La Salle 2
1Q/2004 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2003
Identified By: Self Disclosing
Item Type: FIN Finding
Manipulation of plant equipment by a staff engineer without operations authorization or any written instructions.
A finding of very low safety significance was self-revealed following the unauthorized operation of station equipment by a plant engineer. The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that if left uncorrected, it would represent a more significant safety concern. The finding was determined to be of very low safety significance because the engineer's actions did not result in an actual plant transient.
Inspection Report# : 2003004*(pdf)*

Significance: G Sep 30, 2003
Identified By: Self Disclosing
Item Type: FIN Finding
Repairs performed on plant equipment without written procedures or work control documents.
A finding of very low safety significance was self-revealed following impromptu repairs to the control air for the Unit 2 motor-driven reactor feed pump (MDRFP) minimum flow valve. A maintenance supervisor, conducting what was supposed to have been only a pre-job investigative walkdown, conducted the actual repairs without any written work documents or procedures. The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that if left uncorrected, it would represent a more significant safety concern. The finding was determined to be of very low safety significance because maintenance supervisor's actions did not result in an actual plant transient.
Inspection Report# : 2003004*(pdf)*

Mitigating Systems

Significance: G Dec 31, 2003
Identified By: Self Disclosing
Item Type: FIN Finding
Improperly installed thrust bearing leads to station air compressor failure.
A finding of very low safety significance was self-revealed following the failure of the Unit 2 station air compressor (SAC). During a March 2003 overhaul of the SAC, maintenance personnel installed the main shaft thrust bearing backwards. The improperly installed thrust bearing later contributed to the failure of the Unit 2 SAC on September 18, 2003. Inspectors determined that a primary cause of this finding was related to the cross-cutting area of Human Performance, since the thrust bearing was installed contrary to established instructions and drawings.

The finding was determined to be more than minor because the improperly installed thrust bearing actually caused a hard failure of a risk-significant component in a mitigating system. The finding was of very low safety significance because all other remaining mitigating systems and components were available and the duration of the Unit 2 SAC unavailability as a result of the finding was relatively short. No violations of requlatory requriements were identified as being associated with this finding.
Inspection Report# : 2003005*(pdf)*

Significance: G Sep 30, 2003
Identified By: Self Disclosing
Item Type: FIN Finding
Failure to install O-Ring on Unit 2 station air compressor as required by applicable maintenance procedure.
A finding of very low safety significance was self-revealed following the failure on the part of maintenance personnel to reinstall a required

part during a March 2003 overhaul of the Unit 2 station air compressor (SAC). The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that if left uncorrected, it would represent a more significant safety concern. The finding was determined to be of very low safety significance because the licensee was able to demonstrate in an engineering analysis that the SAC could be considered available and capable of operation for its mission time even with the subject part missing.
Inspection Report# : 2003004*(pdf)*

Significance: Sep 30, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to properly delineate what actions can be performed by plant personnel without having appropriate written procedures or instructions results in inoperable and unavailable EDG.
A finding of very low safety significance was self-revealed involving the licensee's failure to properly delineate what actions can be performed by plant personnel without having appropriate written procedures or instructions. This lack of delineation allowed an operator to attempt to remove dust from a circuit board by blowing on it, which resulted in a partial CO2 system actuation and the closure of the '0' emergency diesel generator (EDG) ventilation dampers. This rendered the '0' EDG inoperable and unavailable for the task of being able to complete its mission time. The majority of the cause for this finding relates to the cross-cutting area of human performance.

The finding was determined to be more than minor in that it had an adverse impact on the availability and capability of the '0' EDG, a mitigating system component. The finding was determined to be of very low safety significance because the licensee was able to demonstrate in an engineering analysis that the '0' EDG would automatically start and load with the fire dampers closed, and that the opposite train's EDG, the 1A EDG, could be made fully available from its surveillance test configuration in a short period of time. A Non-Cited Violation for failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was also identified by the inspectors.
Inspection Report# : 2003004*(pdf)*

Significance: Jun 30, 2003
Identified By: NRC
Item Type: FIN Finding
Inadequate assessment of long term RHR operation in the SPC mode.
A finding of very low safety significance was identified by inspectors when it was determined that the continuous long term operation of a single train of the Residual Heat Removal (RHR) system in the suppression pool cooloing (SPC) mode was not within the licensee's design basis.

In a Phase 3 SDP, the inspectors concluded that the continuous operation of a single train of the RHR system in the SPC mode from May 25, 2001 through September 3, 2001, increased the likelihood of an RHR train failure from a water hammer event. The finding was of very low safety significance due to the low magnitude of the increased probability of RHR train failure. There were no violations of regulatory requirements identified with this finding.
Inspection Report# : 2003003*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

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