United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region III
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
12/17/1999	1999022	Pri:	NRC	POS	Pri:	**Licensee preparations for cold weather were adequate.**
		Sec:			Sec:	Licensee preparations for cold weather were adequate. (Section O1.7)
Dockets Discussed: 05000373 La Salle 1, 05000374 La Salle 2					Ter:	
01/06/2000	1999016	Pri: OPS	NRC	NEG	Pri:	**Licensed operator requal program evaluation**
		Sec:			Sec:	The inspectors were concerned with a lapse in operating crew communications and monitoring of plant status during one simulator scenario evaluation which resulted in inappropriate emergency operating procedural actions. The licensee took appropriate remedial actions for this performance (Section O4.1).
Dockets Discussed: 05000373 La Salle 1, 05000374 La Salle 2					Ter:	
01/06/2000	1999016	Pri: OPS	NRC	POS	Pri:	**Licensed operator requal program evaluation**
		Sec:			Sec:	During observations of control room activities, the inspectors concluded that control room operators demonstrated professional behavior, maintained a businesslike decorum, and focused on performing plant evolutions safely and correctly (Section O1.1).
Dockets Discussed: 05000373 La Salle 1, 05000374 La Salle 2					Ter:	
01/06/2000	1999016	Pri: OPS	NRC	POS	Pri:	**Licensed operator requal program evaluation**
		Sec:			Sec:	Overall operator performance observed by inspectors during the annual licensed operator requalification operating and written examination was satisfactory (Section O4.1).
Dockets Discussed: 05000373 La Salle 1, 05000374 La Salle 2					Ter:	
01/06/2000	1999016	Pri: OPS	NRC	POS	Pri:	**Licensed operator requal program evaluation**
		Sec:			Sec:	The licensed operator requalification training program continued to focus on operator performance improvement and the inspectors noted improvement in the quality of examination material and operator performance evaluations (Section O5.1).
Dockets Discussed: 05000373 La Salle 1, 05000374 La Salle 2					Ter:	
01/06/2000	1999016	Pri: OPS	NRC	POS	Pri:	**Licensed operator requal program evaluation**
		Sec:			Sec:	The licensee satisfactorily administered the annual requalification examinations and evaluated operator performance according to program guidance which was consistent with regulatory guidelines. The overall quality and content of the annual requalification examination material was satisfactory. Examination security and simulator fidelity was satisfactory throughout the examination period (Section O5.2 and Section O5.3).
Dockets Discussed: 05000373 La Salle 1, 05000374 La Salle 2					Ter:	

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01/06/2000	1999016	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Licensed operator requal program evaluation** The licensed operator requalification training program had adequate controls in place to provide an effective systematic approach for incorporating necessary changes to improve training based on various sources of feedback (Section O5.4). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
01/06/2000	1999016	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Licensed operator requal program evaluation** The licensee's remediation training plan preparation, and administration and re-evaluation processes were sufficient to correct identified performance deficiencies and to assure that operators could safely resume licensed duties (Section O5.5). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
01/06/2000	1999016	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Licensed operator requal program evaluation** All licensed operator medical records reviewed by inspectors indicated operators were current in their biennial medical examinations and medical license restrictions. The licensee's program effectively maintained operator licenses active in accordance with 10 CFR 55.53(e) and (f) (Section O5.6 and Section O5.7). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
12/17/1999	1999022	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**An error in the thermal power computer calculation used for Unit 1 and Unit 2 allowed Unit 1 to exceed the lic** An error in the thermal power computer calculation used for Unit 1 and Unit 2 allowed Unit 1 to exceed the licensed thermal power limit (3323 megawatts thermal) by up to 0.14 percent and Unit 2 by up to 0.21 percent. (Section O1.6) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
12/17/1999	1999022	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**During Unit 1 refueling outage L1R08, licensee personnel failed to bypass local power range monitors (LPRM** During Unit 1 refueling outage L1R08, licensee personnel failed to bypass local power range monitors (LPRMs) when the associated LPRM fuses were removed. This resulted in incorrect inputs to the average power range monitors which rendered them inoperable. One Non-Cited violation was identified. (Section O8.1) **Dockets Discussed:** 05000373 La Salle 1
12/17/1999	1999022	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**A number of human performance errors occurred during Unit 1 refueling outage activities.** A number of human performance errors occurred during Unit 1 refueling outage activities. These errors were due, in large part, to the failure of personnel to self-check or independently verify that the correct equipment was being operated, or was being removed for maintenance. (Section O1.2) **Dockets Discussed:** 05000373 La Salle 1

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12/17/1999	1999022	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**Adequate controls for the handling and storage of fuel during the Unit 1 refueling outage were delineated in s** Adequate controls for the handling and storage of fuel during the Unit 1 refueling outage were delineated in station procedures and the vast majority of fuel movement activities were adequately conducted. However, due to a lack of attention-to-detail and a failure to adequately conduct self-checking and independent verifications, four fuel postitioning errors occurred. (Section O1.3) **Dockets Discussed:** 05000373 La Salle 1
12/17/1999	1999022	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**Although the closeout of the Unit 1 drywell was well-controlled, suppression pool closeout activities were not** Although the closeout of the Unit 1 drywell was well-controlled, suppression pool closeout activities were not rigorously controlled. (Section O1.2) **Dockets Discussed:** 05000373 La Salle 1
12/17/1999	1999022	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Overall, the performance of operations department personnel during plant operations at power was good. H** Overall, the performance of operations department personnel during plant operation at power was good. However, in one instance, operator logs were not accurate and this was not identified by licensed operators during shift turnover reviews. (Section O1.1) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
12/17/1999	1999022	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The conduct of heavy load movements during the Unit 1 refueling outage occurred in a slow and controlled** The conduct of heavy load movements during the Unit 1 refueling outage occurred in a slow and controlled manner and were performed well. (Section O1.2) **Dockets Discussed:** 05000373 La Salle 1
12/17/1999	1999022	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Operator actions to address a Unit 2 electro-hydraulic control transient, which included action to manually sc** Operator actions to address a Unit 2 electro-hydraulic control transient, which included action to manually scram the reactor, was good. All equipment responded as required and the plant was placed in a stable condition. One error regarding the verification of plant parameters against Technical Specification limits was observed. (Section O1.4) **Dockets Discussed:** 05000374 La Salle 2
12/17/1999	1999022	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Unit 1 and Unit 2 restart activities were conducted in a well-controlled and deliberate manner.** Unit 1 and Unit 2 restart activities were conducted in a well-controlled and deliberate manner. Although some minor deficiencies, such as the assignment of responsibilities for controlling reactor vessel level and determining criticality, were observed during the Unit 2 startup, licensee actions to address these concerns were effective as demonstrated by Unit 1 startup observations. (Section O1.5) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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12/17/1999	1999022-02	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**Failure to bypass LPRMs** During Unit 1 refueling outage L1R08, licensee personnel failed to bypass local power range monitors (LPRMs) when the associated LPRM fuses were removed. This resulted in incorrect inputs to the average power range monitors which rendered them inoperable. One Non-Cited violation was identified. (Section O8.1)
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
10/28/1999	1999018	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**Two engineered safety feature isolations of the reactor water cleanup system occurred on August 17 and 18, 1** Two engineered safety feature isolations of the reactor water cleanup system occurred on August 17 and 18, 1998, during Unit 1 restart from forced outage L1F35. A root cause investigation attributed the isolations to the failure to adequately revise an abnormal operating procedure following modifications to the system. (Section O8.2)
Dockets Discussed: 05000373 La Salle 1						
10/28/1999	1999018	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 3B **Sec:** **Ter:**	**Operations standards such as procedure adherence and log keeping during routine plant operations not well** Operations standards such as procedure adherence and log keeping during routine plant operations were, at times, not well implemented; and operator knowledge of time to boil during reduced vessel inventory was weak.
Dockets Discussed: 05000373 La Salle 1						
10/28/1999	1999018	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**Operations department performance during infrequent and pre-planned evolutions such as the Unit 1 shutdov** Operations department performance during infrequent and pre-planned evolutions such as the Unit 1 shutdown and cavity floodup was good. However, operations standards such as procedure adherence and log keeping during routine plant operations were, at times, not well implemented; and operator knowledge of time to boil during reduced vessel inventory was weak. (Section O1.1)
Dockets Discussed: 05000373 La Salle 1						
09/16/1999	1999015	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**Several preventable human errors contributed to a Unit 1 automatic reactor shutdown on low reactor vessel** Several preventable human errors contributed to a Unit 1 automatic reactor shutdown on low reactor vessel water level. The errors were not isolated to one department and included operating outside of established procedures, incomplete communications, inadequate pre-job briefs, lack of direct oversight and supervision of activities outside the control room, inadequate control room annunciator response, and lack of specific procedural guidance for the preventative maintenance activity performed. This event provided the second and third examples in a non-cited violation concerning procedure adherence and human performance issues.
Dockets Discussed: 05000373 La Salle 1						
09/16/1999	1999015	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1B **Sec:** **Ter:**	**Operator response to reactor vessel water level oscillations was not in accordance with abnormal operating** Operator response to reactor water level oscillations was not in accordance with abnormal operating procedures and training. This was one of three examples in a non-cited violation concerning procedural adherence and human performance issues. The prompt investigation did not thoroughly address the operator performance issues and as a result very limited corrective actions were taken prior to reactor startup and additional feedwater system testing.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						

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09/16/1999	1999015	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000374 La Salle 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The Unit 2 approach to criticality was conducted in a controlled and deliberate manner.** The Unit 2 approach to criticality was conducted in a controlled and deliberate manner. The material condition problems with the rod sequence control system/reactor manual control system were a challenge to the operators during the startup.
09/16/1999	1999015	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000373 La Salle 1	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Unit 1 startup and return to full power operations was performed in a slow and deliberate manner without prc** Unit 1 startup and return to full power operations was performed in a slow and deliberate manner without problems. The control room crew exhibited a good questioning attitude in identifying, investigating, and resolving unexpected turbine responses during initial turbine roll.
09/16/1999	1999015	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**The control room response to the automatic reactor shutdown was good and rapidly stabilized plant conditior** The control room response to the automatic reactor shutdown was good and rapidly stabilized plant conditions. The licensee's prompt investigation was timely, focused, and highlighted several human errors. Site management made appropriate efforts to engage and improve human performance at the station.
07/28/1999	1999012	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	Self	NEG	**Pri:** 1A **Sec:** **Ter:**	**The operators experienced increased equipment challenges due to long standing degraded equipment issue:** The operators experienced increased equipment challenges due to long standing degraded equipment issues (Section O1.1).
07/28/1999	1999012	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**reactivity management issues** While the individual reactivity management issues, which occurred during the reporting period, were of limited significance, collectively they represented a potential significant challenge to the operators. The licensee had initiated corrective actions for each event; however, management had not evaluated the collective effect of several reactivity management issues on the control room operators (Section O2.1).
07/28/1999	1999012	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The licensee did not ensure the control room and auxiliary electric room ventilation train supporting safe pla** The licensee did not ensure the control room and auxiliary electric room ventilation train supporting safe plant operation was functioning satisfactorily prior to removing the other train from service for preplanned maintenance (Section O2.2).

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07/28/1999	1999012	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The control room operators were knowledgeable of scheduled plant activities and system configurations, att** The control room operators were knowledgeable of scheduled plant activities and system configurations, attentive to the main control room panels, and completed work activities in accordance with approved procedures. In addition, informational briefs conducted by operations shift management were thorough **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**Operators performed well during the power reductions and subsequent power ascensions...** Operators performed well during the power reductions and subsequent power ascensions that were required to establish necessary plant conditions for the Unit 1 condenser cleaning activities (Section M2.2). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** OPS **Sec:**	NRC	WK	**Pri:** 1A **Sec:** **Ter:**	**The inspectors identified that not all shift personnel were attentive during the shift briefs. The inattentivenes** the inspectors identified that not all shift personnel were attentive during the shift briefs. The inattentiveness of the control room operators had been previously identified by Nuclear Oversight but was not corrected prior to the NRC observations (Section O1.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012-01	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 1C **Sec:** **Ter:**	**The Unit Supervisor performed a thorough review of the control room weekly surveillances and identified inv** The Unit Supervisor performed a thorough review of the control room weekly surveillances and identified that invalid assumptions used during an earlier completion of surveillance steps had resulted in the failure to complete all required control rod cycling. The operators promptly completed the missed control rod surveillances. The licensee's root cause investigation and subsequent Licensee Event Report pertaining to the failure to complete rod cycling within the required Technical Specification surveillance interval were thorough (Section O1.2). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**Weak procedural controls associated with valve positions resulted in an improperly configured valve.** Weak procedural controls associated with valve positions resulted in an improperly configured valve. A procedure change request had been initiated but not acted upon to correct the deficiency. This item was similar to a prior, NRC identified, procedural inadequacy documented in Inspection Report 99003, Section O1.2. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**The unexpected and repeated cycling of the Unit 2 "D" Suppression Chamber to Drywell vacuum breaker pre** The unexpected and repeated cycling of the Unit 2 "D" Suppression Chamber to Drywell vacuum breaker presented a burden to control room operators. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**In some instances operators did not consistently adhere to management expectations.** In some instances, however, operators did not consistently adhere to management expectations. Operators were inconsistent in announcing alarm checks and in one instance, did not adhere to station expectations for the conduct of heightened level of awareness briefings.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The operator performing walkdowns of the standby gas treatment system demonstrated good attention to det** The operator performing walkdowns of the standby gas treatment system demonstrated good attention to detail and good operating practices as evidenced by the identification of a rag in the system cubicle.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**A non-licensed operator demonstrated a good questioning attitude during the conduct of rounds.** A non-licensed operator demonstrated a good questioning attitude during the conduct of rounds; the follow-up of the electro-hydraulic control system fluid leak enabled the licensee to identify a deficient procedure.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 3A **Sec:** **Ter:**	**Operators and nuclear engineering personnel appropriately managed an identified fuel bundle leak.** Operators and nuclear engineering personnel appropriately managed an identified fuel bundle leak. Appropriate standing orders and operating instructions were generated for, and understood by, the control room operating crews. The leak was below Technical Specification limits.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	WK	**Pri:** 1C **Sec:** **Ter:**	**A configuration control event occurred due to the failure to update electronic data bases following modificati** A configuration control event occurred due to the failure to update electronic data bases following modification completion. The event itself held minor safety significance.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/22/1999	1999004	**Pri:** OPS **Sec:**	NRC	WK	**Pri:** 3A **Sec:** **Ter:**	**Multiple challenges to operators occurred during the inspection period as a result of human performance wea** Multiple challenges to operators occurred during the inspection period as a result of human performance weaknesses outside of the Operations department. The challenges were self-revealing and the operators appropriately responded to these challenges.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						

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06/22/1999	1999004-03	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 5A **Sec:** **Ter:**	**The licensee's Nuclear Oversight department performed a satisfactory audit of the out-of-service program.** The licensee's Nuclear Oversight department performed a satisfactory audit of the out-of-service program and identified a potential weakness with several long-standing out-of-service checklists. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**A self-induced challenge to plant operations** A self-induced challenge to plant operations occurred when operators failed to ensure that the isolation valve for the turbine stop valve/turbine control valve fast closure alarm was in the correct position. An example of a non-cited violation was identified for the fact that operations personnel inappropriately "N/A'd" the requirement to verify the position of the isolation valve. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 1A **Sec:** **Ter:**	**Unit 1 continued operating safely while considerable station efforts and resources were devoted to supporting** In general, the inspectors observed that operations personnel were knowledgeable of plant and equipment status, maintained accurate records, effectively communicated operational information, and operated equipment in accordance with approved procedures. Unit 1 continued operating safely while considerable station efforts and resources were devoted to supporting the restart of Unit 2. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 1B **Sec:** **Ter:**	**The operators followed approved procedures and took prompt, conservative actions** The operators followed approved procedures and took prompt, conservative actions in response to equipment problems such as the trip of a condensate/condensate booster pump and control rod double notching. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 2A **Sec:** **Ter:**	**Drywell housekeeping was good following completion of the outage** Drywell housekeeping was good following completion of the outage and the condition of the drywell was satisfactory to support the Unit 2 startup. No equipment abnormalities were found and the housekeeping items would not have impacted plant activities. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 3A **Sec:** 2A **Ter:**	**Operators generally performed well during the restart of Unit 2.** Operators generally performed well during the restart of Unit 2. Few material condition deficiencies occurred to significantly challenge the operators. Operator performance, good plant material condition, and acceptable support from other station departments all contributed to a relatively smooth and error-free restart of Unit 2. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 5B **Sec:** **Ter:**	**The circulating water spill accelerated investigation was thorough** The circulating water spill accelerated investigation, after prompting by senior management, was thorough and provided comprehensive corrective actions.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	WK	**Pri:** 1C **Sec:** **Ter:**	**Examples of weaknesses occurred during the performance of fundamental activities** Examples of weaknesses occurred during the performance of fundamental activities such as operator log keeping and entering items into the station's corrective action program. Those examples, combined with several examples of cumbersome written procedures, represented potential weaknesses in the barriers established to ensure sustained, error-free performance. An example of a non-cited violation was identified for failing to log suppression pool temperatures during a surveillance and a non-cited violation was identified for an incorrect annunciator response procedure
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
05/12/1999	1999003	**Pri:** OPS **Sec:**	NRC	WK	**Pri:** 3A **Sec:** **Ter:**	**Operators did not always display a questioning attitude** Operators did not always display a questioning attitude and ensure a thorough understanding of system operation. Operators were not cognizant of the reason for elevated Unit 2 pre-treatment off-gas radiation levels. Operator lack of understanding of the circulating water system operation contributed to a spill of 30,000 gallons of water in the circulating water pit
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
05/12/1999	1999003-01	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**Inadequate annunciator response procedure** On April 13, 1999, during the restart of Unit 2, the inspectors identified that LaSalle Operational Response (LOR) 2PM13J-A101, "Suppression Chamber/Drywell Oxygen Concentration High / Analyzer Trouble," Revision 1, did not provide actions specific to the associated annunciator tile. Specifically, the procedure provided actions to respond to drywell air humidity trouble. The nuclear station operator (NSO) reviewed the LOR following receipt of the alarm and identified that the procedure was not accurate. The NSO reviewed the applicable Unit 1 procedure and did not inform the unit supervisor or initiate a PIF due to the fact that a yellow sticky note with a procedure change request (PCR) number was attached to the inaccurate procedure.
Dockets Discussed: 05000374 La Salle 2						
05/12/1999	1999003-02	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 3A **Sec:** **Ter:**	**A: Procedural compliance with respect to logging data during RCIC surveillance; B: TSV/TCV fast closure al** Two examples of failing to follow procedures. In one case, operators failed to log suppression pool temperatures as required during reactor core isolation cooling system testing. In the second example, operators failed to ensure proper valve configuration associated with the turbine stop valve/turbine control valve fast closure alarm.
Dockets Discussed: 05000374 La Salle 2						
04/02/1999	1999007	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**Some operators lacked knowledge of the difference between the annunciator response procedure setpoints a** The licensee conducted operator training at an acceptable level to provide operators with the skill and knowledge necessary to operate systems modified during the Unit 2 outage. Some operators lacked knowledge of the difference between the annunciator response procedure setpoints and the actual alarming setpoints.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						

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04/02/1999	1999007	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** 2A **Ter:**	**NRC team walk-down inspections identified examples where the licensee's area walk-downs were not thorou** Various plant walk-downs of the reactor water cleanup and standby liquid control systems indicated generally good material condition of plant equipment and components. Equipment was labeled appropriately and in accordance with system drawings. However, team walk-down inspections identified examples where the licensee's area walk-downs were not thorough in identifying miscellaneous housekeeping items. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
04/02/1999	1999007	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 4A **Sec:** **Ter:**	**A discrepancy was identified involving the licensee's Updated Final Safety Analysis Report not being update** A discrepancy was identified involving the licensee's Updated Final Safety Analysis Report not being updated to reflect the physical removal of a valve as part of a design modification. This was identified as a minor violation. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
04/02/1999	1999007	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 1A **Sec:** **Ter:**	**The team concluded that the Integrated Operations Performance Review process was effective in evaluating t** The Nuclear Oversight assessment activities were wide-ranging and effectively challenged the site organizations' overall performance and readiness for plant restart. Based on a review of completed Integrated Operations Performance Review summaries, the team concluded that the Integrated Operations Performance Review process was effective in evaluating the operators' performance against station standards. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
04/02/1999	1999007-01	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**Control room shift manning requirements not met** With one exception, the operating shift staffing met the requirements provided in Technical Specifications and site administrative procedures. One Non-Cited Violation was identified where shift manning requirements were not met during control rod friction testing due to the supervising Senior Reactor Operator having other concurrent duties. Nonetheless, the friction testing was observed to be performed without error and with the appropriate safety focus by licensed individuals performing the test. (Section O1.4) **Dockets Discussed:** 05000374 La Salle 2
03/31/1999	1999002	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**A valve controller designed for automatic operation was being operated in the manual mode was not in the** The inspectors identified a valve controller designed for automatic operation that was being operated in the manual mode, which the licensee did not have in the operator work-around or operator challenge program. The licensee stated its intention to reevaluate the operating practice for the valve. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
03/31/1999	1999002	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** 2A **Ter:**	**In some instances, operations personnel were willing to accept degraded equipment status or operating prac** In some instances, operations personnel were willing to accept degraded equipment status or operating practices and less than expected levels of support from other organizations. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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03/31/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**In general, the inspectors observed the continued good performance of Unit 1 and timely and safe completio** In general, the inspectors observed the continued good performance of Unit 1 and timely and safe completion of the Unit 2 fuel load. The operators' response to events on Unit 1 including failure of the B reactor recirculation flow control valve rotational variable differential transformer controller and the fuel element leak was safe and in accordance with procedures. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
03/31/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee's Restart Issues Review Committee and the Plant Operations Review Committee meetings were** The licensee's Restart Issues Review Committee and the Plant Operations Review Committee meetings were structured and comprehensive. Licensee management on the committees exhibited a questioning attitude and ensured that Unit 2 was ready to load fuel. Detailed system readiness reviews ensured that station management was aware of issues relevant to each system in the process, and the level of senior station management participation in the process indicated the high priority the licensee placed in the process. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
03/31/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee effectively implemented its restart action plans regarding operator work- arounds, temporary mc** The licensee effectively implemented its restart action plans regarding operator work- arounds, temporary modifications and system readiness reviews. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
03/25/1999	1999002	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**The inspectors identified discrepancies on main control room panel indications on both Unit 1 and Unit 2.** The inspectors identified discrepancies on main control room panel indications on both Unit 1 and Unit 2. In addition, the inspectors found a Unit 2 main control panel switch with an out-of-service card affixed which did not have a label indicating switch position. Although control room indicators were operating correctly and measured parameters were within the range of acceptable values, operators continued to accept parameters indicating outside the green band with some indicating in the red band. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
03/18/1999	1999002-01	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**The Shift Manager declared the check valves operable without requiring an engineering evaluation be com** During a review of the licensee's response to the failure of Unit 1 RHR service water keepfill check valves, the inspectors determined that the Shift Manager declared the check valves operable without requiring an engineering evaluation be completed. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
03/10/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Good preparation by the licensee resulted in fuel moves being completed in a safe and efficient manner.** The preparation and movement of fuel in Unit 2 included timely completion of work activities, in depth reviews and approvals by senior licensee management, thorough training of fuel handling personnel, and significant oversight by the Nuclear Oversight organization. These preparations resulted in fuel moves being completed in a safe and efficient manner. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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03/09/1999	1999002	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The Division II and Division III emergency core cooling system integrated response time tests were completed** The Division II and Division III emergency core cooling system integrated response time tests were completed satisfactorily in accordance with plant procedures and in conformance with Technical Specifications.
02/16/1999	1999001	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**Operations personnel did not take action to ensure discrepancies with main and radwaste control room inst** Several main and radwaste control room instrument displays did not indicate within the respective normal operating band or "green" band, although the actual measured parameters were within the design operating range. Operators were knowledgeable of the correct operating bands and the potential design changes; however, the issues were not identified as control room distractions. Operations personnel did not take action to ensure the discrepancies were appropriately resolved in a timely manner.
12/17/1999	1999022	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Observed surveillance activities were satisfactory overall and met Technical Specification requirements.** Observed surveillance activities were satisfactory overall and met Technical Specification requirements. Although some procedure deficiencies and documentation errors were identified, these errors were minor in nature and did not impact the surveillance activities or results. (Section M1.1)
11/04/1999	1999017	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**NDE Examinations for ISI were performed in accordance with applicable procedures by certified personnel** NDE Examinations for ISI were performed in accordance with applicable procedures by certified personnel.
11/04/1999	1999017	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**The licensee's assessment and oversight of the ISI program was appropriate.** The licensee's assessment and oversight of the ISI program was appropriate for the identification of issues that could adversely impact the program. The licensee was extensively involved in the ISI effort and provided 24-hour oversight.
10/28/1999	1999018	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**An inadequate review of a Unit 1 reactor recirc flow converter calibration resulted in flow transmitter output v** An inadequate review of a Unit 1 reactor recirculation flow converter calibration resulted in flow transmitter output voltages being left outside of acceptable tolerance bands. Although the error resulted in conservative scram setpoints, it represented a lack of attention-to-detail in the review of a safety-related surveillance by maintenance personnel. (Section M1.2)

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10/28/1999	1999018	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3B **Sec:** **Ter:**	**Unit 1 C RR flow unit leads were lifted during OPRM modification activities without understanding the operab** Unit 1 "C" reactor recirculation flow unit leads were lifted during oscillating power range monitor (OPRM) modification activities without understanding the operability effects on the average power range monitor flow biased scram function. Until identified during "F" OPRM modification activities, station engineering, maintenance, work planning, and operations personnel failed to understand the significance of lifting the flow unit leads and failed to perform the required technical evaluations. (Section M8.2) **Dockets Discussed:** 05000373 La Salle 1
10/28/1999	1999018	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Surveillance tests observed by the inspectors were conducted utililizing safe work practices, and demonstrat** Surveillance tests observed by the inspectors were conducted utilizing safe work practices, and demonstrated adequate communications and coordination between the control room and workers performing the tests. Procedure use and adherence was proper. (Section M1.1) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
09/16/1999	1999015	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**Operators were unnecessarily challenged on two occasions.** Operators were unnecessarily challenged on two occasions. First, when maintenance personnel acted outside of an approved troubleshooting procedure causing a combined intermediate valve to cycle and, second, when a half-scram occurred during an oscillating power range monitor modification. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** MAINT **Sec:**	Self	NEG	**Pri:** 2A **Sec:** **Ter:**	**The continued cycling of the Unit 2 D vacuum breaker** The continued cycling of the Unit 2 D vacuum breaker in conjunction with inoperable position indication on the Unit 2 A vacuum breaker presented a repetitive challenge of long duration to the operators (Section M2.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**the partial loss of Rod Position Indication System (RPIS) event.** The licensee's accelerated investigation was timely and effectively identified the root causes of the partial loss of Rod Position Indication System (RPIS) event. Operators and instrument technicians responded appropriately to the loss of control rod indication. Failure to consider this activity high risk, which resulted in the unexpected loss of part of the RPIS, presented a burden to control room operators (Section M1.3). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**unnecessary challenges to control room operators during condenser cleaning activities.** Station personnel have, on occasion, presented unnecessary challenges to control room operators during condenser cleaning activities. Inadequate condenser tube inspections also resulted in unnecessary additional radiation exposure to station personnel (Section M2.2). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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07/28/1999	1999012	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**The improperly performed maintenance on the reactor water cleanup air-operated valves** The improperly performed maintenance on the reactor water cleanup air-operated valves represented a burden to operators attempting to perform a routine evolution. A contributing cause to the event was weak procedural guidance which illustrated a continuation of one of the concerns documented in the prior inspection period (IR 50-373/99004; 50-374/99004) (Section M4.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**The emergency diesel generator fast start surveillances.** The emergency diesel generator fast start surveillances were completed satisfactorily in accordance with plant procedures and in conformance with Technical Specifications (Section M1.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**The licensee's accelerated investigation was timely and effectively identified the root causes of the partial los** The licensee's accelerated investigation was timely and effectively identified the root causes of the partial loss of Rod Position Indication System (RPIS) event. Operators and instrument technicians responded appropriately to the loss of control rod indication.(Section M1.3) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**The licensee's investigation into the improperly re-assembled reactor water cleanup air-operated valves** The licensee's investigation into the improperly re-assembled reactor water cleanup air-operated valves was sufficient to identify the contributing causes to the error (Section M4.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
07/28/1999	1999012	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**Initial actions by instrument maintenance personnel and control room operators** Initial actions by instrument maintenance personnel and control room operators to the partial actuation of the reactor protection system during performance of a routine surveillance test were prompt and in accordance with procedures. Actions initiated by the licensee to review recent similar occurrences for common initiators or problems were appropriate considering that corrective actions for two previous partial did not prevent recurrence (Section M1.2). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
06/22/1999	1999004	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**Licensee maintenance activities associated with work on the safety-related Standby Gas Treatment System d** Licensee maintenance activities associated with work on the safety-related Standby Gas Treatment System did not adequately control foreign material and prevent its entry into the system. Consequently, the system was inoperable for a time period longer than necessary. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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06/22/1999	1999004	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**Unit 1 reactor's main/normal heat sink was vulnerable to loss for a longer period of time than necessary.** Due to human performance errors committed during the main condenser cleanings, the time that the west waterbox was unavailable was unnecessarily extended during time periods when the east waterbox was potentially susceptible to mussel fouling. As a result, the Unit 1 reactor's main/normal heat sink was vulnerable to loss for a longer period of time than necessary.
06/22/1999	1999004	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	WK	**Pri:** 3A **Sec:** **Ter:**	**Troubleshooting activities associated with loss of the Division 3 battery and charger indication were not effec** Troubleshooting activities associated with loss of the Division 3 battery and charger indication were not effectively implemented by station personnel. These efforts failed to determine the root cause of failure and the original problem recurred. Other examples of troubleshooting inefficiencies are discussed in Sections E4.2 and M4.4.
06/22/1999	1999004	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	WK	**Pri:** 3A **Sec:** **Ter:**	**Licensee troubleshooting activities directly impacted annunciators associated with the reactor water cleanup** Licensee troubleshooting activities directly impacted annunciators associated with the reactor water cleanup system which presented an unnecessary challenge to the operators. Other examples of troubleshooting inefficiencies are discussed in Sections E4.2 and M4.1.
05/12/1999	1999003	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Maintenance personnel normally performed work activities in a safe and controlled manner.** Maintenance personnel normally performed work activities in a safe and controlled manner. Mechanics followed adequate procedures and work practices and work was properly scheduled. Mechanics responded promptly to a circulating water system leakage event.
05/12/1999	1999003	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	STR	**Pri:** 3A **Sec:** **Ter:**	**The operators responded conservatively to a similar failure and declared the system inoperable.** In contrast to the residual heat removal (RHR) service water keep fill check valve failure discussed in Inspection Report 99002, the operators responded conservatively to a similar failure and declared the system inoperable.
05/12/1999	1999003	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	WK	**Pri:** 2B **Sec:** **Ter:**	**Procedure change request (PCR) was narrow in scope and not timely.** In response to a previous failure, the system engineer generated a procedure change request (PCR) that was narrow in scope as it did not evaluate the acceptance criteria for all RHR service water keep fill check valves. Also, the scheduled procedure revision was not timely as the procedure would have been completed several times prior to revision. Timely revision of the procedure was a concern as a division of the RHR system must be declared inoperable and maintenance performed on the system following each check valve failure. (Section M1.1)

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05/12/1999	1999003	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	WK	**Pri:** 3A **Sec:** **Ter:**	**An inadequate work package for the traversing in-core probe system delayed the Unit 2 reactor startup** Maintenance personnel normally performed work activities in a safe and controlled manner. Mechanics followed adequate procedures and work practices and work was properly scheduled. Mechanics responded promptly to a circulating water system leakage event. However, an inadequate work package for the traversing in-core probe system delayed the Unit 2 reactor startup.
03/15/1999	1999002	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	Licensee	NEG	**Pri:** 2B **Sec:** **Ter:**	**The licensee identified several maintenance program weaknesses during its investigation into the repetitive fa** The licensee identified several maintenance program weaknesses during its investigation into the repetitive failures of a safety-related transformer supplying control power to the primary containment isolation air assisted check valves. The investigation performed to identify the cause of the repetitive failure was thorough. The licensee formulated acceptable plans to correct identified weaknesses and incorporated the plans into its corrective action program.
03/12/1999	1999002	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 2A **Sec:** 2B **Ter:**	**The inspectors identified that poor maintenance practices and inadequate cleanup of the Unit 2 B/C RHR and** During engineering safety feature system walk-downs, the inspectors identified that poor maintenance practices and inadequate cleanup of the Unit 2 B/C RHR and HPCS corner rooms resulted in several housekeeping deficiencies. The cumulative impact of these items caused the inspectors to question the operability of the B/C RHR systems. No safety significance existed as fuel was not yet loaded in the Unit 2 reactor. The licensee stated that programs were in place to ensure room cleanliness prior to Unit 2 fuel load.
02/16/1999	1999001	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000374 La Salle 2	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**The licensee did not maintain adequate foreign material exclusion boundaries during maintenance activities** The licensee did not maintain adequate foreign material exclusion boundaries during maintenance activities in the Unit 2 drywell in some instances.
02/16/1999	1999001	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000374 La Salle 2	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**Contract personnel noted potentially eroded concrete in the drywell but did not forward the concern to the lic** Contract personnel identified a condition potentially adverse to quality, but did not document the issue or notify licensee management of the concern. Specifically, contract personnel noted potentially eroded concrete in the drywell but did not forward the concern to the licensee's corrective action program. The licensee's corrective actions for the issues were appropriate.
02/09/1999	1999006	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	STR	**Pri:** 2B **Sec:** **Ter:**	**The program for evaluating the risk of taking equipment out of service while on-line was a strength. .** The scheduling process used was effective in minimizing the risk of taking equipment out of service. Shift personnel were able to evaluate the effect of taking equipment out of service. The program for evaluating the risk of taking equipment out of service while on-line was a strength.

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02/02/1999	1999001	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**The licensee identified two errors of contract construction personnel not meeting programmatic requirements** The licensee identified two errors of contract construction personnel not meeting programmatic requirements and management expectations for the out-of-service (OOS) program. The consequences were minimal but the events warranted continued station management attention in reinforcing strict compliance with OOS program requirements to ensure that future instances did not result in more significant problems. The licensee's completed and planned corrective actions were adequate.
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12/17/1999	1999022	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** **Sec:** **Ter:**	**During quarterly surveillance testing of the 2A residual heat removal service water pump, the licensee determ** During quarterly surveillance testing of the 2A residual heat removal service water pump, the licensee determined that pump differential pressure was within the inservice testing required action range. Subsequent investigation revealed a weakness in the equipment trending process when it was discovered that engineering personnel had failed to identify a previous step change in pump differential pressure performance. (Section E2.2)
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
12/17/1999	1999022	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Jet pump modification activities were performed in a satisfactory manner.** Jet pump modification activities were performed in a satisfactory manner. Engineering reviews addressed the appropriate recirculation system safety functions. Remote visual inspection techniques properly measured riser-to-jet pump gap dimensions. (Section E2.1)
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
10/28/1999	1999018	**Pri:** ENG **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**On occasion, licensee personnel failed to perform required 10 CFR 50.59 evaluations and/or screenings durin** On occasion, licensee personnel failed to perform required 10 CFR 50.59 evaluations and/or screenings during troubleshooting, maintenance, temporary modification, and out-of-service activities. Although the individual failures were of relatively low risk significance, collectively the events indicated that some weaknesses may exist in the ability to process and manage work activities that change the configuration of the plant. (Section E1.1)
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
10/06/1999	1999020	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** **Sec:** **Ter:**	**Corrective actions to resolve problems with welds not meeting Code required minimum sizes only addressed** Corrective actions to resolve problems with welds not meeting Code required minimum sizes only addressed two specifically identified cases and did not resolve the problem for the extent of the condition. This corrective action problem was treated as a non-ctied violation.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
10/06/1999	1999020	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** **Sec:** **Ter:**	**The basis for the assumed anchor bolt stiffness value used in calculations to address a piping support design** The basis for the assumed anchor bolt stiffness value used in calculations to address a piping support design issue was not adequately demonstrated. This design control problem was treated as a non-cited violation.
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10/06/1999	1999020	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** **Sec:** **Ter:**	**In the majority of the sample problem identification forms selected during this inspection, the scope of the co** In the majority of the sample of problem identification forms selected during this inspection, the scope of the corrective actions and the associated technical evaluations adequately addressed the root causes of problems and adequately resolved the problem.
07/28/1999	1999012	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 5C **Sec:** **Ter:**	**Engineers provided timely, accurate support to operations personnel for operation with elevated lake temper** Engineers provided timely, accurate support to operations personnel in the revision to the Updated Final Safety Analysis Report and completion of the 10 CFR 50.59 Safety Evaluation Form for operation with elevated lake temperatures. However, the rapid response required by engineering personnel to the rising lake temperature was a direct result of not identifying and implementing corrective actions from the information discussed in a previously completed System Functional Performance Review (Section E2.1).
07/28/1999	1999012	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineers provided timely, accurate support to operations personnel for operation with elevated lake temper** Engineers provided timely, accurate support to operations personnel in the revision to the Updated Final Safety Analysis Report and completion of the 10 CFR 50.59 Safety Evaluation Form for operation with elevated lake temperatures. (Section E2.1).
06/22/1999	1999004	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 4A **Sec:** **Ter:**	**Errors associated with the thermal overload setting for motors in the containment cooling system resulted in a** Errors associated with the thermal overload setting for motors in the containment cooling system resulted in a system trip. This self-revealing error caused a small increase in containment pressure and presented an unnecessary challenge to control room operators. Prior corrective actions taken to address a similar past problem on Unit 1 were narrow in scope and did not address the potential generic application of the original problem.
06/22/1999	1999004	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	WK	**Pri:** 5C **Sec:** **Ter:**	**Licensee troubleshooting activities associated with the reactor core isolation cooling system were slow to de** Licensee troubleshooting activities associated with the reactor core isolation cooling system were slow to develop. The governor valve was disassembled, inspected, reassembled, and re-installed without finding the root cause of its failure to control speed. The root cause of failure was found on the second troubleshooting attempt 3 days after the event. Other examples of troubleshooting inefficiencies are discussed in Sections M4.1 and M4.4.
05/12/1999	1999003	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering personnel generally provided timely and accurate support to plant organizations** Engineering personnel generally provided timely and accurate support to plant organizations

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05/12/1999	1999003	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**The Y2K readiness review was completed with acceptable results. TI 2515/141 was closed.** The Y2K readiness review was completed with acceptable results. TI 2515/141 was closed.
05/12/1999	1999003	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	WK	**Pri:** 4B **Sec:** **Ter:**	**Reactor engineers did not adequately communicate the expected specific activity of the Unit 2 primary coolar** In some instances, engineers provided unclear, incomplete, or inaccurate information while providing support to plant organizations. Reactor engineers did not adequately communicate the expected specific activity of the Unit 2 primary coolant to operators prior to the restart. Nuclear Fuels Management personnel did not clearly communicate the effects of the extended shutdown in the Unit 2 core target rod pattern, and system engineering's lack of understanding of the circulating water pump capabilities contributed to a spill of 30,000 gallons of water in the circulating water pit.
05/12/1999	1999003-17	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	WK	**Pri:** 4B **Sec:** **Ter:**	**Nuclear Fuels Management personnel did not clearly communicate the effects of the extended shutdown in** In some instances, engineers provided unclear, incomplete, or inaccurate information while providing support to plant organizations. Reactor engineers did not adequately communicate the expected specific activity of the Unit 2 primary coolant to operators prior to the restart. Nuclear Fuels Management personnel did not clearly communicate the effects of the extended shutdown in the Unit 2 core target rod pattern, and system engineering's lack of understanding of the circulating water pump capabilities contributed to a spill of 30,000 gallons of water in the circulating water pit.
04/02/1999	1999007	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	STR	**Pri:** 5A **Sec:** **Ter:**	**The team concluded that engineering self-assessments were of good quality and well structured.** The team concluded that engineering self-assessments were of good quality and well structured. The self-assessment performed by the corporate staff was comprehensive. The assessment method was logical, and the presentation of the assessment results was effective. This assessment had resulted in many good findings and recommendations for the site engineering to improve its performance.
04/02/1999	1999007-02	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000374 La Salle 2	NRC	NCV	**Pri:** 4B **Sec:** **Ter:**	**Failure to perform safety evaluation** The temporary modification packages were generally of good quality and appropriately installed. The licensee had adequate procedures to provide administrative controls of the process and safety evaluation preparation for new temporary modifications. However, one temporary modification had changed the plant configuration nonconservatively; also, this was not consistent with the design basis specified in the Updated Final Safety Analysis Report, and no written safety evaluation was provided by the licensee to determine that the change did not involve a Unreviewed Safety Question. This was a Non-Cited Violation. (Section E1.1)
03/26/1999	1999008	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**The assigned system and design engineers were qualified, experienced, and knowledgeable of the assigned** The assigned system and design engineers were qualified, experienced, and knowledgeable of the assigned systems and modifications.

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03/26/1999	1999008	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The installations of selected modifications were walked down and physically examined and were found to be** The installations of selected modifications were walked down and physically examined and were found to be good.
03/26/1999	1999008	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4B **Sec:** 2A **Ter:**	**The overall plant material condition was very good.** The overall plant material condition was very good. Plant areas observed during walk-downs had no visible equipment problems and were very clean except for the Unit 2 steam tunnel where outage work had not been completed.
03/26/1999	1999008	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**Control of temporary modifications was acceptable and there was an emphasis, by engineering management** The number of installed Unit 2 temporary modifications was high; however, only seven were expected to remain installed after Unit 2 begins operations. The inspectors did not consider these modifications to have an impact on plant operations. Engineering personnel were adequately involved and were responsive to plant issues in this area. Control of temporary modifications was acceptable and there was an emphasis, by engineering management, on reducing the number of installed temporary modifications.
03/26/1999	1999008	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**A System Readiness Review and Turnover to Operations Program had been developed and was an excellent** A System Readiness Review and Turnover to Operations Program had been developed and was an excellent method for assuring completion of necessary work on important equipment and systems prior to Unit 2 start-up.
03/26/1999	1999008	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4C **Sec:** 4B **Ter:**	**Overall the installation and post-modification testing of installed Unit 2 modifications were good and no signi** Overall the installation and post-modification testing of installed Unit 2 modifications were good and no significant issues were noted. The plant changes were adequately designed, documented and installed and effective post modification testing was specified and performed. Minor problems were noted in a few modification packages and records and problem identification forms were issued for correction.
03/25/1999	1999002	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The engineering department's response to indications of a leaking fuel rod was timely, deliberate, and appe** The engineering department's response to indications of a leaking fuel rod was timely, deliberate, and appeared appropriate. The licensee determined that a fuel clad leak occurred and initiated actions in accordance with plant procedures. The inspectors reviewed a preliminary plan formulated by the station reactor engineer to minimize the impact of the event. The plan appeared acceptable.

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02/09/1999	1999006	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	STR	**Pri:** 2B **Sec:** **Ter:**	**System engineers were knowledgeable of their responsibilities under the Maintenance Rule.** Maintenance rule functional failure determinations were appropriate. System engineers were knowledgeable of their responsibilities under the Maintenance Rule. Action plans and corrective actions for functions classified as (a)(1) were appropriate. The maintenance rule corrective actions for the process radiation system were effective in improving reliability.
12/17/1999	1999022	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**The licensee failed to control a high radiation area in accordance with Technical Specification requirments.** The licensee failed to control a high radiation area in accordance with Technical Specification requirements. One Non-Cited violation was identified. (Section R1.1)
12/17/1999	1999022	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**Compensatory fire watches during the Unit 1 refueling outage were performed in a satisfactory manner.** Compensatory fire watches during the Unit 1 refueling outage were performed in a satsifactory manner. During a walkdown of potential fire hazards, the inspectors identified a lack of station Fire Marshall involvement in a turbine-driven reactor feedwater pump oil leak. (Section F1.1)
11/12/1999	1999023	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** **Sec:** **Ter:**	**Deficiencies with pre-job dose assessments and documentation for planned personnel contamination events** Deficiencies with pre-job dose assessments and documentation for planned personnel contamination events and intakes were identified by the inspectors and were addressed by the licensee during the inspection. (Section R1.2)
11/12/1999	1999023	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** **Sec:** **Ter:**	**Radiation worker performance.** The inspectors and licensee observed failures of the RP staff to correct radworker performance. Poor work practices contributed to a large number of personnel contamination events and lost dosimetry. (Section R4.1).
11/12/1999	1999023	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2	NRC	NEG	**Pri:** **Sec:** **Ter:**	**Container labeling and labeling procedure deficiencies were identified by the inspectors and acknowledged** Container labeling and labeling procedure deficiencies were identified by the inspectors and acknowledged by radiation protection management. Actions to correct the deficiency were being considered (Section R4.2)

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11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** **Sec:** **Ter:**	**NCV type B shipment of rad material without NRC approved QA program.** The station made one Type B shipment of radioactive material without an NRC approved 10 CFR Part 71 quality assurance program, resulting in a Non-Cited Violation (Section R8.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Radiological planning for outage.** The radiation protection department was adequately involved in the outage work planning process, and an effective interface with the work control organization existed. ALARA initiatives, generally good work planning and improved radiological work control and oversight produced the lowest collective refueling outage dose in station history. (Section R1.1) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**ALARA program implementation.** The ALARA program was generally implemented effectively. ALARA plans were adequately developed and sufficiently thorough, as warranted by the potential job hazards, and their consistency and quality was improved. ALARA initiatives and associated engineering controls were properly established in most instances, and efforts to reduce dose were generally successful. (Section R1.2) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Control and oversight of radiological work.** Radiation protection staff oversight and control of radiological work for the outage was generally effective. (Section R1.3) **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Source team reduction.** Source term reduction strategies were implemented effectively and included a new initiative to achieve future station dose savings through the noble metals injection program. Licensee management invested additional resources in the zinc injection process by using depleted zinc, which is more efficient at source term reduction. Rapid identification of a leaking fuel assembly minimized any outage effect. (Section R1.4). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Radiological postings were adequately maintained and accurately reflected the radiological conditions, and l** Radiological postings were adequately maintained and accurately reflected the radiological conditions, and high and locked high radiation areas were controlled consistent with regulatory requirements. Appropriate contamination control practices were observed at work sites, and radiological controls for work activities were as prescribed by the ALARA plan and the radiation work permit (Section R4.2). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Outage staffing and training for the radiation protection (RP) program was generally effective.** Outage staffing and training for the radiation protection (RP) program was generally effective. The selection process for contract RP technician staff was rigorous, and the contract RP staff experience was factored into assigned outage tasks (Section R5.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**The RP organizational scheme contributed to the overall effectiveness of the outage RP program.** The RP organizational scheme contributed to the overall effectiveness of the outage RP program (Section R6.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
11/12/1999	1999023	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**The Nuclear Oversight department assessments of the outage RP program were well planned and staffed, pr** The Nuclear Oversight department assessments of the outage RP program were well planned and staffed, properly focused and added value to the program (Section R7.1). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
10/28/1999	1999018	**Pri:** PLTSUP **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**Control of a Unit 1 low pressure heater bay locked high-high radiation area was lost for about 4 hours when a** Control of a Unit 1 low pressure heater bay locked high-high radiation area was lost for about 4 hours when a radiation protection technician failed to ensure that an access door was locked when exiting a work area. (Section R1.1) **Dockets Discussed:** 05000373 La Salle 1
09/16/1999	1999015	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Radiation Protection personnel performed satisfactory monitoring of new fuel receipt shipments.** Radiation Protection personnel performed satisfactory monitoring of new fuel receipt shipments. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
09/16/1999	1999015	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Radiation Protection and Chemistry personnel exhibited good radiation dose awareness by reducing hydrog** Radiation Protection and Chemistry personnel exhibited good radiation dose awareness by reducing hydrogen injection rates and minimizing personnel radiation exposure during maintenance following the return of Unit 1 to power operation. **Dockets Discussed:** 05000373 La Salle 1

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08/13/1999	1999014	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Licensee personnel performed proper classifications and timely notifications during one actual activation of** Licensee personnel performed proper classifications and timely notifications during one actual activation of the emergency plan. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/13/1999	1999014	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Emergency response facilities, equipment, and supplies were well maintained and in a state of operational re** Emergency response facilities, equipment, and supplies were well maintained and in a state of operational readiness. Demonstration of emergency response equipment verified that the equipment was operable and ready for use. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/13/1999	1999014	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**The EP Department's corrective action items were effectively tracked using both the old and the new item trac** The EP Department's corrective action items were effectively tracked using both the old and the new item tracking systems. Items tracked had a wide range of categories and had been appropriately addressed by the EP staff. Emergency Plan Implementing Procedures were clear and were consistent with the emergency plan and NRC requirements. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/13/1999	1999014	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**The licensee maintained an effective EP training program.** The licensee maintained an effective EP training program. Personnel were qualified for their emergency response positions. Interviewed emergency response organization personnel successfully demonstrated a very good knowledge of their emergency roles and procedures. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/13/1999	1999014	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Management support for the emergency preparedness program was strong as identified through interviews a** Management support for the emergency preparedness program was strong as identified through interviews and identified upgrades to the program. The EP staff and management were professional and responsive. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/13/1999	1999014	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**The licensee's 1998 and 1999 EP Program audit and assessments of the emergency preparedness program w** The licensee's 1998 and 1999 EP Program audit and assessments of the emergency preparedness program were of good scope and depth and satisfied the requirements of 10 Code of Federal Regulations 50.54(t). **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The offsite fire department had not participated in fire brigade drill in two years** The offsite fire department had not participated in fire brigade drill in two years when these drills should be performed annually **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**Emergency lighting units (ELUs) had been (a)1 in the maintenance rule for two years and not all of the ELU fu** Emergency lighting units (ELUs) had been (a)1 in the maintenance rule for two years and not all of the ELU functional failures had been identified **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**There were a low number of plant fires since January 1998.** There were a low number of plant fires since January 1998. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The control of transient combustibles in the plant was excellent.** The control of transient combustibles in the plant was excellent. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2A **Sec:** **Ter:**	**The low number of fire protection impairments requiring a fire watch was a program strength** The low number of fire protection impairments requiring a fire watch was a program strength **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2A **Sec:** **Ter:**	**Most fire protection equipment was well maintained** Most fire protection equipment was well maintained **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**The fire protection surveillance program was well implemented** The fire protection surveillance program was well implemented **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**The fire brigade performance during a fire brigade drill was good** The fire brigade performance during a fire brigade drill was good **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**The fire protection staff was experienced and knowledgeable, and proactive in dealing with plant problems** The fire protection staff was experienced and knowledgeable, and proactive in dealing with plant problems **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The 10 CFR 50.59 screenings and evaluations for fire protection program changes were thorough and had adc** The 10 CFR 50.59 screenings and evaluations for fire protection program changes were thorough and had addressed safety issues **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5A **Sec:** **Ter:**	**Most fire protection problems were identified and corrected** Most fire protection problems were identified and corrected **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
08/11/1999	1999013	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5A **Sec:** **Ter:**	**A recent fire protection self assessment identified most fire protection program problems prior to this inspect** A recent fire protection self assessment identified most fire protection program problems prior to this inspection **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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07/28/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Radiation Protection personnel performed thorough radiological monitoring during testing of a hydrogen wat** Radiation Protection personnel performed thorough radiological monitoring during testing of a hydrogen water chemistry modification with a potentially significant impact on station radiation levels (Section R1.1).
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**Radiological plans and preparation to support initiation of the hydrogen water chemistry addition program w** Radiological plans and preparations to support initiation of the hydrogen water chemistry addition program were adequate
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 3B **Sec:** **Ter:**	**A radiation protection technician that provided job coverage for a resin sluice operation was not familiar witl** A radiation protection technician that provided job coverage for a resin sluice operation was not familiar with the radiological requirements for the job specified in the radiation work permit, which did not satisfy radiation protection management expectations. Also, the Updated Final Safety Analysis Report was not fully consistent with the current waste processing program because it described systems and processes no longer used at the station
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 3B **Sec:** **Ter:**	**Deficiencies were noted with the staff's level of knowledge of the computer software program used to calcula** Deficiencies were noted with the staff's level of knowledge of the computer software program used to calculate shipment radioactivity content, and some radwaste shipments lacked complete documentation to demonstrate that all Department of Transportation requirements were met
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee established and maintained an effective program for the classification of radioactive waste, whi** The licensee established and maintained an effective program for the classification of radioactive waste, which included a sophisticated procedure for scaling factor derivation, trending, and analysis
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The radwaste packaging and transportation program was effectively implemented.** The radwaste packaging and transportation program was effectively implemented. Radwaste shipments were appropriately classified and controlled, vehicle and package surveys were performed as required, and shipments manifests were completed in accordance with regulatory requirements
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06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3C **Ter:**	**Experienced vendor staff and appropriate licensee oversight of waste processing activities ensured effective** Experienced vendor staff and appropriate licensee oversight of waste processing activities ensured effective implementation of the radwaste management program. Wet solid wastes were processed in accordance with both vendor and licensee PCPs and implementing procedures, and dewatered and solidified waste streams were sampled and/or tested to ensure regulatory limits for free standing liquid were met
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**The training provided to the staff involved in packaging, preparation, and shipment of radioactive materials a** The training provided to the staff involved in packaging, preparation, and shipment of radioactive materials and radwaste satisfied Department of Transportation regulations and imparted an adequate level of knowledge to ensure effective program implementation. The licensee's training program also included non-required elements that enhanced staff knowledge, such as a qualification itinerary for radiation protection personnel and review of supplemental information during training sessions
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
06/18/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	**Licensee established and implemented an effective and comprehensive audit program to assess radioactive r** The licensee established and implemented an effective and comprehensive audit program to assess the radioactive materials shipping and radwaste processing programs. Internal reviews were of sufficient scope and depth and identified problems were adequately resolved
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
05/12/1999	1999003	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**In general, actions taken by the licensee were adequate to protect personnel from radiological hazards.** In general, actions taken by the licensee were adequate to protect personnel from radiological hazards.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
04/26/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**Security lighting deficiencies have existed for a long period of time.** Security lighting deficiencies have existed for a long period of time.
Dockets Discussed: 05000373 La Salle 1 05000374 La Salle 2						
04/26/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Your physical security program was determined to have met regulatory requirements, with security force per** Your physical security program was determined to have met regulatory requirements, with security force performance and your self-assessment program being strengths.
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04/26/1999	1999010-08	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**Some contractor employees did not advise their supervisors when they detected the odor of alcohol on othe** A Non-Cited Violation was identified because some contractor employees did not advise their supervisors when they detected the odor of alcohol on other employees so a determination could be made if Fitness-For-Duty for-cause testing was necessary **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
04/09/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Licensee staff was generally effective in implementing and monitoring the initial phases of the improvement** Licensee staff was generally effective in implementing and monitoring the initial phases of the improvement strategy and overall positive steps were taken toward achieving the station's goal to provide superior radiological services. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
04/09/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**The RP organization effectively implemented a process to proactively identify problems in human performan** The RP organization effectively implemented a process to proactively identify problems in human performance and improvement initiatives were underway to correct identified weaknesses **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
03/25/1999	1999002	**Pri:** PLTSUP **Sec:** ENG	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**Radiation protection and chemistry personnel provided prompt and effective support to operations shift persc** Radiation protection and chemistry personnel provided prompt and effective support to operations shift personnel subsequent to the licensee's discovery of a potential fuel leak in the Unit 1 reactor. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2
02/16/1999	1999001	**Pri:** PLTSUP **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**The licensee identified that a construction maintenance technician inappropriately entered the area under th** The licensee identified that a construction maintenance technician inappropriately entered the area under the Unit 2 reactor vessel. The worker's RWP associated with his maintenance activity did not authorize entry to the area. Although the problems appeared to be isolated and the licensee's response was appropriate, the events indicated the need for continued licensee oversight of construction activities. **Dockets Discussed:** 05000374 La Salle 2
02/06/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**The inspectors identified an access path to an area being controlled as a high radiation area which the licens** The inspectors identified an access path to an area being controlled as a high radiation area which the licensee did not properly identify as specified by plant procedures. **Dockets Discussed:** 05000373 La Salle 1 05000374 La Salle 2

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Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs 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 EEIs 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.