

La Salle 2

2Q/2004 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:  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\(pdf\)](#)

G

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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

G

Significance: Jun 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Unauthorized Entry into a High Radiation Area by Maintenance Personnel Building Scaffolding Prior to Required Radiation Protection Surveys

A finding of very low safety significance was self-revealed when a craft person, setting up scaffold in a radiation area, created access to a yet unposted and unmonitored high radiation area (HRA) in the Unit 2 turbine building, and then entered the HRA by climbing the scaffold. This occurrence was detected when the individual's electronic dosimeter (ED) alarmed above the dose rate setting of 80 millirem per hour. The workers immediately acknowledged the alarm, secured the work area, exited the radiologically controlled area (RCA), and notified the radiation protection (RP) department. The RP department confirmed that a HRA existed above the platform of the scaffolding. The individuals were administratively locked out of the RCA and the licensee initiated a prompt investigation. Additionally, all site personnel were notified of this event through a station safety alert. The licensee entered the issue into their corrective action system as condition report (CR) 218052. The fundamental cause of this finding was related to the cross-cutting area of Human Performance.

The cause of this event was incomplete procedural adherence. 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 EDs that alarm to warn personnel of higher than expected dose rates or accumulated dose. The issue was a Non-Cited Violation of Technical Specifications 5.7.1(a) and (b), which require that: (a) each entry way to a HRA shall be barricaded and conspicuously posted as a HRA; and (b) that access to, and activities in each area shall be controlled by means of a radiation work permit that includes specification of radiation dose rates in the immediate work area and other appropriate radiation protection equipment and measures.

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

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : September 08, 2004