <p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>

# United States Nuclear Regulatory Commission

## Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 QUAD CITIES

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
09/08/1999	1999018	NRC	FIN	Initiating Events	Green	<p><b>Maintenance rule functional failures</b></p> <p>Problematic feedwater level control equipment on Unit 2 resulted in two reactor vessel water level transients in early 1999. The licensee initially evaluated these two events as not being maintenance rule functional failures, which was inappropriate. An NRC inspection and a subsequent licensee self-assessment identified the error. The licensee re-evaluated the two transients as being functional failures on July 28, 1999. This issue did not increase the frequency of initiating events and therefore was an issue of very low safety significance (Section 1R12).</p>
<p><b>Dockets Discussed:</b>            05000265 QUAD CITIES 2</p>						
07/20/1999	1999011	NRC	FIN	Initiating Events	Green	<p><b>a 3-inch increase in reactor water level</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
10/20/1999	1999020	NRC	FIN	Mitigating Systems	Green	<p><b>The high pressure coolant injection system outboard steam isolation valve failed to close on October 4, 1999</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1</p>						
10/20/1999	1999020-04	NRC	NCV	Mitigating Systems	Green	<p><b>two examples of inadequate corrective action regarding the Units 1 and 2 safety-related control room emergency ventilation system</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
09/08/1999	1999018	NRC	FIN	Mitigating Systems	Green	<p><b>A grounded resistor in the governor circuit that caused a failure of the Unit 2 reactor core isolation cooling pump</b></p> <p>On August 26, 1999, the licensee identified a grounded resistor in the governor circuit that caused a failure of the Unit 2 reactor core isolation cooling pump. The inspectors used the significance determination process to identify this event as having very low safety significance for the loss of offsite power initiating event due to the availability of other mitigating equipment (Section 1R22.2).</p>
<p><b>Dockets Discussed:</b>            05000265 QUAD CITIES 2</p>						

# United States Nuclear Regulatory Commission

## Revised Oversight Process PLANT ISSUE MATRIX

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09/08/1999	1999018	NRC	FIN	Mitigating Systems	Green	<p><b>Motor-operated valve dynamic testing</b></p> <p>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.</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
09/08/1999	1999018	NRC	FIN	Mitigating Systems	N/A	<p><b>Removal of a high pressure injection pump in parallel with testing on an emergency diesel generator</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
09/03/1999	1999017	NRC	FIN	Mitigating Systems	Green	<p><b>Copy of post-modification test not retained</b></p> <p>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.</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/20/1999	1999011-01	NRC	NCV	Mitigating Systems	Green	<p><b>Corrective Action for Flooding Procedures.</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/16/1999	1999012	NRC	FIN	Mitigating Systems	Green	<p><b>Corrective actions to address a Unit 1 emergency diesel generator failure</b></p> <p>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.</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/16/1999	1999012-02	NRC	NCV	Mitigating Systems	Green	<p><b>Excessive thrust conditions, found during testing of motor operated valves</b></p> <p>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)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						

## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 QUAD CITIES

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
07/15/1999	1999014	NRC	FIN	Mitigating Systems	Green	<p><b>The surveillance procedure for evaluating thermal performance of the residual heat removal heat exchange</b></p> <p>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.</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/15/1999	1999014-01	NRC	NCV	Mitigating Systems	Green	<p><b>Three Examples of Design Control Relating to Original Plant Design</b></p> <p>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</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
09/08/1999	1999018-01	NRC	NCV	Barrier Integrity	Green	<p><b>Failure to promptly correct a design deficiency with the standby gas treatment system.</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/20/1999	1999011-03	NRC	NCV	Barrier Integrity	Green	<p><b>Secondary Containment Penetration.</b></p> <p>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 40A3). 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.</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/02/1999	1999013	NRC	FIN	Public Radiation Safety	Green	<p><b>Lack of Documentation for Offsite Dose Calculation Manual Revisions</b></p> <p>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.</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
10/20/1999	1999020	NRC	FIN	Miscellaneous	N/A	<p><b>The licensee corrected discrepancies with the safety system functional failure indicator.</b></p> <p>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 40A3).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						

## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

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Region 3  
 QUAD CITIES

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
10/20/1999	1999020-01	NRC	NCV	Miscellaneous	N/A	<p><b>The licensee failed to notify the NRC within 4 hours of an event in which the Unit 2 reactor core isolation c</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000265 QUAD CITIES 2</p>						
10/20/1999	1999020-02	NRC	NCV	Miscellaneous	N/A	<p><b>The licensee failed to notify the NRC within 1 hour of identifying a condition in which the control room em</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
10/08/1999	1999022	Licensee	FIN	Miscellaneous	N/A	<p><b>The licensee identified errors in the PI Occupational Radiation Safety Performance Indicator (PI)</b></p> <p>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).</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/23/1999	1999016-01	NRC	URI	Miscellaneous	TBD	<p><b>Perimeter Alarm System Performance Index Change</b></p> <p>The licensee identified that the process used to determine and compute the index value number for the Protected Area Security Equipment Performance Index did not capture all application information. The subsequent calculation of the correct data changed the established response band and placed performance in the white response band for the first two calendar quarters of 1999 instead of the green response band which the licensee had reported to the NRC. A response threshold was crossed. The licensee has entered this issue in their corrective action system.</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						
07/16/1999	1999012-03	NRC	NCV	Miscellaneous	Green	<p><b>the repetitive problem of excessive use of overtime.</b></p> <p>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 40A1.4, page 8)</p>
<p><b>Dockets Discussed:</b>            05000254 QUAD CITIES 1            05000265 QUAD CITIES 2</p>						

**United States Nuclear Regulatory Commission**  
**Revised Oversight Process PLANT ISSUE MATRIX**  
By Cornerstone

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**Legend**

**Type Codes:**

AV	Apparent Violation
FIN	Finding
NCV	NonCited Violation
URI	Unresolved item
VIO	Violation

**ID Codes:**

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

AVs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the AVs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.