

La Salle 1

4Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify and Correct an Oil Leak on the HPCS Waterleg Pump

A finding of very low safety significance and associated non-cited violation of Title 10 of the Code of Federal Regulations Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the failure to promptly identify and correct a condition adverse to quality. Specifically, on November 8, 2011, the inspectors identified that the oil reservoir on the Unit 1 high pressure core spray (HPCS) waterleg pump was empty, with a soiled oil absorbent pad positioned beneath it. The licensee had previously identified a leak from the reservoir and placed the pad beneath it, but did not enter the problem into the corrective action program (CAP) and did not repair the leak. Upon notification of the condition by the inspectors, the licensee immediately entered this issue into the CAP, verified operability of the HPCS system, restored the oil level, established a special log to monitor the leak, and shortly thereafter replaced the waterleg pump. Additionally, the licensee was conducting an apparent cause evaluation to determine the causes of the occurrence and to develop additional corrective actions.

The finding was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance because there was no design deficiency, no actual loss of safety function, no single train loss of safety function for greater than the technical specification allowed outage time, and no risk significance due to external events. This finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program, for the failure to maintain a low threshold for identifying issues within the CAP commensurate with their safety significance (P.1(a)).

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Non-Conservative Voltage Input for Motor Starting Calculations

The inspectors identified a finding of very low safety significance (Green) and associated NCV of Title 10 Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion III, "Design Control," involving the licensee's failure to perform adequate analysis to demonstrate that safety related motors would start during a design basis event. The licensee entered this issue into the corrective action program (CAP) as Action Report (AR) 01139601 and conducted preliminary analysis to verify operability.

The licensee's failure to perform adequate analysis to demonstrate that motors would start during block loading was determined to be more than minor because there was reasonable doubt as to whether motors which are required to start at the onset of an accident would have adequate voltage to start, pending reanalysis. The inspectors determined that this was a design deficiency that did not result in loss of operability or functionality; and therefore, the finding was of very low safety significance (Green). This finding was determined not to have a cross cutting aspect. (1R21.1)

Inspection Report# : [2011004](#) (*pdf*)

Significance:  Jul 29, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Technical Specification Violation Due to Failure to Follow Operability Determination Procedure

A finding of very low safety significance (Green) and associated non-cited violation of Technical Specifications was identified by the inspectors for the licensee's failure to follow station procedure OP-AA-108-115, "Operability Determinations," Revisions 8 and 10. Specifically, the licensee failed to follow their operability determination procedure during loss of shutdown cooling events occurring on July 20, 2009, and February 2, 2011. These events were caused by the closure of the residual heat removal common suction valve. These events also resulted in the violation of TS 3.4.9, 3.4.10, and 3.0.2. The licensee entered this issue into its corrective action program as Issue Report (IR) 1248293.

The finding was considered more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Equipment Performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, failing to follow the Operability Determinations procedure caused the licensee to incorrectly assess the RHR SDC system's capability to perform its safety function, and also led the licensee to make a specific TS required isolation feature unavailable. This finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee used non-conservative assumptions when confronted with unexpected system failures. [H.1(b)] (Section 40A2.1(1))

Inspection Report# : [2011008](#) (*pdf*)

Significance:  Jul 29, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement a Corrective Action to Prevent Recurrence to Address a Significant Condition Adverse to Quality

A finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the licensee's failure to develop and implement adequate corrective action to prevent recurrence in response to a significant condition adverse to quality associated with work activities on the 1D RHR service water pump. The licensee entered this issue into their corrective action program as IR 1241118.

The finding was considered more than minor because it impacted the Reactor Safety Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and affected the cornerstone attribute of Equipment Performance. Specifically, the inadequate corrective action allowed for recurrence of this issue during similar work on other safety-related components. A cross-cutting aspect associated with Problem Identification and Resolution was also assigned to this finding. [P.1(d)] (Section 40A2.1(3))

Inspection Report# : [2011008](#) (*pdf*)

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Post Protected Pathway Signs for a Red Risk Path System

A finding of very low safety significance and associated NCV of 10 CFR 50.65(a)(4), Maintenance Rule, was identified by inspectors for the licensee's failure to implement all necessary prescribed risk management actions during a Unit 2 Reactor Core Isolation Cooling (RCIC) system maintenance window. Specifically, the licensee failed to post protected equipment signs for the Unit 2 systems whose unavailability would have taken the unit into a Red risk condition. The licensee entered this issue into their corrective action program (CAP).

The inspectors determined that this performance deficiency is a finding and greater than minor because the licensee failed to implement prescribed compensatory measures of posting signs and barricades to protect the high pressure core spray (HPCS) equipment during the RCIC work window, hence degrading the HPCS safety function during this time; which is similar to Example 7.g in IMC 0612, Appendix E. The inspectors

performed a Phase 1 screening with assistance from the Regional Senior Reactor Analyst (SRA) using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," Flowchart 2, "Assessment of Risk Management Actions." The calculated change in Incremental Core Damage Probability (ICDP), or actual increase in risk during this work window, was 5.7×10^{-9} , and the incremental large early release probability (ILERP), was 3.3×10^{-10} . In accordance with Flowchart 2, since the ICDP was less than 1×10^{-6} and the ILERP was less than 1×10^{-7} , the finding screened as Green. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices, because the licensee failed to conduct first and second verifications and use independent peer checks or other human error prevention techniques when evaluating risk-significant and/or Technical Specification (TS)-related activities, which led to the missed postings for the protected pathway equipment (H.4(a)).

Inspection Report# : [2011002](#) (pdf)

Significance:  Jan 03, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Supporting Structure for Standby Liquid Control System Test Tank Non-Functional During Postulated Design Basis Earthquake (DBE).

The team identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to have an adequate calculation to demonstrate the seismic qualification of the standby liquid control (SBLC) system test tanks. Specifically, the licensee could not ensure that the Units 1 and 2 SBLC test tanks, if filled with water, would not collapse and damage nearby safety-related components during a design basis event. The licensee entered this finding into their corrective action program and drained the water from the SBLC test tanks to restore seismic qualification.

The team determined that this finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability of the SBLC system to respond to initiating events to prevent undesirable consequences (i.e., core damage). This finding was determined to be of very low safety significance (Green) utilizing the Risk-Assessment Standardization Project Handbook based on the frequency of seismic events. The finding did not have a cross-cutting aspect because it was not reflective of current performance. (Section 1R21.3.b.(1))

Inspection Report# : [2010006](#) (pdf)

Significance:  Jan 03, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

EDG Usable Fuel and RHR Pump NPSH Calculations Failed to Consider Appropriate EDG Frequency Variations

The team identified a finding of very low safety significance and an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" for the licensee's failure to account for allowable frequency variations on the emergency diesel generators (EDG) in the diesel fuel oil consumption and residual heat removal (RHR) pump net positive suction head (NPSH) calculations. Specifically, the team noted the calculations assumed a frequency of 60 Hz whereas the Technical Specifications (TS) allowed steady state operation at a frequency of up to 61.2 Hz. The licensee entered this finding into their corrective action program and implemented a standing order and procedural limitations to ensure an adequate supply of fuel was available.

The team determined that this finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of the EDGs to respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, operating the EDGs at a frequency of 61.2 Hz would result in higher fuel consumption and reduced RHR pump NPSH margins. The finding is of very low safety significance (Green) because it did not result in a loss of operability. This finding had a cross-cutting aspect in the area of problem identification and resolution, operating experience because the licensee did not properly evaluate relevant operating experience. (P.2(a)) (Section 1R21.3.b.(2))

Inspection Report# : [2010006](#) (pdf)

Significance: G Jan 03, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Insufficient Design Bases for Degraded Voltage Time Delay and LOV Relay Settings

The team identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," involving the licensee's failure to have appropriate analyses for the loss of voltage relay setpoints and the second level undervoltage [degraded voltage] relay timer settings. Specifically, licensee's analysis and technical basis for the auxiliary power system (AP) second level undervoltage relay time delay settings failed to demonstrate the ability of the permanently connected safety-related loads to continue to operate during the 5.5 minutes relay time delay without sustaining damage during a worst case, non-accident degraded voltage condition (when voltage was still above the setpoint of the loss of voltage relay setpoint). The licensee entered this finding into their corrective action program to verify the adequacy of the degraded voltage relay setpoint and time delay design.

The team determined that this finding was more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of Design Control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, there was reasonable doubt as to whether the permanently connected safety-related loads would remain operable during a worst case, non-accident degraded voltage condition for the duration of the time delay chosen for the degraded voltage relay. The finding was of very low safety significance (Green) since the existing settings for the inverse time relay currently being used for the loss of voltage relay would limit the duration of degraded voltage below 75 percent to only a few seconds. This finding had a cross-cutting aspect in the area of problem identification and resolution because similar concerns raised at the Byron Nuclear Station, during the 2009 CDBI, were not promptly evaluated and correctly dispositioned at LaSalle. [P1(c)] (Section 1R21.3.b.(3))
Inspection Report# : [2010006](#) (pdf)

Significance: G Jan 03, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Fast Transfer Scheme

The team identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," involving the licensee's failure to analyze the capability of the electrical system to transfer safety related 4160V buses as described in the Updated Final Safety Analysis Report (UFSAR). The licensee entered this finding into their corrective action program and issued a standing order restricting alignment of safety buses to the unit auxiliary transformer (UAT) pending resolution of this issue.

The team determined that this finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Design Control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance (Green) since the safety buses had not been aligned to the UAT, the team determined the finding design deficiency did not result in loss of operability or functionality. The team did not identify a cross-cutting aspect associated with this finding because the finding was not representative of current performance. (Section 1R21.3.b.(4))
Inspection Report# : [2010006](#) (pdf)

Barrier Integrity

Significance: G Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Plant Barrier Control Process Caused Secondary Containment to Become Inoperable

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, was identified by the inspectors for the licensee's failure to follow steps 3.6

and 3.7 of procedure CC-AA-201, Revision 8, "Plant Barrier Control Program." Specifically, two airlock doors were opened simultaneously for a period of time sufficient to allow reactor building air pressure to surpass the TS allowed value for operability of secondary containment. The licensee entered this issue into its CAP as action requests (ARs) 1182255 and 1195987, and, at the time of this report, was in the process of conducting an apparent cause evaluation to determine the causes of the occurrence and to develop corrective actions.

The finding was determined to be more than minor because it was associated with the Barrier Integrity Cornerstone attribute of configuration control and affected the cornerstone objective of providing reasonable assurance that physical design barriers (secondary containment) protect the public from radionuclide releases caused by accidents or events. The inspectors performed a Phase 1 SDP review of this finding using the guidance provided in IMC 0609, and a Region III SRA continued the risk assessment using IMC 0609, Appendix H, "Containment Integrity Significance Determination Process." For Unit 1, since an open pathway existed to the environment from the secondary containment, the SRA performed a Phase 2 SDP analysis using the Appendix H guidance. For Unit 2, the SRA performed a Phase 1 SDP analysis using Figure 6.2, "Road Map for LERF [Large Early Release Frequency]-based Risk Significance Evaluation for Type B Findings at Shutdown." The SRA concluded that the total risk associated with this finding is very low and best characterized as Green. This finding has a cross-cutting aspect in the area of Human Performance, Work Control, because the licensee did not appropriately coordinate work activities by incorporating actions to address the impact of the work on different job activities, and the need for work groups to communicate, coordinate, and cooperate with each other during activities in which interdepartmental coordination is necessary to assure plant and human performance (H.3(b)).

Inspection Report# : [2011002](#) (pdf)

Emergency Preparedness

Significance: SL-IV Jun 22, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Changes to EAL Basis Decreased the Effectiveness of the Plan without Prior NRC Approval.

The inspector identified a violation of very low safety significance involving a Severity Level IV NCV of 10 CFR 50.54(q) for failing to obtain prior approval for an emergency plan change which decreased the effectiveness of the plan. Specifically, the licensee modified the Emergency Action Level (EAL) Basis in EAL HU6, Revision 22, which indefinitely extended the start of the 15 minute emergency classification clock beyond a credible notification that a fire is occurring or indication of a valid fire detection system alarm. This change decreased the effectiveness of the emergency plan by reducing the capability to perform a risk significant planning function in a timely manner.

The violation affected the NRC's ability to perform its regulatory function because it involved implementing a change that decreased the effectiveness of the emergency plan without NRC approval. Therefore, this issue was evaluated using Traditional Enforcement. The NRC determined that a Severity Level IV violation was appropriate due to the reduction of the capability to perform a risk significant planning standard function in a timely manner. The licensee entered this issue into its corrective action program and revised the EAL basis to restore compliance. (1EP4)

The associated performance deficiency is tracked as item 2011-503-02.

Inspection Report# : [2010503](#) (pdf)

Significance:  Jun 22, 2011

Identified By: NRC

Item Type: FIN Finding

Changes to EAL Basis Decreased the Effectiveness of the Plan without Prior NRC Approval.

The inspector identified a finding of very low safety significance involving a Severity Level IV NCV of 10 CFR 50.54 (q) for failing to obtain prior approval for an emergency plan change which decreased the effectiveness of the plan. Specifically, the licensee modified the Emergency Action Level (EAL) Basis in EAL HU6, Revision 22, which indefinitely extended the start of the 15 minute emergency classification clock beyond a credible notification that a fire is occurring or indication of a valid fire detection system alarm. This change decreased the effectiveness of the

emergency plan by reducing the capability to perform a risk significant planning function in a timely manner.

The finding was more than minor using IMC 0612, because it is associated with the emergency preparedness cornerstone attribute of procedure quality for EAL and emergency plan changes, and it adversely affected the cornerstone objective of ensuring that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Therefore, the performance deficiency was a finding. Using IMC 0609, Appendix B, the inspector determined that the finding had a very low safety significance because the finding is a failure to comply with 10 CFR 50.54(q) involving the risk significant planning standard 50.47(b)(4), which, in this case, met the example of a Green finding because it involved one Unusual Event classification (EAL HU6).

Due to the age of this issue, it was not determined to be reflective of current licensee performance and therefore a cross-cutting aspect was not assigned to this finding. (Section 1EP4)

The associated traditional enforcement item is tracked as item 2011-503-01.
Inspection Report# : [2010503](#) (*pdf*)

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: SL-IV Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Make a Non-Emergency Event Notification to the NRC and Submit Required LER Following a Loss of Shutdown Cooling Safety Function on Unit 1

A Severity Level IV NCV of 10 CFR 50.72(b)(3)(v) and 10 CFR 50.73(a)(2)(v) was identified by the inspectors for the licensee's failure to report an event or condition that could have prevented the fulfillment of the residual heat removal shutdown cooling safety function, which is relied upon to remove residual heat from the reactor. Specifically, when attempting to place the Unit 1 shutdown cooling system in service, the common suction valve unexpectedly closed and caused a complete isolation of the system. The licensee entered this issue into its CAP as IR 1244457, and, at the time of this report, was in the process of conducting an apparent cause evaluation to determine the causes of the occurrence and to develop corrective actions.

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, in accordance with the NRC Enforcement Policy. Because this violation did not affect the Reactor Oversight Process cornerstones, a cross cutting aspect was not assigned.

Inspection Report# : [2011003](#) (*pdf*)

Significance: SL-IV Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Make a Required 10 CFR 50.72 report for an Inoperable Secondary Containment

A Severity Level IV NCV of 10 CFR 50.72(b)(3)(v) was identified by the inspectors for the licensee's failure to report an event or condition that could have prevented the fulfillment of the secondary containment's safety functions, which are relied upon to control the release of radioactive material. Specifically, the licensee had not properly controlled the opening of two airlock doors that served as a boundary to maintain the ventilation envelope of the reactor building. The licensee entered this issue into its CAP as ARs 1182255 and 1195987, and, at the time of this report, was in the process of conducting an apparent cause evaluation to determine the causes of the occurrence and to develop corrective actions.

Violations of 10 CFR 50.72 are considered to be violations that potentially impact the regulatory process and are dispositioned using the traditional enforcement process instead of the Reactor Oversight Process SDP. As such, a cross-cutting aspect was not assigned to this violation.

Inspection Report# : [2011002](#) (*pdf*)

Last modified : March 02, 2012