

La Salle 2

3Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2003

Identified By: Self Disclosing

Item Type: FIN Finding

Manipulation of plant equipment by a staff engineer without operations authorization or any written instructions.

A finding of very low safety significance was self-revealed following the unauthorized operation of station equipment by a plant engineer. The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that if left uncorrected, it would represent a more significant safety concern. The finding was determined to be of very low safety significance because the engineer's actions did not result in an actual plant transient.

Inspection Report# : [2003004\(pdf\)](#)

Significance:  Sep 30, 2003

Identified By: Self Disclosing

Item Type: FIN Finding

Repairs performed on plant equipment without written procedures or work control documents.

A finding of very low safety significance was self-revealed following impromptu repairs to the control air for the Unit 2 motor-driven reactor feed pump (MDRFP) minimum flow valve. A maintenance supervisor, conducting what was supposed to have been only a pre-job investigative walkdown, conducted the actual repairs without any written work documents or procedures. The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that if left uncorrected, it would represent a more significant safety concern. The finding was determined to be of very low safety significance because maintenance supervisor's actions did not result in an actual plant transient.

Inspection Report# : [2003004\(pdf\)](#)

Mitigating Systems

Significance:  Sep 30, 2003

Identified By: Self Disclosing

Item Type: FIN Finding

Failure to install O-Ring on Unit 2 station air compressor as required by applicable maintenance procedure.

A finding of very low safety significance was self-revealed following the failure on the part of maintenance personnel

to reinstall a required part during a March 2003 overhaul of the Unit 2 station air compressor (SAC). The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that if left uncorrected, it would represent a more significant safety concern. The finding was determined to be of very low safety significance because the licensee was able to demonstrate in an engineering analysis that the SAC could be considered available and capable of operation for its mission time even with the subject part missing.

Inspection Report# : [2003004\(pdf\)](#)



Significance: Sep 30, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to properly delineate what actions can be performed by plant personnel without having appropriate written procedures or instructions results in inoperable and unavailable EDG.

A finding of very low safety significance was self-revealed involving the licensee's failure to properly delineate what actions can be performed by plant personnel without having appropriate written procedures or instructions. This lack of delineation allowed an operator to attempt to remove dust from a circuit board by blowing on it, which resulted in a partial CO2 system actuation and the closure of the '0' emergency diesel generator (EDG) ventilation dampers. This rendered the '0' EDG inoperable and unavailable for the task of being able to complete its mission time. The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that it had an adverse impact on the availability and capability of the '0' EDG, a mitigating system component. The finding was determined to be of very low safety significance because the licensee was able to demonstrate in an engineering analysis that the '0' EDG would automatically start and load with the fire dampers closed, and that the opposite train's EDG, the 1A EDG, could be made fully available from its surveillance test configuration in a short period of time. A Non-Cited Violation for failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was also identified by the inspectors.

Inspection Report# : [2003004\(pdf\)](#)



Significance: Jun 30, 2003

Identified By: NRC

Item Type: FIN Finding

Inadequate assessment of long term RHR operation in the SPC mode.

A finding of very low safety significance was identified by inspectors when it was determined that the continuous long term operation of a single train of the Residual Heat Removal (RHR) system in the suppression pool cooling (SPC) mode was not within the licensee's design basis.

In a Phase 3 SDP, the inspectors concluded that the continuous operation of a single train of the RHR system in the SPC mode from May 25, 2001 through September 3, 2001, increased the likelihood of an RHR train failure from a water hammer event. The finding was of very low safety significance due to the low magnitude of the increased probability of RHR train failure. There were no violations of regulatory requirements identified with this finding.

Inspection Report# : [2003003\(pdf\)](#)

Barrier Integrity



Significance: Dec 28, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Entry Into Region B of the Power-To-Flow-Map

Licensee personnel inadvertently placed Unit 2 in a prohibited region of the power-to-flow map during a control rod maneuver on November 10, 2002. Entry into this region increased the likelihood of power oscillations.

The issue was of very low safety significance since no actual power oscillations occurred and the region was exited promptly after the condition was identified. A violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified since this condition had occurred previously, but had not been identified. (Section 40A3)

Inspection Report# : [2002006\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety



Significance: Jan 30, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Radiological intakes during RHR system drain valve replacement.

Failure to follow the requirements of the RWP by performing high energy (grinding) work outside the bounding conditions established by the ALARA evaluation, resulting in intakes to two workers.

Inspection Report# : [2003002\(pdf\)](#)

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : December 01, 2003