

# La Salle 1

## 1Q/2016 Plant Inspection Findings

---

### Initiating Events

---

### Mitigating Systems

**Significance:** G Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

#### **Failure to Perform Required Monthly Fire Extinguisher Inspections per National Fire Protection Association Code**

The inspectors identified a finding of very low safety significance (Green) and an associated non-cited violation of LaSalle Unit 1 and Unit 2 operating licenses, NFP 11 section 2.C.(25) and NFP 18 section 2.C.(15), respectively, for failing to ensure that the inspection requirements of National Fire Protection Association (NFPA) 10 for portable fire extinguishers were satisfied. Specifically, on two separate occasions, the licensee failed to perform the required monthly inspection on all applicable portable fire extinguishers in the reactor building due to a deficiency in station procedure, LMS FP 21, "Monthly Inspection of Portable Fire Extinguishers." The licensee entered this issue into the corrective action program (CAP) as action request (AR) 02574270, AR 02574457, and AR 02604244.

The failure to meet the inspection requirements of NFPA 10 for portable fire extinguishers was a performance deficiency. The performance deficiency was determined to be more than minor because it is associated with the Mitigating Systems cornerstone attribute of protection against external factors, including fire, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, this performance deficiency could have led to the failure of a fire extinguisher to perform when called upon by station personnel or the fire brigade. The inspectors determined the finding was of very low safety significance (Green) in accordance with IMC 0609 Appendix F, "Fire Protection Significance Determination Process." This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because the licensee failed to initially evaluate the issue thoroughly in order to determine the root cause and extent of condition to prevent subsequent inspections from being missed after the issue was brought to their attention by the NRC inspectors.

Inspection Report# : [2015004](#) (*pdf*)

**Significance:** N/A Jul 17, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

#### **Use of an Analytical Method to Determine the Core Operating Limits without Prior NRC Approval (Section 1R17.1.b.(1))**

Severity Level IV. The inspectors identified a Severity Level IV NCV of Technical Specification (TS) Section 5.6.5, for using an analytical method that was not previously reviewed and approved by the NRC. Specifically in 2013, the licensee used TRACG04P code to determine the Oscillation Power Range Monitor setpoints prior to NRC approval. The TRACG04P code was reviewed and approved in April 24, 2015. TS Section 5.6.5.b stated, in part that the analytical methods used to determine the core operating limits shall be those previously reviewed and approved by the NRC, specifically those described in the TS. The licensee entered this finding into their Corrective Action Program

(CAP) as IR 02528609 and IR 02528612 to correct the issue.

The inspectors determined that this issue was a performance deficiency and because the issue had the potential to affect the NRC's ability to perform its regulatory function, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using the Enforcement Manual, the inspectors characterized the violation as Severity Level IV because the underlying analytical method required NRC approval prior to use. The inspectors did not assign a cross-cutting aspect to this violation in accordance with IMC 0612, Section 07.03.c. (Section 1R17.1.b (1))

Inspection Report# : [2015009](#) (pdf)

**Significance:**  Jul 17, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to Perform a Required 50.59 Evaluation (Section 1R17.1.b.(2))**

Severity Level IV/Green. The inspectors identified a Severity Level IV, NCV of Title 10, Code of Federal Regulations (CFR), Part 50.59, "Changes, Tests, and Experiments," and an associated finding of very low safety significance (Green) for the failure to perform and maintain a written evaluation to demonstrate that a calculation revision did not require a license amendment. Specifically, calculation L-003263, "Volume Requirements for ADS Back-up Compressed Gas System (Bottle Banks)," was revised and resulted in new required time critical operator manual actions, procedure changes, UFSAR changes, and an update to the TS Surveillance Requirements; however, a 10 CFR 50.59 evaluation was not performed. The licensee entered this finding into their CAP as IR 2528988.

The inspectors determined 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 capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the licensee failed to account for new required time critical operator manual actions, procedure changes, Updated Final Safety Analysis Report (UFSAR) changes, and an update to the TS Surveillance Requirements. This finding has a cross-cutting aspect in the area of Problem, Identification, and Resolution, in the area of evaluation because the licensee did not thoroughly evaluate the extent of condition of revising the design calculation. Specifically, the licensee failed to evaluate revising design calculation L 003263 resulting in time critical operator manual actions, procedure changes, UFSAR changes, and an update to the TS Surveillance Requirements. [P.2] (Section 1R17.1.b (2))

Inspection Report# : [2015009](#) (pdf)

## Barrier Integrity

**Significance:**  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to Ensure that Painting Instructions were Appropriate to Preclude Challenging the Operability of Standby Gas Treatment and Control Room Ventilation Charcoal Filters**

The inspectors identified a finding of very low safety significance (Green) and an associated NCV of Title 10, Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings" for the licensee's failure to have instructions or procedures that were appropriate to the circumstances for activities affecting quality. Specifically, procedure LAP-900-1, "LaSalle In Plant Painting," Revision 22, did not contain instructions or limitations to safeguard against the potential overloading of the charcoal absorber beds of the safety related standby

gas treatment (SBGT) system or the control room ventilation/auxiliary electrical equipment room (VC/VE) due to the volatile organic compounds (VOC) present in painting products (e.g., paint, primer, thinner, etc.).

The performance deficiency was determined to be more than minor because if left uncorrected, it had the potential to lead to a more significant safety concern. Specifically, the failure to limit the quantity or type of paint used within the ventilation boundaries of the safety related SBGT or VC/VE emergency filtration systems could have caused those systems to be unable to perform their safety function in the presence of uncontrolled quantities of VOC. In accordance with IMC 0609, Appendix H, "Containment Integrity Significance Determination Process," the inspectors determined the finding to have very low safety significance (Green). This finding has a cross cutting aspect in the area of Human Performance, Design Margins, because design margins were not carefully guarded with special attention placed on safety related equipment. Specifically, licensee staff failed to recognize the importance of understanding the VOC loading limitations of the SBGT and VC/VE systems with respect to operability, given the large scale of the painting activities throughout the plant.

Inspection Report# : [2015004](#) (pdf)

---

## Emergency Preparedness

---

## Occupational Radiation Safety

**Significance:**  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Follow Procedure Associated with Sealed Source Inventory and Leak Testing**

The inspectors identified a finding of very low safety significance (Green), and an associated non-cited violation of Technical Specification (TS) requirements for the failure to perform leak tests required by station procedures. The inspectors identified multiple discrepancies with the records that are required to demonstrate that sealed radioactive sources were leak tested to prevent the spread of radioactive contamination.

The inspectors determined that the finding was more than minor in accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening." Specifically, if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern, in that, the failure to ensure that the sources are free of external contamination could spread radioactive contamination, including alpha contamination that is not readily detected by personnel monitoring equipment, and result in increased exposure to radiation. The inspectors concluded that this activity was within the licensee's ability to foresee and should have been prevented. This finding was not subject to traditional enforcement since the incident did not result in a significant safety consequence, did not impact the NRC's ability to perform its regulatory function, and was not willful. The finding was assessed using the Occupational Radiation Safety Significance Determination Process, and was determined to be of very low safety significance (Green) because the problem was not an as-low-as-reasonably-achievable (ALARA) planning issue, there were no overexposures nor substantial potential for overexposures, and the licensee's ability to assess dose was not compromised. The inspectors determined that the cause of this incident involved a cross-cutting component in the area of problem identification and resolution. Specifically, the licensee did not conduct self-critical and objective assessment of the program and practice.

Inspection Report# : [2015004](#) (pdf)

**Significance:**  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Entry into an Area with Unknown Dose Rates**

The inspectors reviewed a finding of very low safety significance (Green) with an associated non-cited violation of Technical Specification (TS) 5.7.1, that was self-revealed when a worker received a dose rate alarm from an electronic dosimeter when he entered an area with an unknown dose rate.

The inspectors determined that the finding was more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening." Specifically, in that the finding impacted the program and process attribute of the Occupational Radiation Safety Cornerstone, and adversely affected the cornerstone objective of ensuring adequate protection of worker's health and safety from exposure to radiation, in that, the unauthorized entry into an area where the dose rates were unknown removed a barrier intended to prevent the worker from receiving unexpected dose. The inspectors concluded that this activity was within the licensee's ability to foresee and should have been prevented. This finding was not subject to traditional enforcement since the incident did not result in a significant safety consequence, did not impact the NRC's ability to perform its regulatory function, and was not willful. The finding was assessed using the Occupational Radiation Safety Significance Determination Process, and was determined to be of very low safety significance (Green) because the problem was not an as-low-as-reasonably-achievable (ALARA) planning issue, there were no overexposures nor substantial potential for overexposures, and the licensee's ability to assess dose was not compromised. The inspectors concluded that the cause of the issue involved a cross-cutting component in the human performance area of teamwork due to communication issues that were reported by the licensee during the pre-job brief for the job.

Inspection Report# : [2015004](#) (*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**

Last modified : July 11, 2016