

La Salle 2

4Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Aug 15, 2009

Identified By: NRC

Item Type: FIN Finding

Reactor SCRAM during turbine testing

The inspectors identified a finding of very low safety significance for the licensee failing to recognize that an existing alarm condition in the Unit 2 DEHC trip logic would result in a turbine trip and subsequent reactor SCRAM when weekly turbine trip testing was performed. The licensee entered this issue into its corrective action program as Issue Report (IR) 953784.

The finding was greater than minor because it affected the initiating events objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations and was associated with the cornerstone attribute of configuration control. The inspectors determined that the finding was Green or of very low safety significance by answering no to the Inspection Manual Chapter (IMC) 0609 Phase 1 Screening Worksheet question “Does the finding contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available?” The finding had a cross cutting aspect in the area of Human Performance (resources) in that the site’s design documentation was not complete and accurate with regards to the necessary ramifications of a control module communications failure (H.2(c)).

Inspection Report# : [2009004](#) (*pdf*)

Significance:  Jun 24, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to implement a fire protection program procedure for combustible controls

A finding of very low safety significance and associated NCV of Technical Specifications was identified by the inspectors for the failure to implement a fire protection program procedure for combustible controls. Specifically, the inspectors identified three examples where transient combustible materials were staged adjacent to cable risers contrary to Procedure OP-AA-201-009, “Control of Combustible Material,” Revision 7.

Description: On June 24, 2009, during a Fire Protection walkdown, the inspectors identified three examples of transient combustible material staged adjacent to cable risers in the Unit1 and Unit 2 reactor buildings. Specifically, the inspectors found a cabinet containing oil absorbing pads that was staged adjacent to safety-related cable risers in the 761’ elevation of the Unit 2 auxiliary building. The inspectors also identified a cart with the same contents (oil absorbing pads) in the 761’ elevation of the Unit 1 auxiliary building; however, this cart also contained anti-contamination clothing and mop heads. In addition, the inspectors identified a third example in the 820’ elevation of the Unit 2 reactor building where a maintenance cart containing welding equipment was staged near a safety-related cable riser. The carts containing transient combustible materials described in the three examples were staged less than two feet from the safety-related cable risers. The licensee placed the issue into their corrective action program (Action Request (AR) 934986, “NRC Identified: Transient Combustibles Near Cable Riser”) and subsequently removed the carts and cabinets with combustible material from all three locations.

Inspection Report# : [2009003](#) (*pdf*)

Mitigating Systems

Significance: G Sep 18, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Revision for Technical Requirement Manual Section

A finding of very low safety-significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedure, and Drawings" was identified by the inspectors for the licensee's failure to ensure that specific requirements of the Technical Requirement Manual (TRM) Section 3.8.b. would be performed as written. Specifically, the licensee inappropriately revised the applicability section of TRM 3.8.b. and added that the TRM actions were applicable when the circuit breaker associated with an inoperable protective device was closed and receiving power from an energized source. This revision did not ensure that verification of circuit breaker position would be performed on a periodic basis when/if the breaker was open. The licensee subsequently entered the issue into their corrective action program as AR 00961522.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. The revised applicability section of TRM 3.8.b did not ensure that necessary action, i.e. verification of circuit breaker position, would be performed to ensure that primary containment electrical penetrations would not be subject to excessive fault currents. The finding was of very low safety-significance based on a Phase 1 screening in accordance with IMC 0609, Appendix A, A Significance Determination of Reactor Inspection Findings for At-Power Situations. This finding was not associated with a cross-cutting aspect because the finding was not indicative of the licensee's current performance.

Inspection Report# : [2009006](#) (*pdf*)

Significance: G Jul 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to declare SBLC system inoperable during surveillance testing

The inspectors identified a finding of very low safety significance during a monthly SBLC pump run on Unit 2. Specifically, operations personnel performing LOS-SC-Q1, "SBLC pump operability test," did not possess appropriate procedural guidance while performing this test and as a result did not declare both trains for SBLC system inoperable and did not enter the associated LCO Action Statements as required per Technical Specifications. A non-cited violation of Technical Specification 5.4.1, "Procedures," was also identified for failure to use a procedure appropriate for the circumstance to provide adequate precautionary guidance to account for the inoperability of the SBLC system during the surveillance performance.

The inspectors determined that the finding was more than minor because it was associated with the procedure quality attribute of the Mitigating Systems cornerstone, and it affected the cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, operations personnel would not have been able to return SBLC to a standby configuration if needed in case of an anticipated transient without a SCRAM (ATWS) in 120 seconds as required by the design basis. The finding was determined to be of very low safety significance using the significance determination process (SDP) Phase 2. This finding was also related to the cross cutting area of Human Performance (resources) because the procedure used for this evolution was inaccurate in that it provided improper guidance to maintain SBLC operability provided that a dedicated operator was briefed and stationed locally. Corrective actions by the licensee include the future revision of procedure LOS-SC-Q1, to remove the statement that indicates that the system can be maintained operable during the surveillance and to include an emergency restoration attachment with steps to quickly return the system to its standby configuration if required in case of an ATWS.

Inspection Report# : [2009004](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Nov 20, 2009

Identified By: NRC

Item Type: FIN Finding

PI&R Report Summary

Overall, the corrective action program (CAP) was being effectively implemented. Issues were identified at a low threshold, evaluated and corrected. Self-assessments and audits by Nuclear Oversight (NOS) were thorough and critical of the assessed areas. Operating experience was recognized as valuable and was effectively communicated. Interviews with licensee staff and a review of the Employee Concerns Program (ECP) indicated that the licensee had a positive safety culture environment that encouraged identification of issues in the CAP.

However, the inspectors identified several areas of concern that may negatively impact the licensee's ability to identify and resolve issues. In some cases, these issues had been recognized by the licensee, but effective corrective action had not been taken. Briefly, the issues were:

- The current CAP performance indicators were not always effectively used or sufficient to monitor the program. Although the licensee was aware of these issues, CAP staff appeared willing to live with the shortcomings and had not formally taken corrective action.
- There were some examples of long-standing issues that were either not corrected or not evaluated. In some cases, the licensee had identified the issues, but had not evaluated why previous corrective actions were ineffective.
- There were several examples where the review of operating experience (OE) in cause evaluations were not documented in accordance with licensee procedures. Additionally, there was no formal requirement to evaluate whether the failure to use OE was a precursor during the evaluation of events. Although the licensee had identified these issues in the CAP, the corrective actions were somewhat limited.
- Issues that were reviewed by the ECP, but not captured in a formal case file, were not always well documented. This resulted in some uncertainty regarding whether potentially significant issues were appropriately dispositioned.

Inspection Report# : [2009007](#) (*pdf*)

Significance: SL-IV Jul 20, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to make required non-emergency 50.72 notification to NRC following loss of shutdown cooling

The inspectors identified a Green (Severity Level IV) NCV of 10 CFR 50.72 (b)(3)(v) for the licensee's failure to make a required non-emergency eight hour notification to the NRC for a loss of safety function of a system which was required to remove residual heat from the reactor. The licensee entered this issue into their corrective action program

as IR 971982.

The inspectors determined that the finding should be evaluated using the traditional enforcement process, since the failure to make a required report to the NRC had the potential to impact the agency's ability to perform its regulatory function. The finding was considered to be Severity Level IV as the NRC Enforcement Policy states in part that, "the severity level of a violation involving the failure to make a required report to the NRC will be based upon the significance of and the circumstances surrounding the matter that should have been reported." As such, the ability of the operators to restore a train of the RHR system by non-extraordinary means and in a timely manner (without experiencing an unplanned mode change) to a shutdown cooling lineup was considered by the inspectors to have mitigated the effects of the loss of functionality of the decay heat removal system to a very low safety impact on the plant.

Inspection Report# : [2009004](#) (*pdf*)

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