

La Salle 2

3Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  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 regulatory requirements were identified as being associated with this finding.

Inspection Report# : [2003005\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  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\(pdf\)](#)

G

Significance: Jun 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Unauthorized Entry into a High Radiation Area by Maintenance Personnel Building Scaffolding Prior to Required Radiation Protection Surveys

A finding of very low safety significance was self-revealed when a craft person, setting up scaffold in a radiation area, created access to a yet unposted and unmonitored high radiation area (HRA) in the Unit 2 turbine building, and then entered the HRA by climbing the scaffold. This occurrence was detected when the individual's electronic dosimeter (ED) alarmed above the dose rate setting of 80 millirem per hour. The workers immediately acknowledged the alarm, secured the work area, exited the radiologically controlled area (RCA), and notified the radiation protection (RP) department. The RP department confirmed that a HRA existed above the platform of the scaffolding. The individuals were administratively locked out of the RCA and the licensee initiated a prompt investigation. Additionally, all site personnel were notified of this event through a station safety alert. The licensee entered the issue into their corrective action system as condition report (CR) 218052. The fundamental cause of this finding was related to the cross-cutting area of Human Performance.

The cause of this event was incomplete procedural adherence. 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 EDs that alarm to warn personnel of higher than expected dose rates or accumulated dose. The issue was a Non-Cited Violation of Technical Specifications 5.7.1(a) and (b), which require that: (a) each entry way to a HRA shall be barricaded and conspicuously posted as a HRA; and (b) that access to, and activities in each area shall be controlled by means of a radiation work permit that includes specification of radiation dose rates in the immediate work area and other appropriate radiation protection equipment and measures.

Inspection Report# : [2004003\(pdf\)](#)

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : December 29, 2004