La Salle 1
3Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2004
Identified By: Self Disclosing
Item Type: FIN Finding
Division 1 125 Vdc Battery Charger Grounded Due to Use of Wrong Test Instrument
A finding of very low safety significance was self-revealed when plant electricians performing troubleshooting on the Unit 1 Division 1 125 Vdc battery charger induced an external ground onto the system. The electricians had selected an unfiltered AC oscilloscope for use in the troubleshooting, which was not a compatible instrument with the DC system. The fundamental cause of this finding was related to the cross-cutting area of Human Performance. An investigation by the licensee determined that the apparent cause of the event was the use of an AC-powered oscilloscope on DC-powered equipment without appropriate filtering capabilities, as well as personnel not fully understanding the limitations for the instrument's use.

The inspectors determined that the finding was more than minor in that it increased the probability of failure of a safety-related system, Division 1 125 Vdc power. The finding was assessed to be of very low safety significance because it did not represent a design or qualification deficiency, did not represent any actual loss of safety function for any system, and did not screen as risk significant due to seismic, fire, flooding, or other severe weather related events. No violations of regulatory requirements were identified.
Inspection Report# : 2004003*(pdf)*

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Lack of proper procedural guidance for throttling an instrument nitrogen system isolation valve.
A finding of very low safety significance was identified by the inspectors after the licensee throttled an instrument nitrogen system pressure regulator isolation valve without adequate written instructions in an attempt to compensate for a degraded pressure regulator. The licensee failed to adequately assess the impact of the valve throttling on N2 system performance prior to the evolution, and, therefore, did not provide appropriate acceptance criteria in plant procedures regarding the extent to which the valve could be throttled closed before system operability was impacted.

This finding was greater than minor because it had the potential to be a more significant safety concern. If left uncorrected, operations personnel could have throttled the isolation valve closed to the extent that the safety function of the subject N2 header was lost. The finding was of very low safety significance because a licensee engineering evaluation subsequently determined that the isolation valve had not been throttled closed far enough to have impacted any safety function. Enforcement for this finding resulted in a non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."
Inspection Report# : 2004002*(pdf)*

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)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: G Sep 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Entry into a Neutron Radiation Area by Operations Personnel without Procedurally Required Neutron Radiation Dose Estimates
The inspectors identified a Green finding and associated Non-Cited Violation (NCV) when they observed operations personnel entering a posted neutron dose area without proper neutron monitoring, contrary to the licensee's Technical Specifications. This finding was considered NRC-identified as radiation protection personnel were unaware of this issue until questions by inspectors indicated a lack of proper neutron dose control for both this event and similar past occurrences.

The cause of the error was a failure of communication between the operations and radiation protection (RP) staff. The finding, under the Occupational Radiation Safety Cornerstone, does not involve the application of traditional enforcement because it did not result in actual safety consequences or potential to impact the NRC's regulatory function, and was not the result of any willful actions. The finding was more than minor as it involves the failure of the licensee to adhere to procedures to monitor and control radiation exposure, a key attribute under the objective of the radiation safety cornerstone to ensure adequate protection of worker health and safety from exposure to radiation. The finding is of very low safety significance because the personnel involved were using electronic dosimeters that alarm to warn workers of higher than expected dose rates or accumulated dose. The issue was a Non-Cited Violation of Technical Specifications 5.4.1(a), which requires written procedures be established, implemented, and maintained in accordance with the requirements of Regulatory Guide 1.33. Section 7.e(7). of Regulatory Guide 1.33 lists the requirement for radiation protection procedures for personnel monitoring. RP-AA-210, "Dosimetry Issue, Usage, and Control," is the plant procedure governing neutron dose estimation and monitoring.

The licensee conducted a human performance investigation to determine the cause of the event and identified a failure of communication between the RP and operation staffs. The individuals involved were coached, site personnel were informed of the event, and RP staff personnel were provided additional training on the requirements for entering neutron areas.
Inspection Report# : 2004004*(pdf)*

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Unauthorized entry into 1B RHR room HRA by contract personnel.
A finding of very low safety significance was self-revealed when two technicians logged onto a general area Radiation Work Permit (RWP), entered the 1B Residual Heat Removal (RHR) Room, a posted high radiation area (HRA), and one of their electronic dosimeters alarmed.

The cause of this event was failure to follow procedures. The finding was more than minor as it could be reasonably viewed as a precursor to a more significant event. The finding was of very low safety significance because the personnel were using electronic dosimeters that alarm to warn the workers of higher than expected dose rates or accumulated dose. The issue was a non-cited violation of Technical Specifications 5.7.1b and e., which required that an appropriate RWP be utilized by workers and a pre-job brief be provided prior to entry into a HRA.
Inspection Report# : 2004002*(pdf)*

Significance: G Mar 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Unauthorized entry into Unit 1 heater bay HRA by licensee craft personnel.
A finding of very low safety significance was self-revealed when a craft person, entered a posted HRA and highly contaminated area in the 1B Heater Bay without a HRA brief. This occurrence resulted in the person becoming contaminated and it was detected when the person exited the Radiologically Controlled Area (RCA).

The cause of this event was failure to follow procedure. The finding was more than minor as it could be reasonably viewed as a precursor to a

more significant event. The finding was of very low safety significance because the individual was using electronic dosimeters that alarm to warn the workers of higher than expected dose rates or accumulated dose. The issue was a non-cited violation of Technical Specifications 5.7.1b and e., which required that a pre-job brief be provided prior to entry into a HRA.
Inspection Report# : 2004002*(pdf)*

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate survey results in unposted radiation area.
A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR Part 20. The licensee failed to adequately evaluate the radiological hazards associated with radiation dose rates at a temporary walkway outside the radiologically controlled area in the turbine building.

This finding was greater than minor because it had the potential to be more significant due to the location, adjacent to the main turbine bioshield during operation. The finding was of very low safety significance because no personnel had used the walkway. The issue was a non-cited violation of 10 CFR 20.1501(a).
Inspection Report# : 2004002*(pdf)*

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : December 29, 2004