

La Salle 1

2Q/2012 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: N/A Jun 30, 2012

Identified By: NRC

Item Type: FIN Finding

Failure to Perform Surveillance Test Procedure Step

A finding of very low safety significance was identified by the inspectors for the licensee's failure to implement a station required procedure step during surveillance testing of the standby gas treatment (SBGT) system. Specifically, the licensee failed to perform the step in LaSalle procedure LOS VG M1, "Standby Gas Treatment System Operability and Inservice Test", which directs the SBGT manual initiation pushbuttons be tested every three years. Since the particular function of the pushbuttons is not required by regulation, and the procedure step was created only as a self imposed station requirement, no violation of regulatory requirements occurred. Upon notification by the inspectors of the discrepancy, the licensee promptly entered the issue into its corrective action program (CAP) for evaluation and resolution.

The finding was determined to be more than minor because the performance deficiency of failing to meet procedure requirements, if left uncorrected, could have 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 Mitigating Systems Cornerstone, dated January 10, 2008. The finding was determined to be of very low safety significance because all questions in the Mitigating Systems column were answered "No." This finding has a cross cutting aspect in the area of human performance, work control, for failing to appropriately coordinate work activities and keep personnel apprised of work status. Specifically, because there was no "predefine" in the work management system, operators performing the surveillance test were not aware of the status of the triennial requirement (H.3(b)).

Inspection Report# : [2012003](#) (*pdf*)

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*)

G

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*)

G

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*)

G

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

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : September 12, 2012