

La Salle 1

1Q/2012 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)

Barrier Integrity

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Proceduralized Corrective Actions

A finding of very low safety significance and associated NCV of Title 10 of the Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to implement appropriate proceduralized compensatory measures associated with LaSalle Operability Evaluation (OpEval) 11 002, "Drywell Temp Used as Input for the Containment Analysis." Specifically, non conservative temperature limits were established for the control room shiftly surveillance procedure and written instructions were not included for drywell penetration local leak rate test parameters to ensure the adequate

performance of the tests. Upon notification by the inspectors, the licensee promptly entered the issues into the corrective action program (CAP) for evaluation and revised the surveillance procedure and test instructions. The finding was determined to be more than minor because it was associated with the Barrier Integrity Cornerstone attribute of procedure quality and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Additionally, if left uncorrected, the finding had the potential to lead to a more significant safety concern. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, Attachment 0609.04, "Phase 1 Initial Screening and Characterization of Findings," Table 4a, for the Containment Barrier, dated January 10, 2008. The finding was determined to be of very low safety significance because all questions in the Containment Barrier column were answered "No." This finding has a cross cutting aspect in the area of problem identification and resolution (PI&R) CAP, because the licensee did not take appropriate corrective actions to address safety issues in a timely manner, commensurate with their safety significance and complexity. Specifically, failing to appropriately execute corrective actions that were established in an OpEval resulted in the failure to establish appropriate instructions and procedures (P.1(d)).

Inspection Report# : [2012002](#) (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*)

Last modified : May 29, 2012