

## La Salle 1 3Q/2013 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:** G Sep 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Inadequate Procedures Led to Pin Hole Leaks in High Pressure Core Spray Piping**

A self revealed finding of very low safety significance and associated non cited violation of Title 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified for the failure to have procedures adequate for the circumstances during long-term operation of the high pressure core spray (HPCS) system on minimum flow. Specifically, three small holes developed in the Unit 2 HPCS minimum flow line elbow due to cavitation and other flow related wear caused by inconsistent procedural guidance regarding operation in the minimum flow mode.

The licensee promptly repaired the system leak and entered the issue into its CAP as ARs 1503825 and 1530682, which included the performance of an apparent cause evaluation. Further corrective actions included the revision of the affected procedures.

The finding was determined to be more than minor because it was associated with the Mitigating Systems and Barrier Integrity cornerstone attributes of Procedure Quality and adversely affected the cornerstone objectives of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the procedural guidance given to operate the HPCS system was inadequate to prevent long-term operation of the system in the minimum flow mode of operation, which led to cavitation and flow-induced wear, causing the failure of the Unit 2 HPCS minimum flow line and inoperability of the HPCS system as well as the primary containment boundary. The inspectors determined that the finding could be evaluated in accordance with

IMC 0609, Appendix A, “The Significance Determination for Findings At Power,” and Appendix H, “Containment Integrity Significance Determination Process.” Further, it was determined that a phase two risk assessment was necessary because the finding impacted suppression pool integrity, and through that process, this issue screened as Green. The inspectors did not identify a cross-cutting aspect associated with this finding.

Inspection Report# : [2013004](#) (*pdf*)

**Significance:** G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Perform a Required Risk Assessment Following a Failed RCIC Surveillance**

A finding of very low safety significance and associated NCV of 10 CFR 50.65, Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants, section (a)(4), was identified by inspectors for the licensee’s failure to perform an adequate risk assessment after failing a Unit 1 reactor core isolation cooling system surveillance

test. Specifically, the licensee failed to declare the reactor core isolation cooling system unavailable when its high flow isolation switch failed to reset. As a result, for approximately 98 minutes, risk was maintained as green when it should have been yellow, which would have required additional risk management actions. The licensee entered this issue into its corrective action program.

The performance deficiency 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 inspectors performed a Phase 1 screening with assistance from the Regional Senior Reactor Analyst using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," Flowchart 1, "Assessment of Risk Deficit." The finding screened as green. This finding has a cross cutting aspect in the area of Human Performance, Work Control, because the licensee failed to appropriately plan the work activity by incorporating risk insights which resulted in the licensee's failure to declare the reactor core isolation cooling system unavailable and change on line risk to yellow (H.3(a)).

Inspection Report# : [2013003](#) (*pdf*)

**Significance:**  Apr 18, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Satisfy 10 CFR 50.72 Reporting Requirements**

The inspectors identified a finding of very low safety significance with an associated Severity Level IV non cited violation of the NRC's reporting requirements in 10 CFR 50.72(a)(1), "Immediate Notification Requirements for Operating Nuclear Power Reactors." The licensee failed to make a required 8 hour non-emergency notification call to the NRC Operations Center after discovery of a condition that could have prevented fulfillment of the safety function of the low pressure core spray (LPCS) system. The licensee entered this issue into its corrective action program (CAP) for evaluation and made an appropriate notification call to the NRC Operations Center.

This finding was of more than minor significance because the NRC relies on licensees to identify and report conditions or events meeting the criteria specified in the Technical Specifications and the regulations in order to perform its regulatory function. Because this issue affected the NRC's ability to perform its regulatory function, the inspectors evaluated it using the traditional enforcement process and assessed the significance of the underlying issue using the Significance Determination Process (SDP). The underlying technical issue (i.e., an inoperable LPCS system) was determined to be of very low safety significance using the SDP. Consistent with the guidance in Section 6.9, Paragraph d.9, of the NRC Enforcement Policy, the violation associated with this finding was determined to be a Severity Level IV Violation. This finding affected the cross cutting area of problem identification and resolution. Specifically, the licensee did not implement and institutionalize operating experience from a similar event reported at another licensee's facility while evaluating the reportability of the inoperable single train safety system with respect to the 10 CFR 50.72 reporting requirements

Inspection Report# : [2013009](#) (*pdf*)

**Significance:**  Apr 18, 2013

Identified By: NRC

Item Type: FIN Finding

#### **Failure to Satisfy 10 CFR 50.72 Reporting Requirements**

The inspectors identified a finding of very low safety significance with an associated Severity Level IV non cited violation of the NRC's reporting requirements in 10 CFR 50.72(a)(1), "Immediate Notification Requirements for Operating Nuclear Power Reactors." The licensee failed to make a required 8 hour non-emergency notification call to the NRC Operations Center after discovery of a condition that could have prevented fulfillment of the safety function of the low pressure core spray (LPCS) system. The licensee entered this issue into its corrective action program (CAP)

for evaluation and made an appropriate notification call to the NRC Operations Center.

This finding was of more than minor significance because the NRC relies on licensees to identify and report conditions or events meeting the criteria specified in the Technical Specifications and the regulations in order to perform its regulatory function. Because this issue affected the NRC's ability to perform its regulatory function, the inspectors evaluated it using the traditional enforcement process and assessed the significance of the underlying issue using the Significance Determination Process (SDP). The underlying technical issue (i.e., an inoperable LPCS system) was determined to be of very low safety significance using the SDP. Consistent with the guidance in Section 6.9, Paragraph d.9, of the NRC Enforcement Policy, the violation associated with this finding was determined to be a Severity Level IV Violation. This finding affected the cross cutting area of problem identification and resolution. Specifically, the licensee did not implement and institutionalize operating experience from a similar event reported at another licensee's facility while evaluating the reportability of the inoperable single train safety system with respect to the 10 CFR 50.72 reporting requirements.

Inspection Report# : [2013009](#) (*pdf*)

**Significance:**  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*)

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## **Barrier Integrity**

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## **Emergency Preparedness**

## Occupational Radiation Safety

**Significance:**  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*)

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## Public Radiation Safety

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### 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.

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## **Miscellaneous**

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