

La Salle 2

3Q/2008 Plant Inspection Findings

Initiating Events

Significance: SL-IV Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Analyze Potential Internal Flood Sources

• SL-IV. The inspectors identified an NCV of 10 CFR 50.59, "Changes, Tests, and Experiments," which had very low safety significance. Specifically, the licensee failed to include non-seismically designed piping outside of the turbine building watertight enclosures as a potential source of internal flooding in a 50.59 evaluation. The licensee entered the issue into their corrective action program, performed an operability evaluation, and initiated corrective actions.

Because this issue affected the NRC's ability to perform its regulatory function, it was evaluated using the traditional enforcement process. With the assistance of the NRC Regional Senior Reactor Analyst (SRA), the inspectors determined from the initiating events evaluation in the phase one and phase three screenings that the underlying technical issue was of very low safety significance (Green). In accordance with the Enforcement Policy, the violation was therefore classified as a Severity Level IV violation. The inspectors determined that there was no cross cutting aspect to this issue.

Inspection Report# : [2007005](#) (*pdf*)

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Significance: Dec 14, 2007

Identified By: NRC

Item Type: FIN Finding

Failure to perform root cause for significant condition adverse to quality

The NRC identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to perform an adequate RCA to determine the corrective actions necessary to prevent recurrence for a SCAQ. Specifically, the licensee did not evaluate whether there were any aspects under their control that may have identified or prevented the incorrect machining of the Unit 1 jet pump riser brace clamps. The modification was initiated and processed in accordance with the licensee's process, but the contractor had the primary responsibility for implementation. The licensee assigned the performance of the RCA to the contractor. The contractor identified that they had provided incorrect measurements. However, the licensee did not perform an evaluation of their involvement with the modification; specifically, they did not look at those aspects of the modification directly under their control. By not performing an independent evaluation, the licensee failed to identify the root cause of any weaknesses within their oversight of the work that may have identified the incorrect measurements. As such, they were not able to determine a corrective action to prevent recurrence of similar oversight of contractor activities. The performance deficiency has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because the licensee did not evaluate whether there were any aspects under their control that may have identified or prevented the incorrect machining of the clamps. [P.1(c)]

Inspection Report# : [2007006](#) (*pdf*)

Mitigating Systems

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Significance: Mar 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Unacceptable Preconditioning of MSIV prior to performing ASME Stroke Time Testing

The inspectors identified a finding of very low safety significance involving the unacceptable preconditioning of the Unit 1 Main Steam Isolation Valves (MSIVs). Specifically, the inspectors identified that the licensee performed maintenance on the MSIVs prior to performing the American Society of Mechanical Engineers (ASME) required inservice testing (IST). The inspectors concluded that pre-stroking all the MSIVs during the limit switch calibration and replacing the ASCO test solenoid valve on the 'D' MSIV unacceptably preconditioned the valves and as a consequence masked the results of the as-found closing stroke of the MSIVs. A non-cited violation of the Code of Federal Regulations (CFR), 10 CFR 50, Appendix B, Criterion XI, "Test Control" was also identified for the failure to establish test procedures that appropriately demonstrated that a safety related component will perform satisfactorily in-service.

The inspectors determined that the finding was more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone, and it affected the cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. However, since the MSIVs would have been able to perform their safety function, the finding was considered to be of very low safety significance. The finding is also related to the cross cutting area of Problem

Identification and Resolution (PI&R). Specifically, the finding is related to the Operating Experience component (Aspect P.2(b)) because the licensee did not properly use and evaluate relevant operating experience information received from other Exelon plants, nor apply it to the station procedures. Corrective actions by the licensee included additional examination of the MSIV maintenance practices to further evaluate preconditioning cases.

Inspection Report# : [2008002](#) (*pdf*)

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Significance: Mar 31, 2008

Identified By: NRC

Item Type: FIN Finding

Failure to Restore Available Seismic Monitoring System Channels to an Operable and Available Status in a Timely Manner

The inspectors identified a finding of very low safety significance involving the licensee's seismic monitoring system. Specifically, the inspectors identified that the licensee had not appropriately prioritized restoration activities for three channels of the station's seismic monitoring system following a scheduled instrument calibration surveillance during which a fourth channel had failed calibration. During several ensuing weeks, the licensee missed several opportunities to identify the exact nature of the problem and restore the three potentially available and operable channels of the system to service.

Because the seismic monitoring system was not within the scope of 10 CFR 50, Appendix B, no violation of regulatory requirements was identified in conjunction with the finding. The licensee entered this issue into their corrective action program (CAP) as issue report (IR) 725240. Corrective actions planned and completed by the licensee included sending out an internal operating experience communication on the seismic monitoring system. In addition, the inspectors determined that the finding was related primarily to the cross cutting area of PI&R as defined in NRC IMC 0305, "Operating Reactor Assessment Program," since the licensee did not take appropriate corrective actions to address the partial restoration of potentially available channels of the seismic monitoring system in a timely manner (Aspect P.1(d)).

Inspection Report# : [2008002](#) (*pdf*)

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Significance: Dec 14, 2007

Identified By: NRC

Item Type: FIN Finding

Failure to correct a significant condition adverse to quality

The NRC identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to correct a SCAQ in a timely manner. Specifically, the licensee had not repaired or replaced all of the affected CSCS valves that are susceptible to separation of the valve disc from the valve stem. The first failure was in September 1996. The cause was determined to be vibration accelerated corrosion and erosion of the valves internal carbon steel components. There were at least four additional failures between 2002 and 2006. Corrective actions included the refurbishment or replacement of the 88 susceptible valves, as appropriate. As of this inspection, ten valves have not been refurbished or replaced. The valves are associated with safety-related and important-to-safety systems. The performance deficiency has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because the licensee did not take the appropriate corrective actions to address a safety issue in a timely manner, commensurate with the safety significance. [P.1(d)]

Inspection Report# : [2007006](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

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

Last modified : November 26, 2008