La Salle 1

Initiating Events

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 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:  Sep 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Essential Switchgear Room Degraded Fire Barriers
The inspectors identified dried paint on the side of a safety-related switchgear bus duct which led to the identification of openings between the Unit 1 and Unit 2 Division 1 and Division 2 Essential Switchgear Rooms. These openings compromised the 3-hour fire protection barrier separating the two fire zones. The issue was of very low safety significance since it was not likely that redundant safe shutdown equipment would be significantly impacted. A Non-Cited Violation of License Condition 25 concerning the LaSalle Unit 1 and Unit 2 Fire Protection Program was identified.
Inspection Report# : 2002005*(pdf)*

Significance:  Sep 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Corrective Actions to Address Degraded Fire Barriers
A Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was also identified due to the failure to take adequate corrective action to address a similar issue that occurred in June 2000.
Inspection Report# : 2002005*(pdf)*

Significance:  Sep 27, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Translate Starting Air System Design Basis Requirements into Specifications, Procedures, or Instructions
The inspection team identified a Non-Cited Violation (NCV) of 10 CFR Part 50, Appendix B, "Criterion III, Design Control," that applied to the air start systems for all the emergency diesel generators on both units. Specifically, the inspectors identified that the design basis requirement that the starting air systems have enough air to permit either five (Division 1 and 2 diesel generators) or three (Division 3 diesel generators) normal starts in rapid succession was not translated into specifications, procedures, and instructions. As a result, there was no objective evidence that the required starting air system capacity was being maintained. The finding was greater than minor based on the potential that degradation of the design basis capability of a starting air system would not be detected by the licensee. Degradation of the design function impacts the base probabilistic risk assessment values used for diesel generator reliability. The finding was of low safety significance because it does not represent an actual loss of the starting air

system safety function. (Section 1R21.1)
Inspection Report# : 2002011*(pdf)*

Significance: G Sep 27, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
High Pressure Core Spray Diesel Generator Fuel Oil Storage Tank Volumes on Both Units Incorrectly Calculated
The inspection team identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, that applied to the fuel oil storage tanks for the high pressure core spray diesel generators on both units. Specifically, the inspectors identified that the licensee had incorrectly calculated the necessary volume for the fuel oil storage tanks. The finding was greater than minor based on the number of deficiencies associated with the diesel generator fuel storage tank capacities requiring preparation of new calculations and corrections to existing calculations, the updated final safety analysis report, the technical specification bases, to procedures, and, possibly, to the technical specifications themselves. The finding was of low safety significance because it did not represent an actual loss of the high pressure core spray diesel generator fuel oil storage volume as currently required by technical specifications. Furthermore, in the unlikely event that extended operation of the diesel generators was necessary, the licensee would likely be able to get fuel on site before the end of the seven day period. (Section 1R21.2)
Inspection Report# : 2002011*(pdf)*

Significance: G Sep 27, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Test Valves Modified to Ones Having a Different Form, Fit and Function and Change was Not Commensurate with Original Design
The inspection team identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, that applied to all the emergency diesel generators on both units. The test control valves on the diesel heads of all five emergency diesels were replaced by valves having a different form, fit, and function. The licensee did not ensure that the change was commensurate with the original design. The finding was greater than minor because it involved the licensee failing to implement a required regulatory process. The finding was of low safety significance because of a warning currently in the licensee's procedure and the fact that the valves are only opened during surveillance. (Section 1R21.2)
Inspection Report# : 2002011*(pdf)*

Significance: G Jun 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Drywell Sump Screen Design
Debris collected on the drywell floor clogged the drywell floor drain sump due to an inadequate sump screen design. This rendered the leakage detection system incapable of identifying increases in unidentified leakage as required by the Technical Specifications. The issue was of very low safety significance since other means remained available to detect an increase in unidentified leakage. A Non-Cited Violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," was identified for the failure to design an adequate drywell floor drain sump screen.
Inspection Report# : 2002004*(pdf)*

Significance: G Jun 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
1A EDG Governor Adjustment Error
Licensee personnel failed to properly perform a governor adjustment procedure associated with the 1A Emergency

Diesel Generator (EDG) which unexpectedly rendered the EDG inoperable. The issue was of very low safety significance since the 1A EDG was restored to service within the Technical Specification Allowed Outage Time. A Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified.
Inspection Report# : 2002004*(pdf)*

Significance: G Mar 31, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inoperable 0 Emergency Diesel Generator
Licensee personnel failed to properly evaluate a modification which reduced the size of the lube oil tubing used in the 0 Emergency Diesel Generator (EDG) which rendered the EDG inoperable. The issue was of very low safety significance since the 0 EDG was restored to service within the Technical Specification Allowed Outage Time and the redundant EDGs were available during the entire time that the 0 EDG was inoperable.
Inspection Report# : 2002003*(pdf)*

Significance: G 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: G 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: 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: 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
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: 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: 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 Sep 30, 2000
Identified By: NRC
Item Type: FIN Finding
The inspectors completed the assessment of an issue identified involving two holes between the U1, Div 1 and U1, Div 2 Essential Switchgear Rooms.
Green. The inspectors completed the assessment of an issue identified in NRC Inspection Report 50-373/2000-11 (DRP); 50-374/2000-11(DRP) involving two holes between the Unit 1, Division 1 and Unit 1, Division 2 Essentail Switchgear Rooms. A Non-Cited violation was identified because the holes represented a condition where the 3-hour fire barrier requirement of License Condition 25 for LaSalle Unit 1 was not met. The issue was of very low safety significance due to the relatively small transient combustible loading in the Essential Switchgear Rooms, the historical effectiveness of the fire brigade, and heat propagation models which demonstrated that in the event of a fire, temperatures inside the Unit 1, Division 2 Essential Switchgear Room breaker cubicles were insufficient to significantly impact breaker operation.
Inspection Report# : 2000013*(pdf)*

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: G 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)*

Barrier Integrity

Significance: G 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: 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 Mar 31, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
1RF012 Primary Containment Isolation Valve Leakage
No Color. The inspectors identified a Non-Cited Violation for the failure to identify that the solenoid valve associated with primary containment isolation valve 1RF012 had an air leak which could have rendered the system for measuring unidentified leakage inoperable. The finding was of very low safety significance since other diverse means were available to identify an increase in reactor coolant system leakage. (Section 1R23)
Inspection Report# : 2001003*(pdf)*

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)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Sep 28, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Improperly Posted and Controlled Locked High Radiation Area in Off Gas Building Cooler/Condenser room (= 1000 mrem/hour exactly).

Inspection Report# : 2002005*(pdf)*

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

Significance: G May 18, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadequate survey of contaminated worker that alarmed a portal monitor.
Violation of Technical Specification 5.4.1 for the failure to perform an adequate radiological survey of a contaminated worker that alarmed the portal monitor, as required by procedure, which allowed a discrete radioactive particle to be released from the site undetected.
Inspection Report# : 2002004*(pdf)*

Physical Protection

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)*

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)*

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 : December 02, 2002