UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE RD. SUITE 210
LISLE, IL 60532-4352

May 2, 2014

EA-13-221

Mr. Michael J. Pacilio
Senior VP, Exelon Generation Co., LLC
President and CNO, Exelon Nuclear
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: LASALLE COUNTY STATION, UNIT 2
NRC 95001 SUPPLEMENTAL INSPECTION REPORT 05000374/2014009
AND ASSESSMENT FOLLOWUP LETTER

Dear Mr. Pacilio:

On July 2, 2013, your staff reported the Unplanned Scrams with Complications Performance Indicator (PI) crossed the Green-to-White threshold because of scrams of Unit 2 on April 17 and April 25. Based on your report, the U.S. Nuclear Regulatory Commission (NRC) assigned a White PI Action Matrix input to the Initiating Events Cornerstone starting in the second quarter of 2013. In response to this Action Matrix input, the NRC informed you that a supplemental inspection under Inspection Procedure (IP) 95001, "Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area," would be required.

Based on the results of a baseline inspection (NRC Inspection Report 05000373/2013004; 05000374/2013004, dated November 15, 2013), the NRC concluded that on April 25, 2013, your staff failed to follow procedure LOP-CW-10, "Dewatering the Circulating Water System." This performance deficiency resulted in the Unit 2 reactor scram on April 25. Using the Significance Determination Process (SDP), Risk Assessment of Operational Events Handbook guidance, and the modified Standardized Plant Analysis Risk model, the NRC characterized the performance deficiency as an inspection finding of low to moderate safety significance (White). The final significance determination for this inspection finding was documented in NRC Inspection Report 05000374/2014007, dated January 30, 2014, and the NRC assigned a White inspection finding to the Initiating Events Cornerstone starting the third quarter of 2013. Because the White inspection finding and one of the scrams for the White PI were from the same issue, the White PI would no longer be considered an Action Matrix input. Therefore, only one supplemental inspection would be conducted for both the White inspection finding and the White PI using IP 95001.

On February 4, 2014, you informed the NRC that LaSalle County Station, Unit 2, was ready for the 95001 supplemental inspection.

On March 21, 2014, the NRC completed the 95001 supplemental inspection and discussed the results of this inspection and the implementation of your corrective actions with Mr. P. Karaba, the LaSalle Site Vice-President, and other members of your staff. This meeting was also the regulatory performance meeting required by Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program." The inspector documented the results of this inspection in the enclosed inspection report.

The NRC performed this 95001 supplemental inspection to determine if (1) the root and contributing causes for the significant issues were understood, (2) the extent of condition and extent of cause for the identified issues were understood, and (3) your completed or planned corrective actions were sufficient to address and prevent repetition of the root and contributing causes. The inspector determined that your root cause evaluations (RCEs) were conducted at a level of detail commensurate with the significance of the problem and that the RCEs reached reasonable conclusions as to the root and contributing causes of the event. The inspector also concluded that you identified reasonable and appropriate corrective actions for the root and contributing causes and that the corrective actions appeared to be prioritized commensurate with the safety significance of the issues. The inspector further concluded that your analysis appropriately addressed extent of condition and extent of cause concerns. Your evaluation identified the primary root causes of the issues to be degraded grounding connections in the 138-kiloVolt (kV) switchyard for the April 17 dual-unit loss of offsite power and automatic reactor scram and the use of unverified assumptions in lieu of strict procedural adherence for the April 25 waterbox leak manual reactor scram. Corrective actions were taken to prevent recurrence as well as to address the extent of problem. These corrective actions included repairing all degraded connections and ground cables in the 138-kV switchyard, creating new maintenance activities to periodically test both the 138-kV ground system and that of the adjoining 345-kV switchyard, and implementing formal training using case studies to address issues with procedure adherence.

The NRC has determined that the inspection objectives were met. Therefore, in accordance with IMC 0305, "Operating Reactor Assessment Program," the NRC determined the performance at LaSalle County Station, Unit 2, will be in the Licensee Response Column at the beginning of the third quarter of 2014. The finding will still be considered for agency actions in accordance with the Action Matrix until the end of the second quarter of 2014.

The NRC inspector did not identify any findings or violations of more than minor significance.

Please note, however, that Unresolved Item 05000373/2013009-01; 05000374/2013009-01, "Review of the Loss of Offsite Power Event Root Cause Evaluation and Switchyard Design Basis," remains open. This Item was identified during the NRC Special Inspection conducted following the April 17, 2013, dual-unit loss of offsite power and automatic reactor scram. Completion of our review of the switchyard design basis and closure of this Item is expected later this year and will be documented in a separate inspection report.

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, “Public Inspections, Exemptions, Requests for Withholding,” of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC’s Public Document Room or from the Publicly Available Records System (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Michael Kunowski, Chief
Branch 5
Division of Reactor Projects

Docket No. 50-374
License No. NPF-18

Enclosure:
Inspection Report 05000374/2014009
w/Attachment: Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	05000374
License No:	NPF-18
Report No:	05000374/2014009
Licensee:	Exelon Generation Company, LLC
Facility:	LaSalle County Station, Unit 2
Location:	Marseilles, IL
Dates:	March 17 through March 21, 2014
Inspectors:	J. Beavers, Resident Inspector (Acting)
Approved by:	M. Kunowski, Chief Branch 5 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

Inspection Report (IR) 05000374/2014009; 03/17/14 - 03/21/14; LaSalle County Station, Unit 2; Supplemental Inspection – Inspection Procedure (IP) 95001.

This report covers a one-week period of an announced supplemental inspection of a White Performance Indicator (PI) for Unplanned Scrams with Complications and a White inspection finding in the Initiating Events Cornerstone. The inspection was conducted by the acting resident inspector. The Nuclear Regulatory Commission's (NRC) program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4.

Cornerstone: Initiating Events

The NRC staff performed this supplemental inspection in accordance with IP 95001, "Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area," at the LaSalle County Station, Unit 2, to assess the licensee's evaluation of the April 17 and April 25, 2013, scrams with complications (loss of condenser) and the failure of operators to follow procedures while isolating a condenser waterbox that resulted in the manual reactor scram on April 25. As discussed in the Annual Assessment Letter dated March 4, 2014, the NRC characterized the Unplanned Scrams with Complications Performance Indicator (PI) as having low to moderate safety significance (White) and the failure to follow procedures as an inspection finding of low to moderate safety significance (White). During this supplemental inspection, the inspector determined that the licensee's root cause evaluations (RCEs) of these White issues were conducted at a level of detail commensurate with the significance of the problem, the RCEs reached reasonable conclusions as to the root and contributing causes, and the resulting corrective actions appeared to be prioritized commensurate with the safety significance of the issues. The inspector further concluded that the licensee's analyses appropriately addressed extent of condition and extent of cause concerns. The licensee identified the primary cause for the April 17 dual-unit loss of offsite power and automatic reactor scram to be degraded grounding connections in the 138-kV switchyard and for the April 25 waterbox leak manual reactor scram to be the use of unverified assumptions in lieu of strict procedural adherence. Corrective actions were taken to prevent recurrence as well as address the extent of the problem. These actions included repairing all degraded connections and ground cables in the 138-kV switchyard, creating new maintenance activities to periodically test the ground system in both the 138-kV switchyard and the adjoining 345-kV switchyard, and implementing formal training using case studies to address issues with procedure adherence.

Given the licensee's acceptable performance in addressing the initial plant construction issues that resulted in the degraded grounding connections in the 138-kV switchyard and the use of unverified assumptions in lieu of strict procedural adherence, the White inspection finding associated with this performance issue will not be considered in the Action Matrix after the end of the second quarter of 2014 in accordance with guidance in IMC 0305, "Operating Reactor Assessment Program." As stated in the NRC letter dated March 4, 2014, the White PI was no longer considered an input as of the third quarter 2013.

Findings

No findings were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (95001)

.1 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with IP 95001, "Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation of one White PI for Unplanned Scrams with Complications and one White inspection finding in the Initiating Events Cornerstone. The inspection objectives were to:

- provide assurance that the root causes and contributing causes of risk-significant performance issues were understood;
- provide assurance that the extent of condition and extent of cause of risk-significant issues were identified; and
- provide assurance that licensee corrective actions for risk-significant performance issues were sufficient to address the root causes and contributing causes, and to prevent recurrence.

LaSalle County Station, Unit 2, entered the Regulatory Response Column of NRC's Action Matrix in the second quarter of 2013 as the result of the Unplanned Scrams with Complications PI exceeding the Green-to-White threshold. On April 17, 2013, Unit 2 scrammed as part of a dual-unit loss of offsite power (LOOP) and automatic reactor scram during severe weather, and on April 25, Unit 2 was manually scrammed after a condenser waterbox developed a large water leak. In the third quarter of 2013, the NRC identified one inspection finding of low to moderate safety significance (White) for a failure to follow procedure that led to the waterbox leak and manual reactor scram on April 25. In accordance with Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," guidance on double counting Performance Indicators, the White finding became an Action Matrix input as of the third quarter of 2013 and the White PI was no longer considered a White Action Matrix input. The details of the finding are documented in NRC IR 05000373/2013004; 05000374/2013004, dated November 15, 2013, and NRC IR 05000374/2014007, dated January 30, 2014.

By letter dated February 14, 2014, the licensee notified the NRC that it had completed its evaluation of the circumstances surrounding the degraded performance and was ready for the NRC to assess the licensee's evaluation and subsequent corrective actions. In preparation for the inspection, the licensee performed RCEs for the April 17, 2013, dual-unit LOOP and automatic reactor scram (RCE 1503409-04); the April 25 waterbox leak manual reactor scram (RCE 1506809-04); and the White PI (RCE 1542247-02).

The inspector reviewed the licensee's RCEs, in addition to other evaluations conducted in support and as a result of the RCEs. The inspector reviewed corrective actions that were taken or planned to address the identified causes. The inspector also held discussions with licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood and corrective actions taken or planned were appropriate to address the causes and prevent recurrence.

Documents reviewed during this inspection are listed in the attachment.

.2 Evaluation of the Inspection Requirements

2.01 Problem Identification

a. Determine That the Evaluation Identified Who (i.e., Licensee-Identified, Self Revealing, or NRC-Identified), and Under What Conditions the Issue Was Identified

The RCEs for the dual-unit LOOP and automatic reactor scram on April 17 and for the waterbox leak manual reactor scram on April 25 both concluded the issues were self-revealing and identified the results of the respective events. The RCE for the White PI concluded the issue was identified by the licensee following the scram on April 25, per OP-AA-108-114, "Post Transient Review," and subsequent PI compilation per LS-AA-2001, "Collecting and Reporting of NRC Performance Indicator Data."

The inspector determined that the RCEs adequately identified who identified the issues and under what conditions the issue was identified.

b. Determine That the Evaluation Documented How Long the Issue Existed and Prior Opportunities for Identification

The inspector reviewed the RCE associated with the dual-unit LOOP and automatic reactor scram, which concluded that workmanship issues resulted in degraded 138-kiloVolt (kV) switchyard grounding connections that had existed since initial plant construction. No opportunities for identification of this problem since construction were documented. An unresolved item (URI), "Review of the Loss of Offsite Power Event Root Cause Evaluation and Switchyard Design Basis" (URI 05000373/2013009-01; 05000374/2013009-01), remains open pending completion of NRC review of the switchyard design basis. The RCE associated with the waterbox leak manual reactor scram concluded that procedural adherence issues led to the leak and the subsequent scram. Contributing causes, such as low quality procedures, operational flawed mental models, and material condition of the circulation water isolation valves, were documented as failed barriers to the event and provided opportunities for prior identification. The RCE associated with the White finding documented no additional opportunities for prior identification.

The inspector determined that the RCEs adequately identified how long the issue existed and whether there were any prior opportunities for identification.

c. Determine That the Evaluation Documented the Plant Specific Risk Consequences, As Applicable, and Compliance Concerns Associated With the Issue

Although the licensee's Root Cause Analysis Manual (PI-AA-125-1001) did not direct licensee staff to conduct risk assessments for these RCEs because the root causes had been identified, these risk assessments were conducted and provided to the inspector upon arrival. Licensee Action Request (AR) 1523528-02, "Supplemental Inspection Procedure 95001 Readiness Assessment," had identified the need for risk impact assessments of reactor scram events to support the inspection. Also, AR 01615306 was generated by another Exelon station to evaluate the manual's threshold for performing risk assessments. Action Request 1523528-02 also addressed the compliance concerns of the performance deficiency as characterized in the January 30, 2014, White inspection finding final significance determination letter from the NRC to the licensee.

Based upon the above documented observations, the inspector concluded that the licensee appropriately documented the risk consequences and compliance concerns associated with the issue.

2.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation

a. Determine That the Licensee Evaluated the Issue Using a Systematic Methodology to Identify the Root and Contributing Causes

The licensee used the following systematic methods to complete RCEs 1503409-04, 1506809-04, and 1542247-02:

- Barrier Analysis
- TapRoot System
- Change Analysis
- Failure Modes and Effects
- Interviewing
- Event and Causal Factor Chart

Based upon this, the inspector determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

b. Determine That the Root Cause Evaluation Was Conducted to a Level of Detail Commensurate With the Significance of the Issue

The licensee's RCEs included Barrier Analysis, TapRoot System, Change Analysis, and other methods as listed in the previous section. The root cause of the April 17, 2013, dual-unit LOOP and automatic reactor scram was degraded grounding connections in the 138-kV switchyard. The licensee determined the contributing cause was a less-than-adequate 138-kV switchyard lightning shield. The root cause of the April 25 waterbox leak manual reactor scram was unverified assumptions in lieu of strict procedure adherence. The licensee determined the contributing causes were latent organization weakness for procedure quality, degraded valve seats, and operators' flawed mental model.

Based upon the work performed for these RCEs, the inspector concluded that the RCEs were conducted to a level of detail commensurate with the significance of the problem and adequately addressed the finding.

c. Determine That the Root Cause Evaluation Included a Consideration of Prior Occurrences of the Issue and Knowledge of Prior Operating Experience

The licensee's RCEs included an evaluation of prior internal and external operating experience. Previous events at LaSalle and other sites that resulted in transients or scrams were examined. These events helped to provide direction to the licensee's investigation team. An event at Indian Point nuclear plant that involved a lightning strike leading to a scram and suspected ground mat deficiencies, and an event at Forsmark nuclear plant (in Sweden) where overvoltage resulted in abnormal responses and led to a unit scram, were relevant to the dual-unit LOOP and automatic reactor scram. An event at Beaver Valley nuclear plant involving a similar circulating water system valve seat over-travel problem was relevant to the LaSalle 2 waterbox leak manual reactor scram and incorporated the same corrective action of installing hard stops on the

isolation valve. LaSalle's internal operating experience was from the first attempt to isolate a waterbox at power, resulting in a similar transient in 1999. However, the corrective actions from that early event to change the operating procedure did not prevent the 2013 event as the 1999 event was not captured in a sustainable form for subsequent operating crews.

Based upon the considerations described in the analysis, the inspector concluded that the licensee's RCEs included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

d. Determine That the Root Cause Evaluation Addressed the Extent of Condition and Extent of Cause of the Issue

In its dual-unit LOOP and automatic reactor scram RCE, the licensee considered the extent of condition to be limited to the 138-kV switchyard, as the adjoining 345-kV switchyard was of a different design and had a full lightning shield. Also, an evaluation of the 345-kV switchyard ground system identified no degradation. Periodic testing plans were developed for both systems. The waterbox leak manual reactor scram RCE identified a number of operational procedures with the potential for conflicting or vague directions as well as procedural adherence vulnerabilities. The licensee's Operations Performance Improvement Integrated Matrix, dated October 15, 2013, described the completed actionable initiatives to address the forced outage learnings and focus on operating fundamentals in order to reinforce and heighten awareness.

In its dual-unit LOOP and automatic reactor scram RCE, the licensee considered the extent of cause could impact all electrical switchyard and equipment grounding systems. In this case, the specific cause of the ground system degradation was due to a workmanship issue during original plant construction. Various causes could have led to ground system degradation, including installation practices, material compatibility, soil quality, and ground motion. Testing of the grounding system should have been performed to ensure any installation defect/degradation was identified and could be corrected before it was at a level that could cause a fault that flashed over and damaged equipment. The waterbox leak manual reactor scram RCE identified procedure quality, degraded material condition, and inadequate risk perception impact across the processes in the operations department.

The inspector concluded that the licensee's analysis appropriately addressed extent of condition and extent of cause.

e. Determine That the Root Cause Evaluation, Extent of Condition, and Extent of Cause Appropriately Considered the Safety Culture Components as Described in IMC 0305

The inspector reviewed the RCEs and validated the licensee had systematically considered each of the safety culture components. Three safety culture components, Work Practices, Operating Experience, and Continuous Learning Environment, were identified. These insights were considered when addressing the root and contributing causes. Associated corrective actions contained appropriate elements to improve overall human performance.

The inspector determined that the RCEs, extent of conditions, and extent of causes appropriately considered the safety culture components as described in IMC 0305.

2.03 Corrective Actions

a. Determine That Appropriate Corrective Actions Were Specified for Each Root and Contributing Cause or That the Licensee Evaluated Why No Actions Were Necessary

The licensee's RCEs specified corrective actions to address the root and contributing causes. The documented root causes of the issues were:

- workmanship issues resulting in degraded grounding connections in the 138-kV switchyard; and
- unverified assumptions in lieu of strict procedural adherence.

The licensee determined that the contributing causes included:

- a less than adequate 138-kV switchyard lightning shield;
- latent organization weakness for procedure quality;
- degraded material condition; and
- operators' flawed mental model.

The corrective actions for root cause issues included:

- repairing all degraded connections and ground cables in the 138-kV switchyard;
- creating new maintenance activities to periodically test both the 138-kV and 345-kV ground systems; and
- implementing formal training on the waterbox leak manual reactor scram using case studies to address issues with procedure adherence and the use of unverified assumptions.

The corrective actions for contributing causes were:

- install lightning shielding for the 138-kV switchyard;
- eliminate judgment and knowledge-based use by revising LOP-CW-10, "Dewatering the Circulation Water System (CW)," and perform training on the revision;
- scope waterbox isolation valve seat cleaning and inspection into the appropriate outage; and
- provide licensed operator requalification training on team work, decision-making, and critical thinking.

The inspector concluded that the corrective actions specified were appropriate to prevent recurrence.

b. Determine That the Corrective Actions Were Prioritized With Consideration of the Risk Significance and Regulatory Compliance

The licensee's corrective actions to address the root and contributing causes were prioritized in accordance with PI-AA-125, "Root Cause Evaluation Manual," which ensures compliance with the quality requirements as well as fulfilling the requirements of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action."

The inspector concluded that the corrective actions had been prioritized with consideration of the risk significance and regulatory compliance.

c. Determine That a Schedule Was Established for Implementing and Completing the Corrective Actions

The inspector concluded that the licensee adequately established a schedule for implementing and completing the corrective actions in accordance with its corrective action program. As documented in the RCEs, 5 of 5 immediate actions, and 22 of 22 corrective actions were completed prior to the beginning of this inspection.

d. Determine That Quantitative or Qualitative Measures of Success Were Developed for Determining the Effectiveness of the Corrective Actions to Preclude Repetition

The licensee's RCEs developed quantitative or qualitative measures of success for determining effectiveness of the corrective actions to prevent recurrence. The RCEs resulted in two planned effectiveness reviews. The first, to review and evaluate the lightning history and switchyard fault history following completion of the listed corrective actions, was due June 20, 2014. If an adequate fault history challenge could not be demonstrated, actions to perform ground system testing as a challenge to the switchyard condition would be initiated. The second, using the CAP to identify any relevant trends to determine the effectiveness of the case study and coaching to prevent Operations procedure-adherence events, were due July 15, 2015. The inspector determined that both evaluations were on schedule.

The inspector concluded that the licensee had established quantitative or qualitative measures to validate the effectiveness of the corrective actions to prevent recurrence of the White PI and the White inspection finding.

4OA5 Other Activities

.1 (Closed) Finding (FIN) 05000374/2013004-01: "Failure to Follow Procedure Led to Manual Scram with Complications"

The inspector determined that the licensee's RCEs were conducted to a level of detail commensurate with the significance of the problem and reached reasonable conclusions as to the root and contributing causes of the event. The inspector also concluded that the licensee identified reasonable and appropriate corrective actions for each root and contributing cause and that the corrective actions appeared to be prioritized commensurate with the safety significance of the issues. No other instance of the finding was identified. This finding is closed.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspector presented the inspection results to Mr. P. Karaba, the Site Vice-President, and other members of licensee management on March 21, 2014. The inspector asked licensee management whether any materials examined during the inspection should be considered proprietary. No documents provided to the NRC contained proprietary information.

.2 Regulatory Performance Meeting

On March 21, 2014, as part of the exit meeting for the 95001 supplemental inspection, the NRC met with the licensee to discuss regulatory performance, in accordance with Section 10.01a of IMC 0305. During this meeting, the NRC and licensee discussed the primary issues related to the White PI for Unplanned Scrams with Complications and the White inspection finding in the Initiating Events Cornerstone that resulted in LaSalle County Station, Unit 2, being placed in the Regulatory Response Column of the Action Matrix. This discussion included the causes, corrective actions, extent of condition, extent of cause, and other planned licensee actions.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

P. Karaba, Site Vice President
J. Kowalski, Engineering Director
J. Kutches, Maintenance Director
P. Hansett, On-Line Manager
G. Ford, Regulatory Assurance Manager
G. Kaegi, Corporate Licensing Director
C. Howard, Radiation Protection
J. Houston, Nuclear Oversight
J. Bauer, Training Director
L. Blunk, Regulatory Assurance

Nuclear Regulatory Commission

M. Kunowski, Chief, Reactor Projects Branch 5
R. Ruiz, Senior Resident Inspector

Attachment

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened

None

Closed

05000374/2013004-01	FIN	Failure to Follow Procedure Led to Manual Scram with Complications (Section 4OA5)

Discussed

05000373/2013009-01; 05000374/2013009-01	URI	Review of the Loss of Offsite Power Event Root Cause Evaluation and Switchyard Design Basis (Section 4OA4)

LIST OF DOCUMENTS REVIEWED

The following is a partial list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspector reviewed the documents in their entirety, but rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

4OA4 Supplemental Inspection (95001)

- RCE 1503409-04; Lightning Strike in 138KV Switchyard Results in Automatic Reactor Shutdown of LaSalle Units 1 and 2; 06/20/13
- RCE 1506809-04; Trip of Running CW Pumps and Unit 2 Manual SCRAM Due to Procedure Adherence When Isolating a Main Condenser Waterbox; 07/18/2013
- RCE 1542247-02; WHITE NRC Performance Indicator for Unit 2 Unplanned Scrams with Complications; 09/10/13
- AR 01513225; White NRC PI for Unplanned SCRAMS with Complications; 05/13/2013
- AR 01523528-02; Supplemental Inspection Procedure 95001 Readiness Assessment; 10/16/2013
- AR 01542247; RCR for White NRC PI for Unplanned SCRAMS with Complications; 08/01/2013
- AR 01615306; Evaluate the Requirement for Performing Risk Assessments; 02/26/2014
- AT 1522619-02; Operations Knowledge Gaps from LOOP CCA; 07/11/13
- AT 1550244; Deltas in Operator Response Strategies Dual Loss of Offsite Power Scram RCE; 10/03/13
- CRC Forced Outage Training; 05/08/2013
- CRC LOOP Training; 08/08/2013
- LOA-LOOP-101; Loss of Off-Site Power; Revision 2
- LOA-LOOP-201; Loss of Off-Site Power; Revision 2
- LOP-CW-10; Dewatering the Circulation Water System (CW); Revision 33
- LS-AA-2001; Collecting and Reporting of NRC Performance Indicator Data; Revision 14
- LS-MD83-01R1; PRA Risk Impact of Dual Loss of Offsite Power
- LS-SDP-03R1; PRA Risk Impact of Circulating Water SCRAM
- OP-AA-108-114; Post Transient Review; Revision 9
- PI-AA-125-1001; Root Cause Analysis Manual; Revision 0
- PIIMS; Operations Performance Improvement Integrated Matrix; 10/15/2013

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
CFR	Code of Federal Regulations
CW	Circulating Water
DRP	Division of Reactor Projects
IMC	Inspection Manual Chapter
IP	Inspection Procedure
IR	Inspection Report
kV	KiloVolt
LLC	Limited Liability Corporation
LOOP	Loss of Offsite Power
NRC	U.S. Nuclear Regulatory Commission
PARS	Publicly Available Records System
PI	Performance Indicator
RCE	Root Cause Evaluation
SDP	Significance Determination Process
URI	Unresolved Item

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, “Public Inspections, Exemptions, Requests for Withholding,” of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC’s Public Document Room or from the Publicly Available Records System (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Michael Kunowski, Chief
Branch 5
Division of Reactor Projects

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Letter to Michael Pacilio from Michael Kunowski dated May 2, 2014

SUBJECT: LASALLE COUNTY STATION, UNIT 2
NRC 95001 SUPPLEMENTAL INSPECTION REPORT 05000374/2014009
AND ASSESSMENT FOLLOWUP LETTER

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