

## La Salle 1

### 2Q/2004 Plant Inspection Findings

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#### 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\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Jun 30, 2004  
Identified By: Self Disclosing  
Item Type: FIN Finding

**Division 1 125 Vdc Battery Charger Grounded Due to Use of Wrong Test Instrument**

A finding of very low safety significance was self-revealed when plant electricians performing troubleshooting on the Unit 1 Division 1 125 Vdc battery charger induced an external ground onto the system. The electricians had selected an unfiltered AC oscilloscope for use in the troubleshooting, which was not a compatible instrument with the DC system. The fundamental cause of this finding was related to the cross-cutting area of Human Performance. An investigation by the licensee determined that the apparent cause of the event was the use of an AC-powered oscilloscope on DC-powered equipment without appropriate filtering capabilities, as well as personnel not fully understanding the limitations for the instrument's use.

The inspectors determined that the finding was more than minor in that it increased the probability of failure of a safety-related system, Division 1 125 Vdc power. The finding was assessed to be of very low safety significance because it did not represent a design or qualification deficiency, did not represent any actual loss of safety function for any system, and did not screen as risk significant due to seismic, fire, flooding, or other severe weather related events. No violations of regulatory requirements were identified.

Inspection Report# : [2004003\(pdf\)](#)

**Significance:**  Mar 31, 2004  
Identified By: NRC  
Item Type: NCV NonCited Violation

**Lack of proper procedural guidance for throttling an instrument nitrogen system isolation valve.**

A finding of very low safety significance was identified by the inspectors after the licensee throttled an instrument nitrogen system pressure regulator isolation valve without adequate written instructions in an attempt to compensate for a degraded pressure regulator. The licensee failed to adequately assess the impact of the valve throttling on N2 system performance prior to the evolution, and, therefore, did not provide appropriate acceptance criteria in plant procedures regarding the extent to which the valve could be throttled closed before system operability was impacted.

This finding was greater than minor because it had the potential to be a more significant safety concern. If left uncorrected, operations personnel could have throttled the isolation valve closed to the extent that the safety function of the subject N2 header was lost. The finding was of very low safety significance because a licensee engineering evaluation subsequently determined that the isolation valve had not been throttled closed far enough to have impacted any safety function. Enforcement for this finding resulted in a non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2004002\(pdf\)](#)

**Significance:**  Dec 31, 2003

Identified By: Self Disclosing

Item Type: FIN Finding

**Improperly installed thrust bearing leads to station air compressor failure.**

A finding of very low safety significance was self-revealed following the failure of the Unit 2 station air compressor (SAC). During a March 2003 overhaul of the SAC, maintenance personnel installed the main shaft thrust bearing backwards. The improperly installed thrust bearing later contributed to the failure of the Unit 2 SAC on September 18, 2003. Inspectors determined that a primary cause of this finding was related to the cross-cutting area of Human Performance, since the thrust bearing was installed contrary to established instructions and drawings.

The finding was determined to be more than minor because the improperly installed thrust bearing actually caused a hard failure of a risk-significant component in a mitigating system. The finding was of very low safety significance because all other remaining mitigating systems and components were available and the duration of the Unit 2 SAC unavailability as a result of the finding was relatively short. No violations of regulatory requirements were identified as being associated with this finding.

Inspection Report# : [2003005\(pdf\)](#)

**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\(pdf\)](#)

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## Barrier Integrity

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## Emergency Preparedness

## Occupational Radiation Safety

**Significance:**  Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### **Unauthorized entry into 1B RHR room HRA by contract personnel.**

A finding of very low safety significance was self-revealed when two technicians logged onto a general area Radiation Work Permit (RWP), entered the 1B Residual Heat Removal (RHR) Room, a posted high radiation area (HRA), and one of their electronic dosimeters alarmed.

The cause of this event was failure to follow procedures. The finding was more than minor as it could be reasonably viewed as a precursor to a more significant event. The finding was of very low safety significance because the personnel were using electronic dosimeters that alarm to warn the workers of higher than expected dose rates or accumulated dose. The issue was a non-cited violation of Technical Specifications 5.7.1b and e., which required that an appropriate RWP be utilized by workers and a pre-job brief be provided prior to entry into a HRA.

Inspection Report# : [2004002\(pdf\)](#)

**Significance:**  Mar 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

### **Unauthorized entry into Unit 1 heater bay HRA by licensee craft personnel.**

A finding of very low safety significance was self-revealed when a craft person, entered a posted HRA and highly contaminated area in the 1B Heater Bay without a HRA brief. This occurrence resulted in the person becoming contaminated and it was detected when the person exited the Radiologically Controlled Area (RCA).

The cause of this event was failure to follow procedure. The finding was more than minor as it could be reasonably viewed as a precursor to a more significant event. The finding was of very low safety significance because the individual was using electronic dosimeters that alarm to warn the workers of higher than expected dose rates or accumulated dose. The issue was a non-cited violation of Technical Specifications 5.7.1b and e., which required that a pre-job brief be provided prior to entry into a HRA.

Inspection Report# : [2004002\(pdf\)](#)

**Significance:**  Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate survey results in unposted radiation area.**

A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR Part 20. The licensee failed to adequately evaluate the radiological hazards associated with radiation dose rates at a temporary walkway outside the radiologically controlled area in the turbine building.

This finding was greater than minor because it had the potential to be more significant due to the location, adjacent to the main turbine bioshield during operation. The finding was of very low safety significance because no personnel had used the walkway. The issue was a non-cited violation of 10 CFR 20.1501(a).

Inspection Report# : [2004002\(pdf\)](#)

## Public Radiation Safety

### Physical Protection

[Physical Protection](#) information not publicly available.

### Miscellaneous

Last modified : September 08, 2004