La Salle 2

Initiating Events

Significance: N/A Dec 14, 2001
Identified By: NRC
Item Type: FIN Finding
Supplemental Inspection Results. The Common Cause Evaluation did not Review the Effectiveness of Past Corrective Actions for Root Causes of the Individual Scrams.
While the licensee's corrective action program included a process for performing reviews to assess the effectiveness of corrective actions implemented in response to the common cause evaluation, the common cause evaluation did not review the effectiveness of past corrective actions for root causes of the individual scrams. As a result, a problem in the implementation or effectiveness of corrective actions may have existed which contributed to subsequent scrams. This was a missed opportunity to more fully understand potential contributing factors to the scrams that occurred.
Inspection Report# : 2001018*(pdf)*

Significance: N/A Dec 14, 2001
Identified By: NRC
Item Type: FIN Finding
Supplemental Inspection Results. The Licensee's Overall Evaluation of the White Performance Indicator for the Unplanned Scrams Per 7,000 Critical Hours was Acceptable.
The licensee's overall evaluation of the White Performance Indicator for the Unplanned Scrams Per 7,000 Critical Hours was acceptable. A structured approach was utilized to identify potential common causes by evaluating the circumstances of the individual plant scrams and their collective significance. The licensee's corrective actions for the common causes were determined to be acceptable and were found to be either completed or being tracked for completion.
Inspection Report# : 2001018*(pdf)*

Significance: N/A Oct 02, 2001
Identified By: NRC
Item Type: FIN Finding
The inspectors concluded that the licensee adequately identified, evaluated, and resolved problems within the requirements of the corrective action program (CAP).
The inspectors concluded that the licensee adequately identified, evaluated, and resolved problems within the requirements of the corrective action program (CAP). The inspectors found that station personnel identified and entered problems into the CAP using condition reports. The significance threshold for entering issues into the corrective action program appeared appropriate. Overall, the station adequately identified and resolved problems. Station management established a safety-conscious work environment where people were not reluctant to raise issues due to potential harassment or chilling concerns. While the overall program allowed the station to identify and resolve problems, there were several weaknesses in the station's implementation of the program.
Inspection Report# : 2001016*(pdf)*

Significance: N/A Oct 02, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to follow procedure adequately comply with procedural requirements to further evaluate common cause analysis outcomes.
During this inspection, several examples of procedural non-compliance were identified that were associated with the station corrective action program procedure. An adverse performance trend in procedural compliance appeared to be developing in several cornerstone elements. The specific procedural adherence issues were associated with AD-AA-106 "Corrective Action Process Program Procedure", Section 4.6.2.2, Class B Evaluations where the licensee had not implemented the requirement to initiate new condition reports following a class B Common Cause Analysis when a potential adverse trend was validated. One non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified. The issue was of very low safety significance based on the inspector risk significance screening of this finding in accordance with NRC Inspection Manual Chapter 0610*, "Power Reactor Inspection Reports," Appendix B, "Thresholds for Documentation." Because the failure to initiate Condition Reports (CRs) when common causes or trends were identified did not have an actual or credible impact on safety, the issue was not evaluated using NRC Manual Chapter 0609, "Significance Determination Process". However, the finding was more than minor based on extenuating circumstances (Group 3 Questions). The finding was considered to be a substantive cross-cutting issue because the issue was captured in a number of examples noted in the different functional areas examined during the inspection and across plant departments which indicated an adverse performance pattern.
Inspection Report# : 2001016*(pdf)*

Significance: G Sep 30, 2001
Identified By: Licensee

Item Type: NCV NonCited Violation
Inadequate Heater Drain Procedure
Operators failed to have an adequate procedure to control the operation of the heater drain system. As a result, the plant was operated in a manner which caused multiple heater string isolations and required a manual scram. One Non-Cited Violation of Technical Specifications 5.4.2, "Administrative Controls," was identified. The issue was of very low safety significance since sufficient mitigating equipment was available to place and maintain the plant in a stable condition following the scram.
Inspection Report# : 2001011*(pdf)*

Significance: N/A May 19, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Inadequate Gamma TIP Modification
10 CFR 50, Appendix B, Criterion III, requires that design changes be subject to design control measures commensurate with those applied to the original design and that measures be established for the selection and review of suitability of application of equipment essential to the safety-related functions of structures, systems, and components. Unit 2 utilized a revised Powerplex deck which did not contain all the gamma traversing incore probe (TIP) data constants necessary to monitor core thermal limits to the correct accuracy. This issue was entered into the licensee's corrective action program as CR L2001-02269.
Inspection Report# : 2001007*(pdf)*

Significance: G Apr 13, 2001
Identified By: NRC
Item Type: FIN Finding
A reactor scram resulted from the failure to adequately evaluate the potential consequences of a maintenance activity associated with the f/w control system and implement contingency actions.
Green. A reactor scram resulted from the failure to adequately evaluate the potential consequences of a maintenance activity associated with the feedwater control system and implement appropriate contingency actions. The issue was of very low safety significance since sufficient plant equipment was available to place and maintain the plant in a stable condition (Section 1R2).
Inspection Report# : 2001009*(pdf)*

Significance: N/A Nov 09, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
The inspectors reviewed a loss of f/w heaters which occurred during a load drop on 10/ 9 and concluded that due to inadequate preparation, operators were challenged with an unanticipated condition.
No color. The inspectors reviewed a loss of feedwater heaters which occurred during a load drop on October 9 and concluded that due to inadequate preparation, operators were challenged with an unanticipated condition for which they had not been specifically trained. The inspectors identified a Non-Cited Violation for failure to have an adequate procedure for directing operator actions in the event of a loss of a large portion of feedwater heaters and thereby ensuring that the plant was operated within analyzed boundaries. (Section 1R14).
Inspection Report# : 2000018*(pdf)*

Mitigating Systems

Significance: G Aug 11, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
The design basis for the correction of suppression pool temperature for the effects of thermal stratification was not adequately translated into operating procedures
A Non-Cited Violation was identified because the design basis for the correction of suppression pool temperature for the effects of thermal stratification was not adequately translated into operating procedures. The issue was of very low safety significance because, after further review by the licensee, the correction factor was determined to be appropriate.
Inspection Report# : 2000011*(pdf)*

Significance: G Aug 04, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to identify and correct discrepancies regarding replacement air intake filters associated with the 2B EDG

GREEN. Engineering personnel failed to adequately evaluate the replacement of air intake filters associated with the 2B emergency diesel generator (EDG) prior to their installation. After high differential pressure alarms were received during surveillance testing, the licensee did not adequately resolve the issue. As a result, a review of the impact of the design change on the ability of the emergency diesel generator ventilation system to fulfill its safety function was not completed until after the inspectors identified the issue. Since the operability of the EDG was not adversely impacted, this issue was screened as having very low risk significance following a Phase 1 Significance Determination Process review. One Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI was identified. (4OA2.2)
Inspection Report# : 2000012*(pdf)*

Significance:  May 08, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Corrective actions to address 1E51-F013 leakage
Green. Operators failed to adequately consider the potential consequences of an active body-to-bonnet leak on the reactor core isolation cooling system injection valve. As a result, a review of the impact on system operability was not completed until after the resident inspectors identified the leak during a plant tour. In addition, important assumptions which provided a basis for operability were not validated until questioned by the inspectors. Due to high pressure core spray system availability, this issue was screened as Green (very low risk significance) after a Phase 2 Significance Determination Process review. One non-cited violation was identified. (Section 1R13)
Inspection Report# : 2000004*(pdf)*

Significance:  Feb 16, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inoperable 2A EDG
Licensee personnel failed to identify during work activities in March 2000, that a 2A Emergency Diesel Generator (EDG) governor guard clip was missing, which if installed, would have prevented a 2A EDG testing failure on November 7, 2001. The issue was of very low safety significance since the 2A EDG was restored to service within the Technical Specification Allowed Outage Time and the redundant EDG was available during the entire time that the 2A EDG was inoperable.
Inspection Report# : 2001019*(pdf)*

Significance:  Dec 29, 2001
Identified By: NRC
Item Type: FIN Finding
NUMBER OF CREW FAILURES EXCEEDING LICENSED OPERATOR REQUALIFICATION SDP METRICS
The inspectors identified that two of nine crews examined during the licensee's calendar year 2001 licensed operator requalification operating test had failed. The finding was of very low safety significance because both crews that had failed received remedial training prior to being returned to shift, and the results of the licensee's operating licensing requalification operating test given in calendar year 2000 indicated that only one crew, out of a total of eight crews tested, had failed.
Inspection Report# : 2001013*(pdf)*

Significance:  Nov 17, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Untimely Response to RHR Anomaly
Licensee personnel failed to address an anomaly observed during operation of the 2A Residual Heat Removal (RHR) system in a timely manner. As a result, air trapped in the Unit 2 RHR and Low Pressure Core Spray (LPCS) system piping, which potentially impacted system operability, was not identified in a timely manner. One Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Correction Action," was identified. The issue was of very low safety significance since further evaluation determined that there was no adverse impact on the operability of the Unit 2 RHR or LPCS systems.
Inspection Report# : 2001012*(pdf)*

Significance: N/A Nov 17, 2001
Identified By: NRC
Item Type: FIN Finding
An Adverse Performance Trend in Human Performance-Related Errors Appears to be Developing in Several Cornerstone Elements.
An adverse performance trend in human performance-related errors appears to be developing in several cornerstone elements. The relationship between these errors is that poor human performance during implementation of established procedures or during actions which were not prescribed in an approved procedure directly resulted in a number of plant events. The individual errors each had an adverse impact on safety,

increasing the frequency of initiating events, or potentially or actually affecting the reliability, operability, and functionality of a structure, system, or component. This adverse performance trend is considered a substantive cross-cutting issue not captured in individual issues indicating a performance trend.
Inspection Report# : 2001012*(pdf)*

Significance: G Nov 17, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Improper Actions to Address Elevated RHRSW System Pressure Condition
During actions to address a Unit 2 Division 2 RHR Service Water (RHRSW) system elevated pressure condition, operators performed actions which were not specified in a procedure addressing the specific high pressure condition, rendering the system inoperable for about 6 minutes. One Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified. The issue was of very low safety significance since the Unit 2 Division 2 RHRSW system was restored to service within the Technical Specification Allowed Outage Time and the Unit 2 Division 1 RHRSW system was available during the entire time that the Division 2 RHRSW system was inoperable.
Inspection Report# : 2001012*(pdf)*

Significance: N/A Nov 17, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Revise HELB Analysis
10 CFR 50, Appendix B, Criterion III, "Design Control," requires that measures shall be established to assure that the design basis is correctly translated into specifications, drawings, procedures, and instructions and that design changes shall be subject to the design control measures commensurate with those applied to the original design. Contrary to the above, floor plugs on the refueling floor were altered and doors assumed open in the event of a High Energy Line Break were closed which was not evaluated as required. This issue was entered into the licensee's corrective action program as Condition Report (CR) L2001-05531.
Inspection Report# : 2001012*(pdf)*

Significance: G Oct 02, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to promptly correct condition adverse to quality (operators' lack of recognition of Technical Specification entry requirements).
Following the April 6, 2001, reactor scram, licensed operators entered the wrong Technical Specification associated with the reactor core isolation cooling system (RCIC) discharge check valves. The licensee established and implemented corrective actions to improve operator understanding of Technical Specification 3.4.6, "Reactor Coolant System (RCS) Pressure Isolation Valve (PIV) Leakage." During similar circumstances following the September 3, 2001 reactor scram, licensed operators again demonstrated poor understanding of the Technical Specification requirements for the RCIC system. The corrective actions implemented for the failure on April 6, 2001, to properly recognize and enter the appropriate technical specifications, were not performed in a timely manner. One non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," was identified. The event was of very low safety significance based on the inspectors risk significance screening of this finding in accordance with the guidance contained in Appendix B, "Thresholds for Documentation," of Inspection Manual Chapter (IMC) 0610*, "Power Reactor Inspection Report." The inspectors evaluated the issue with the SDP Group 1 questions and concluded that the failure to correct the operator understanding of Technical Specification requirements was more than minor in that, if left uncorrected, the issue could under the same condition become a more significant safety concern. Using the Group 2 questions, the inspectors concluded that the issue could credibly affect the availability, reliability, or function of a mitigating system. The Group 3 question, item 6, was addressed and the issue was determined to be greater than minor during review of Group 1 questions, resulting in the issue being screened Green.
Inspection Report# : 2001016*(pdf)*

Significance: N/A Aug 30, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
LICENSED OPERATOR REQUALIFICATION PROGRAM EVALUATION - 10 CFR 55.25 MEDICAL
Title 10 CFR 55.25 requires the facility licensee to notify the NRC within 30 days of identifying any licensed operator who develops a permanent physical conditions that could potentially affect the ability to perform assigned licensed duties. In mid-1999, the licensee identified four operators who developed permanent changes in their physical conditions. However, the licensee failed to notify the NRC of such changes within 30 days. The licensee did not notify the NRC until an internal audit was performed in September 2000, as described in the licensee corrective action program Reference CR# L2000-05122.
Inspection Report# : 2001012*(pdf)*

Significance: N/A Aug 18, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Procedure LTS-200-28 inadequate.

10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality be prescribed by adequate procedures. Adequate plant conditions were not prescribed in LTS-200-28, "1A DG Division 2 Flow Balance Test," which potentially impacted safety-related cooler flow. This issue was entered into the licensee's corrective action program as CR L2001-04480.
Inspection Report# : 2001010*(pdf)*

Significance: N/A May 19, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Dampers Open Without HELB Review
10 CFR 50, Appendix B, Criterion III, requires that the design basis is correctly translated into specifications, drawings, and procedures. Back draft dampers in the Unit 1 and Unit 2 Division 1 Essential Switchgear Rooms were locked open without a High Energy Line Break impact review. This issue was entered into the licensee's corrective action program as CR L2001-01932.
Inspection Report# : 2001007*(pdf)*

Significance: G Feb 10, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Temporary Plant Modification
During a review of a temporary modification associated with the reactor recirculation system, the inspectors identified that the licensee had failed to recognize that the temporary modification defeated a reactor recirculation pump control circuit safety interlock which prevented shifting a reactor recirculation pump from slow to fast speed.
Inspection Report# : 2001002*(pdf)*

Significance: G Dec 31, 2000
Identified By: NRC
Item Type: FIN Finding
The licensee failed to perform required American Society of Mechanical Engineers Code non-destructive examination of RCIC system piping during modification activities until questioned by the inspector
Green. The licensee failed to perform required American Society of Mechanical Engineers (ASME) Code non-destructive examination of Reactor Core Isolation Cooling system piping during modification activities until questioned by the inspectors. The finding was considered to be of very low safety signifiicance because an expanded ultrasonic examination detected no flaws in the subject section of piping. (Section 1R17).
Inspection Report# : 2000019*(pdf)*

Significance: G Dec 31, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Suppression Pool Debris
Green. The inspectors reviewed videotaped documentation of suppression pool inspections accomplished during L2R08 and identified a piece of piping clamped underneath and between two suppression pool downcomers which posed a potential challenge to Emergency Core Cooling System (ECCS) suction strainers in the event that they were forcibly swept away from their installed location during an accident. The finding was considered to be of very low safety significance because the potential for an impact on the ECCS was small. (Section 1R22).
Inspection Report# : 2000019*(pdf)*

Barrier Integrity

Significance: N/A Aug 04, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to identify, correct, and prevent recurrence of delinquent ASME Code Requirements.
NO COLOR. The inspectors identified several failures to implement the corrective action program when Unit 1 and Unit 2 ASME Code Replacement and Repair Program requirements for Class 1 and 2 maintenance work quality reviews were not met. On several occasions the licensee did not enter into the plant's corrective action program 19 maintenance work packages that did not meet all 10 CFR 50.55a ASME Code or program procedure requirements. In each case, corrective actions were not taken to correct the situation. Over the past year, the licensee had identified technical Code errors in several Class 2 work packages. This reinforced the importance of the quality review process. The inspectors were concerned that since the problem had occurred on multiple occasions during both of the last 2 outages, that if left uncorrected, the issue could become a more safety significant concern. Failure to promptly identify and correct the failure to meet ASME Code quality requirements for Class 1

and Class 2 repair and replacement work was considered a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI. The safety significance of this issue was considered very low based on the absence of adverse consequences and the fact that no technical problems were identified at the time of the inspection. Since the issue does not immediately affect a cornerstone, the finding has no color. (4OA2.1)
Inspection Report# : 2000012*(pdf)*

Significance:  Dec 29, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Unlocked High-High Radiation Area Door
Licensee personnel failed to adequately control a high radiation area door which provided access into a high-high radiation area with radiation levels greater than 1000 mrem per hour. One Non-Cited Violation of Technical Specification 5.7.4 was identified. The finding was of very low safety significance since there was not an actual overexposure or substantial potential for an overexposure, and the ability to assess dose was not compromised.
Inspection Report# : 2001013*(pdf)*

Significance: N/A Nov 17, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Untimely Response to Moisture Carryover Fraction Error
Licensee personnel failed to recognize in a timely manner that the moisture carryover fraction used in the computer core heat balance calculation was inaccurate and caused Unit 1 and Unit 2 to be operated at a power level which exceeded the licensed thermal power limit. One Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified. The issue was of very low safety significance since the actual power level operated at only slightly exceeded the licensed thermal power and was within design analysis limits.
Inspection Report# : 2001012*(pdf)*

Significance: N/A Nov 17, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Inappropriate Revision of Moisture Carryover Fraction in Power Calculation
10 CFR 50, Appendix B, Criterion III, requires that the design basis is correctly translated into specifications, drawings, procedures and instructions and that design changes shall be subject to the design control measures commensurate with those applied to the original design. Contrary to the above, on February 2, 1998, licensee personnel inappropriately revised the moisture carryover input into the Unit 1 and Unit 2 reactor power calculation which resulted in the an indicated reactor power level which was slightly lower that actual reactor power. This issue was entered into the licensee's corrective action program as Condition Report (CR) L2001-05688.
Inspection Report# : 2001012*(pdf)*

Significance:  Sep 21, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to correctly implement required operations procedures.
The inspectors identified a Non-Cited Violation for the failure of operators to execute all of the required steps of the abnormal procedure for isolating the control rod drive system following a trip of the reactor recirculation pumps. This finding was of low safety significance. Although the Technical Specification limits were exceeded, actual reactor conditions did not exceed the parameters contained in the design thermal stress analysis and the excessive heatup rate was determined to not be a threat to the integrity of the reactor fuel.
Inspection Report# : 2001017*(pdf)*

Significance: N/A May 19, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Inoperable Containment Radiation Monitors
No Color. The inspectors identified a Non-Cited Violation for the failure of operators to recognize that the Unit 1 and Unit 2 containment air particulate and gaseous radiation monitors, 1(2)PL15J and 1(2)PL75J, were inoperable when they were isolated from containment and therefore unable to sample the containment atmosphere. The finding was of very low safety significance since the periods during which the monitors were inoperable was of a relatively short duration and other diverse means were available to identify an increase in reactor coolant system leakage (Section 1R15).
Inspection Report# : 2001007*(pdf)*

Significance: N/A Feb 10, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Unit 2 Div 2 Post-LOCA Monitoring

10 CFR 50, Appendix B, Criterion XVI, requires that conditions adverse to quality be promptly identified and corrected. Open feed breakers on the Unit 2 Division 2 Post Loss-of-Coolant-Accident (LOCA) monitoring system which rendered the system inoperable were not promptly identified. This issue was entered into the licensee's corrective action program as CR L2000-07353.
Inspection Report# : 2001002*(pdf)*

Significance: N/A Feb 10, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Unit 2 Offgas Radiation Monitor Isolated
10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality be performed in accordance with prescribed procedures. During chemistry sampling activities on January 20, 2001, chemistry personnel failed to properly adhere to a sampling procedure and inadvertently isolated the Unit 2 offgas pre-treatment radiation monitor, which rendered the monitor inoperable for about 10 minutes. This issue was entered into the licensee's corrective action program as CR L2001-00353.
Inspection Report# : 2001002*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Jan 17, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
ALARA Plan not implemented during Unit 1 refueling outage work on flow control valve.
The radiological engineering controls required by the ALARA Plan during the disassembly of the recirculation system flow control valve were not fully implemented, resulting in radioactive material intakes to three workers.
Inspection Report# : 2001019*(pdf)*

Significance: G Jan 11, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Technical Specification High Radiation Area access control problem.
Access to a high-high radiation area that existed in the drywell during the Unit 1 refueling outage was not adequately controlled because the area was not properly posted, roped-off/barricaded, and a flashing light was not activated as a warning device for entry into the area.
Inspection Report# : 2001019*(pdf)*

Public Radiation Safety

Physical Protection

Significance: N/A Jun 28, 2000
Identified By: NRC
Item Type: FIN Finding
Supplemental review - comprehensive evaluation for the causes of the unavailability of protected area security equipment (white PI).
The licensee conducted a comprehensive evaluation for the causes of the unavailability of protected area security equipment. The evaluation appropriately identified that the root cause for the protected area security equipment issue was the results of inadequate practices and procedures involving the scheduling and work activities of maintenance for protected area security equipment. Licensee corrective actions were verified to have been implemented, and those actions appeared to have been effective at improving security equipment performance during the first quarter of 2000.

Inspection Report# : 2000010*(pdf)*

Significance: G Jul 16, 2001
Identified By: NRC
Item Type: FIN Finding
Reduced Contingency Response
GREEN - An issue of low safety significance was identified pertaining to the impact of security computer failures on the response capabilities of the armed response force. (The details and significance determination discussion of this issue are considered Safeguards Information.)
Inspection Report# : 2001015*(pdf)*

Miscellaneous

Significance: N/A Aug 04, 2000
Identified By: NRC
Item Type: FIN Finding
problem identification and resolution
The corrective action program was fully functional and typically identified and corrected conditions adverse to quality. In general, station personnel effectively identified and entered problems as problem identification forms (PIFs) into the corrective action program. The significance threshold for entering issues into the program appeared appropriate. However, over the past year some weaknesses were identified at LaSalle County Station with both the identification and effective resolution of problems. The inspectors noted examples where station personnel failed to capture specific items into the corrective action program. Additionally, the inspectors noted some cases where repetitive items suggested that the station's initial resolution of issues was not fully effective. Although none of these items was considered safety significant, and thousands of other items were satisfactorily opened and closed in that time frame, these items represented weaknesses in the licensee's program.
Inspection Report# : 2000012*(pdf)*

Significance: N/A May 08, 2000
Identified By: NRC
Item Type: FIN Finding
Failure to make timely 4-hour ENS report.
No Color. Operations personnel failed to report a reactor water cleanup system isolation within 4 hours in accordance with the requirements of 10 CFR 50.72. One non-cited violation was identified. (Section 4OA4)
Inspection Report# : 2000004*(pdf)*

Last modified : March 29, 2002