La Salle 2
2Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Sep 21, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform a Written Safety Evaluation for TRM Changes Section
The inspectors identified a Severity Level IV Non-Cited Violation and an associated finding of very low safety significance (Green) of 10 CFR 50.59, “Changes, Tests, and Experiments,” Section (d)1 for the licensee’s failure to perform a written safety evaluation to demonstrate that the deletion of the Technical Requirements Manual (TRM), Section 3.4.a did not require a license amendment. The licensee entered this issue into their Corrective Action Program and initiated a Standing Order reinstating the TRM in Section 3.4.a.

The inspectors determined that the violation was more than minor because the finding, if left uncorrected would become a more significant safety concern. Iin addition, the inspector could not reasonably determine that the changes would not have ultimately required NRC prior approval. The inspectors determined that the finding was of very low safety significance (Green) based on a review of the licensee’s operability determination and corrective actions for non-conformance to the ASME code requirements issues identified since the deletion of the TRM section. The inspectors determined that the licensee’s actions in the four instances did not have any technical safety concerns. This finding had a cross-cutting aspect in the area of Human Performance within the Decision Making component because the licensee did not use conservative assumptions to ensure the proposed activity was safe. Specifically, the licensee made an inadequate assumption when they determined that the removal of TRM, Section 3.4.a did not have an adverse effect.

Inspection Report# : 2012007 *(pdf)*

Significance: G Sep 21, 2012
Identified By: NRC
Item Type: FIN Finding
Failure to Perform a Written Safety Evaluation for TRM Changes
The inspectors identified a Severity Level IV Non-Cited Violation and an associated finding of very low safety significance (Green) of 10 CFR 50.59, “Changes, Tests, and Experiments,” Section (d)1 for the licensee’s failure to perform a written safety evaluation to demonstrate that the deletion of the Technical Requirements Manual (TRM), Section 3.4.a did not require a license amendment. The licensee entered this issue into their Corrective Action Program and initiated a Standing Order reinstating the TRM Section 3.4.a.

The inspectors determined that the violation was more than minor because the finding, if left uncorrected would become a more significant safety concern. Iin addition, the inspector could not reasonably determine that the changes would not have ultimately required NRC prior approval. The inspectors determined that the finding was of very low safety significance (Green) based on a review of the licensee’s operability determination and corrective actions for non-conformance to the ASME code requirements issues identified since the deletion of the TRM section. The inspectors determined that the licensee’s actions in the four instances did not have any technical safety concerns. This finding had a cross-cutting aspect in the area of Human Performance within the Decision Making component because

the licensee did not use conservative assumptions to ensure the proposed activity was safe. Specifically, the licensee made an inadequate assumption when they determined that the removal of TRM, Section 3.4.a did not have an adverse effect.

Inspection Report# : 2012007 *(pdf)*

Mitigating Systems

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Properly Implement Steps Outlined in Technical Specification Surveillance Procedure
A finding of very low safety significance and associated NCV of Technical Specification 5.4.1, "Procedures," was self-revealed on March 14, 2013, when an unexpected isolation of the Reactor Core Isolation Cooling (RCIC) system occurred as a result of the licensee's failure to properly implement the steps outlined in Technical Specification Surveillance Procedure LIS-RI-201, "Unit 2 RCIC Steam Line High Flow Isolation Calibration." Specifically, during performance of the surveillance for the testing and calibration of RCIC instrumentation, a conditional step was inappropriately answered which led to bypassing the remaining sections in the applicable surveillance procedure for resetting the RCIC high steam flow isolation signal and resulted in the Unit 2 RCIC steam supply outboard isolation valve (2E51-F008) going shut upon closure of its associated breaker, 2AP71E-B4.

The finding was determined to be more than minor because the performance deficiency of failing to properly implement the steps in the procedure impacted the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the cornerstone objective to ensure 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 (Green). This finding has a cross-cutting aspect in the area of human performance, work practices, for failing to communicate human error prevention techniques, such as, performing the proper self and peer checks. Specifically, the licensee committed a human performance error by inappropriately performing a procedural step without performing the proper self and peer checks, which resulted in an isolation of the RCIC system.

Inspection Report# : 2013002 *(pdf)*

Significance: G Dec 31, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Take Prompt Corrective Actions to Address a Safety Related Degraded Component
A finding of very low safety significance and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the licensee's failure to take prompt corrective actions to address the degraded condition of a safety-related component associated with the auxiliary electrical equipment room (AEER) ventilation (VE) system's "A" train emergency makeup (EMU) low flow alarm function. Specifically, the licensee failed to resolve the degraded condition of the 0FY-VE027 low flow alarm component at the earliest available opportunity and was unable to provide appropriate justification to allow the condition to persist with a scheduled correction date of 21 months after its initial discovery, without any compensatory measures in place. Upon notification to the licensee of the inspectors' concern regarding the apparent lack of promptness of the corrective actions, the licensee entered the issue into the corrective action program and put in place a number of compensatory measures. Additionally, based on the engagement of the inspectors, the licensee reprioritized the repair schedule of the

0FY-VE027 component and completed its repair on December 13, 2012, which restored compliance.

The finding was determined to be more than minor because the performance deficiency of failing to promptly correct conditions adverse to quality, if left uncorrected, could lead to a more significant safety concern. The finding was determined to be of very low safety significance (Green). This finding has a cross cutting aspect in the area of problem identification and resolution, corrective action program, for failing to appropriately evaluate problems, and failing to properly classify and prioritize them. Specifically, the licensee inappropriately assigned a very low priority to the degraded alarm component, which allowed the degraded condition to persist beyond the point of timeliness (P.1 (c)).

Inspection Report# : 2012005 *(pdf)*

Significance: G Sep 30, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Lack of Adequate Design Review of Effects of Fish Kills on Systems Needed During an Ultimate Heat Sink Design Basis Accident
The inspectors identified 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 III, "Design Control," for the failure to adequately verify the adequacy of the design of systems needed during a design basis accident. Specifically, the inspectors identified the licensee failed to evaluate the effects of fish mortality resulting from the elevated ultimate heat sink (UHS) temperatures predicted to occur during design basis accidents. The licensee entered the issue into their corrective action program (CAP) and based on engineering judgment, concluded the fish mortality or fish kills would not prevent systems from performing their safety functions during a design basis accident.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Design Control and the objective of ensuring the capability of the system to respond to an initiating event to prevent undesirable consequences. Specifically, based on previous operating experience, there was reasonable doubt equipment would remain operable due to the anticipated fish kill from elevated lake temperatures if a design basis accident had occurred. The finding was screened as very low safety significance (Green) because the design deficiency did not result in a loss of operability or functionality. The inspectors determined the finding had a cross cutting aspect in the area of problem identification and resolution because the licensee did not adequately analyze the potential adverse effects of fish kills on systems needed during design basis accidents when evaluating the adverse affects of the high UHS temperatures during the August 13, 2010, event (P.1 (c)).
Inspection Report# : 2012004 *(pdf)*

Significance: G Sep 30, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Plant Barrier Control Process for High Energy Line Break Protection Doors
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 procedure CC AA 201, Revision 9, "Plant Barrier Control Program." Specifically, the licensee propped open two doors that were required to remain shut at all times as high energy line break (HELB) barriers. Upon identification, the licensee immediately closed the doors and promptly entered the issue into the CAP for evaluation.

The finding was determined to be more than minor because if left uncorrected, the failure to follow the requirements of the plant barrier control program would lead to a more significant safety issue and was associated with the

Mitigating Systems Cornerstone. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609 Appendix A, "The Significance Determination Process for At Power Findings" to evaluate the finding for Unit 2 and IMC 0609 Appendix G "Shutdown Operations Significance Determination Process" for Unit 1. Since the finding did not cause the affected ventilation systems to be inoperable, the systems could still perform their safety function with the HELB door blocked open, so the finding did not meet the criteria for performing a detailed risk assessment. For the shutdown SDP, checklist 6 was reviewed. All safety function checklist items were met, and none of the criteria for performing a phase 2 or 3 evaluation were met. As a result, the finding screened as very low safety significance (Green) for both units. This finding had a cross cutting aspect in the area of human performance, work practices, for failing to effectively define and communicate expectations regarding procedural compliance, and personnel following procedures (H.4(b)).

Inspection Report# : 2012004 *(pdf)*

Significance: G Sep 30, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain an Adequate Testing Program for Safety-Related Watertight Doors
A finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion XI, "Test Control," was identified by the inspectors for the licensee's failure to maintain an adequate testing program for the station's safety related watertight doors. Specifically, the licensee's watertight door inspection procedure failed to satisfy the testing standard, set forth in regulations, that all testing required to demonstrate that safety related structures, systems, and components (SSCs) will perform satisfactorily in service, be identified and performed in accordance with written test procedures which incorporate the requirements and acceptance limits contained in applicable design documents. Upon notification by the inspectors, the licensee entered the issue into the CAP and concluded that a revision to the watertight door inspection procedure was warranted.

The finding was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of procedure quality 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). The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, Appendix A, "The Significance Determination Process for Findings At Power," Exhibit 2, dated June 19, 2012. The finding was determined to be of very low safety significance because all questions were answered "No." This finding did not have a cross cutting aspect because the deficient inspection procedure was created more than three years ago and was not considered indicative of current performance.
Inspection Report# : 2012004 *(pdf)*

Significance: G Sep 30, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Operability of Low Pressure Core Injection and Containment Cooling In Mode 3 Not Maintained
The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to ensure low pressure coolant injection (LPCI) and containment cooling (CC) operability in Mode 3. Specifically, the licensee did not correct two conditions adverse to quality that adversely impacted the operability of these modes of operation of the RHR system while realigned for shutdown cooling mode of operation. This finding was entered into the licensee's CAP to reconcile the licensing requirements and design of the RHR system.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System 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. In addition, the finding was associated with the Containment Barrier Cornerstone attribute of structures, systems, components and barrier performance and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The finding screened as of very low safety significance (Green) using a Phase II evaluation. Specifically, all the core damage sequences affected were calculated to have a frequency of 1x10 8 per year or less. The inspectors determined the cause of this finding did not represent current licensee performance and, thus, no cross cutting aspect was assigned.

Inspection Report# : 2012004 *(pdf)*

Significance: G Sep 30, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Assessment of Pressure Locking and Thermal Binding of the RHR Suction Isolation Valves from the Suppression Pool
The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for the failure to adequately assess the susceptibility to pressure locking and thermal binding of the RHR suction isolation valves from the suppression pool. Specifically, the design reviews for susceptibility to pressure locking and thermal binding did not consider the operational configuration of these valves when the RHR system is operated in the shutdown cooling mode. This finding was entered into the licensee’s CAP to reconcile the licensing requirements and design of the RHR system.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System 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. In addition, the finding was associated with the Containment Barrier Cornerstone attribute of structures, systems, components and barrier performance and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The finding screened as of very low safety significance (Green) using a Phase II evaluation. Specifically, all the core damage sequences affected were calculated to have a frequency of 1x10 8 per year or less. The inspectors determined the cause of this finding did not represent current licensee performance and, thus, no cross cutting aspect was assigned.

Inspection Report# : 2012004 *(pdf)*

Significance: G Sep 30, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Piping Interaction Between SW and RHR Systems Was Not Evaluated
The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for the failure to evaluate piping interactions between the service water (SW) and residual heat removal (RHR) systems. Specifically, the SW piping was observed to vibrate and an associated support clamp was oscillating very closely to another support clamp of a nearby RHR pipe. The loads of the potential impact between the clamps were not analyzed. This finding was entered into the licensee’s CAP to perform a formal evaluation of the condition to accept it as part of the design of the systems or to eliminate the condition.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System 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 screened as of very low safety significance (Green) because it was a design deficiency confirmed not to result in loss of operability. Specifically, the licensee performed an operability determination which concluded the affected pipe supports remained functional. The inspectors did not find an applicable cross cutting aspect which represented the underlying cause of this performance deficiency; therefore, no cross cutting aspect was assigned.
Inspection Report# : 2012004 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform Radiological Surveys to Ensure Appropriate Control and Access to a High Radiation Area
The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR 20.1501, and licensee Technical Specification(TS) 5.4, “Procedures.” Specifically, the licensee failed to adequately identify, plan, evaluate, and control the radiological conditions and potential hazards associated with the system flow paths created by the reverse flow flushing of the Unit 2 low pressure core spray (LPCS) / emergency core cooling system (ECCS) in accordance with licensee procedures RP AA 401, “Operational ALARA Planning and Controls,” and RP-AA-401-1002, “Radiological Risk Management.” As an immediate corrective action, the licensee instituted appropriate controls and initiated an apparent cause evaluation of the event. The licensee documented the issue in its corrective action program (CAP) as action report (AR) 01475014.

The licensee’s failure to plan, identify, assess, and control radiological hazards associated with the LPCS/ECCS system reverse flushing was a performance deficiency. The finding was more than minor because, if left uncorrected, the performance deficiency could have led to a more significant safety concern. Specifically, not evaluating the radiological impact and controlling personnel exposures associated with the LPCS/ECCS reverse flow flushing resulted in unnecessary and unplanned elevation of ambient radiation fields where workers were present. The transiting radioactive particle(s) caused unexpected dose rate alarms on electronic dosimeters worn by station personnel. The inspectors concluded that the finding was of very low safety significance (Green) using Inspection Manual Chapter 0609, Appendix C, as guidance. This finding had a cross-cutting aspect in the area of human performance, work-control for failing to appropriately plan work activities when developing the work package and authorizing the work. Specifically, the licensee assumed that the radiological conditions associated with reverse flow flushing of the LPCS/ECCS would have a nominal impact on general area radiation fields in the reactor building and the reactor drywell.
Inspection Report# : 2013002 *(pdf)*

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

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