

La Salle 1

4Q/2004 Plant Inspection Findings

Initiating Events

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\(pdf\)](#)

Barrier Integrity

Significance:  Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Effective Corrective Action on Degraded/Nonconforming Unit 1 RCIC F028 Containment Isolation Check Valve

The inspectors identified a finding of very low safety significance and an associated NCV during a review of the maintenance and performance history surrounding the 1E51-F028 reactor core isolation cooling (RCIC) containment isolation check valve. The licensee failed to effectively diagnose and correct a recurring performance problem with the valve sticking open following a failed local leak rate test (LLRT) and maintenance performed during the most recent Unit 1 refueling outage (L1R10) in January 2004. This failure to effectively diagnose and correct a degraded and nonconforming condition was determined to constitute a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion

XVI, "Corrective Action."

The performance deficiency with this issue was a failure on the part of the licensee to have properly diagnosed the 1E51-F028 degraded condition and to have effectively enacted repairs in early 2004. The finding was of more than minor significance in that it had a direct impact on this cornerstone objective. Specifically, the licensee's failure to properly diagnose and effectively correct a degraded condition with the 1E51-F028 containment isolation check valve resulted in a subsequent failure, which occurred with the unit operating at power in a condition where the valve was required to be operable. Because the finding did not represent a degradation of the radiological barrier function provided for the control room, auxiliary building, reactor building, or the standby gas treatment (SBGT) system, and did not represent a degradation of the smoke or toxic gas barrier function for the control room, and did not represent an actual open pathway in the physical integrity of the primary containment or involve an actual reduction in defense-in-depth for the atmospheric pressure control or hydrogen control functions of the primary containment, it was determined to be of very low safety significance. Corrective actions planned or completed by the licensee included replacement of the 1E51-F028 valve disc and spring on September 17, 2004; replacement of the entire 1(2)E51-F028 check valves on both units during refuel outages in 2006 and 2007 with valves manufactured using austenitic stainless steel; repair of the ball float valve in the Unit 1 RCIC barometric condenser vacuum tank air discharge separator; repairs to the 1E51-F028 check valve line slope; and an additional on line test for the 1E51-F028 check valve by April 29, 2005, to confirm that it is operating properly. The finding was determined to involve the cross-cutting aspect of problem identification and resolution.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate VE System Test Procedure Causes Auxiliary Electric Equipment Room High Humidity Condition and Renders Multiple Control Room Annunciator Alarms Inoperable

A finding of very low safety significance and an associated NCV were self-revealed following a trip of the 'A' train of the auxiliary electric equipment room (AEER) ventilation (VE) system while operating in the purge mode. Written procedures for the operation of the VE system failed to properly account for ventilation compressor heat load capacity limitations during VE system alignment in the purge mode. The lack of proper written procedural guidance was determined to constitute a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

The performance deficiency with this issue was a failure on the part of the licensee to establish and maintain adequate written procedures for the testing and operation of the VE system in the purge mode. The finding was of more than minor significance in that if left uncorrected it would constitute a more significant safety concern. The finding was determined to be of very low safety significance because it only involved the barrier function provided for the AEER. Corrective actions planned and completed by the licensee include revisions to procedures LTS-400-17, LOP-VC-01, and LOP-VE-01 to account for the newly identified limitations associated with VE operation in the purge mode.

Inspection Report# : [2004005\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Entry into a Neutron Radiation Area by Operations Personnel without Procedurally Required Neutron Radiation Dose Estimates

The inspectors identified a Green finding and associated Non-Cited Violation (NCV) when they observed operations personnel entering a posted neutron dose area without proper neutron monitoring, contrary to the licensee's Technical Specifications. This finding was considered NRC-identified as radiation protection personnel were unaware of this issue until questions by inspectors indicated a lack of proper neutron dose control for both this event and similar past occurrences.

The cause of the error was a failure of communication between the operations and radiation protection (RP) staff. The finding, under the Occupational Radiation Safety Cornerstone, does not involve the application of traditional enforcement because it did not result in actual safety consequences or potential to impact the NRC's regulatory function, and was not the result of any willful actions. The finding was more than minor as it involves the failure of the licensee to adhere to procedures to monitor and control radiation exposure, a key attribute under the objective of the radiation safety cornerstone to ensure adequate protection of worker health and safety from exposure to radiation. The finding is of very low safety significance because the personnel involved were using electronic dosimeters that alarm to warn workers of higher than expected dose rates or accumulated dose. The issue was a Non-Cited Violation of Technical Specifications 5.4.1(a), which requires written procedures be established, implemented, and maintained in accordance with the requirements of Regulatory Guide 1.33, Section 7.e(7). of

Regulatory Guide 1.33 lists the requirement for radiation protection procedures for personnel monitoring. RP-AA-210, "Dosimetry Issue, Usage, and Control," is the plant procedure governing neutron dose estimation and monitoring.

The licensee conducted a human performance investigation to determine the cause of the event and identified a failure of communication between the RP and operation staffs. The individuals involved were coached, site personnel were informed of the event, and RP staff personnel were provided additional training on the requirements for entering neutron areas.

Inspection Report# : [2004004\(pdf\)](#)

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 : March 09, 2005