

La Salle 1

4Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Operator Manual Actions For Maintaining EDG Availability During Surveillance Testing Not Adequately Implemented, as Required by 10 CFR 50.65(a)(4)

A finding of very low safety significance was identified by inspectors during observation of a scheduled 1A emergency diesel generator (EDG) fast start surveillance. Specifically, the inspectors identified that the licensee's manual operator actions in place to ensure EDG availability during the surveillance testing did not meet the requirements of NUMARC 93-01, Section 11. A non-cited violation of 10 CFR 50.65(a)(4) was also identified for failure to adequately assess and manage the increase in risk that result from the proposed activity.

The performance deficiency identified was associated with the licensee's planning and use of operator manual actions to ensure EDG availability during surveillance testing. Specifically, the licensee's manual restoration actions intended to maintain EDG availability during the surveillance test were not properly captured in written instructions or the licensee's procedures. In addition, the inspectors determined that diagnosis by the on-watch operations crew would have been required to successfully restore the EDG in the event of an emergency start demand. The finding was of more than minor significance in that the licensee failed to adequately implement and manage risk compensatory measures (i.e., the use of operator manual actions to ensure component availability) associated with the EDG surveillance activity. Because the Risk Deficit for the finding was calculated to have been significantly less than 1E-6, the inspectors concluded that the finding was of very low safety significance (Green) and within the licensee's response band. Corrective actions planned and completed by the licensee included a review of all procedural uses of operator manual actions to ensure component availability during testing to ensure that adequate written restoration instructions exist, as well as other NUMARC 93-01, Section 11, requirements.

Inspection Report# : [2006006](#) (*pdf*)

Significance:  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure Used for GL 89-13 Program Thermal Performance Tests on RHR Heat Exchangers

A finding of very low safety significance was identified by inspectors during observation of a GL 89-13 residual heat removal system heat exchanger (RHR HX) thermal performance test. Specifically, the inspectors identified that the licensee's engineering staff failed to develop and use an adequate test procedure to implement the RHR HX performance monitoring program in accordance with docketed commitments and the established NRC Generic Letter (GL) 89-13 program basis. A non-cited violation of 10 CFR 50, Appendix B, Criterion V, for an inadequate RHR HX thermal performance test procedure was also identified.

The inspectors determined that the licensee's failure to establish and maintain an adequate GL 89-13 RHR HX thermal performance testing procedure represented a performance deficiency on the part of licensee engineering personnel. The issue was determined to be of more than minor significance in that it directly affected the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, this finding impacted one of the key attributes of this objective, which is to ensure the quality of maintenance and test procedures for systems that must respond to initiating events. The inspectors determined that the finding could be evaluated

using the SDP in accordance with IMC 0609, "Significance Determination Process," and conducted a Phase 1 characterization and initial screening. Despite the widespread issues the inspectors identified with the licensee's GL 89-13 program and associated bases, the licensee's engineering staff was able to provide the inspectors with sufficient maintenance and testing records to permit the inspectors to conclude that each RHR HX remained fully capable of performing its design basis and safety functions. As a result, because the finding did not represent a actual loss of operability or safety function and was not potentially risk significant with respect to a seismic, flooding, or severe weather initiating event, the inspectors determined it to be of very low safety significance (Green) and within the licensee's response band. Corrective actions by the licensee included: performing evaluations to document the basis for the 4-year HX clean and inspection interval; evaluating the material condition of the 2B RHR HX, conducting an analysis to determine how the current performance monitoring program meets the intent of GL 89-13; revising commitments to the NRC to be consistent with the current GL 89-13 program; and revising LTS-200-17, the RHR HX test procedure, per the recommendations of that analysis.

Inspection Report# : [2006005](#) (*pdf*)

Significance:  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Correct Identified Issues Associated with the GL 89-13 Program for RHR Heat Exchangers

A finding of very low safety significance was identified by the inspectors. The inspectors determined that the licensee did not fully evaluate problems and properly prioritize corrective actions with respect to the RHR HX thermal performance test procedure and GL 89-13 HX performance monitoring program. An associated non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was also identified by the inspectors.

The inspectors determined that there was a performance deficiency associated with the corrective actions taken by the licensee. Specifically, the inspectors determined that the licensee had not thoroughly evaluated, nor given proper priority to, identified deficiencies in the RHR HX test procedure as identified in Issue Report 98176. Further, the inspectors also determined that the licensee had failed to complete the GL 89-13 bases review and revision called for under Apparent Cause Evaluation 263535 in 2004. The inspectors determined that the finding was of more than minor significance in that it directly affected the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, this finding impacted one of the key attributes of this objective which is to ensure the quality of maintenance and test procedures for systems that must respond to initiating events. The inspectors conducted a Phase 1 characterization and initial screening in accordance with the SDP. Because the finding did not represent a actual loss of operability or safety function and was not potentially risk significant with respect to a seismic, flooding, or severe weather initiating event, it was determined to be of very low safety significance (Green) and within the licensee's response band. Licensee corrective actions planned include review of GL 89-13 program Corrective Action Program documents to determine if any other identified issues were not fully dispositioned or resolved and to confirm that all corrective actions have been implemented and documented. The finding was also determined to involve the cross-cutting area of problem identification and resolution.

Inspection Report# : [2006005](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish and Maintain Written Procedures and Instructions for the Technical Specification Administrative Control of Primary Containment Isolation Valve 1E51-F069

Inspectors identified a finding of very low safety significance for the lack of written procedures and instructions related to the Technical Specification administrative control of a primary containment isolation valve (PCIV). An associated Non-Cited Violation (NCV) of 10 CFR 50, Appendix B, Criterion V, was also identified.

The finding was determined to be more than minor in that it directly affected the configuration control and procedure

quality attributes of the Barrier Integrity cornerstone (containment) and affected the cornerstone objective of providing reasonable assurance that physical design barriers (i.e., containment) protect the public from radionuclide releases caused by accidents or events. 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, the inspectors determined it to be of very low safety significance (Green) and within the licensee's response band. The licensee had entered this issue into their corrective action program as Issue Report (IR) 475214. Corrective actions planned by the licensee included development of a formal process for using administrative controls to meet Technical Specification requirements.

Inspection Report# : [2006003](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Mar 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Instrument Maintenance Technician Enters a High Radiation Area on the Wrong RWP

A finding of very low safety significance was self-revealed as a result of an alarm on a worker's electronic dosimeter. The issue was identified when an instrument maintenance technician logged onto the wrong radiation work permit (RWP) and entered the assigned work area in the radiologically controlled area (RCA), Unit 1 Division 1 residual heat removal (RHR) room, a posted high radiation area (HRA). The primary cause of this finding was related to human performance. The technician failed to verify that he/she was on the correct RWP for the assigned work.

The finding was more than minor because the occurrence involved an individual worker's potential unplanned, unintended dose resulting from actions or conditions contrary to licensee procedures, and could be reasonably viewed as a precursor to a more significant event. The finding was determined to be of very low safety significance because the finding did not involve an as low as reasonably achievable (ALARA) issue, as collective dose was not an issue and the individual's radiation exposure was low relative to regulatory limits; there was not a substantial potential for a worker overexposure; and the licensee's ability to assess worker dose was not compromised. The finding was a Non-Cited Violation of Technical Specification 5.4.1.a., which requires the licensee to establish, implement and maintain procedures recommended by Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Corrective actions planned by the licensee included increased management oversight during RWP log in and issuance of a site communication regarding the event.

Inspection Report# : [2006003](#) (*pdf*)

Public Radiation Safety

Physical Protection

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

Miscellaneous

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