

## La Salle 2

# 3Q/2006 Plant Inspection Findings

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## Initiating Events

**Significance:**  Oct 07, 2005

Identified By: NRC

Item Type: FIN Finding

### **Weaknesses in Corrective Action Program and NRC Performance Indicator Procedure Implementation and Use**

The inspectors identified a finding of very low safety significance. Specifically, the inspectors identified several examples where the licensee did not adequately implement applicable corrective action and performance indicator procedural requirements associated with the White PI issue. Because the submission of PI program data is voluntary and not required by code or regulation, no associated violations of regulatory requirements were identified by the inspectors.

Because this finding was related to a PI that exceeded a threshold, the inspectors determined that it was of more than minor significance. The inspectors determined that the finding was not suitable for SDP evaluation because non-compliance with CAP and PI procedures did not directly result in degraded or inoperable equipment. Therefore, this finding was reviewed by NRC Regional Management, in accordance with IMC 0612, Section 05.04c, and determined to be of very low safety significance. Corrective actions by the licensee include the planned completion of an overall root cause evaluation (RCE) to identify problems, evaluate root causes, and determine corrective actions relative to this White PI.

Inspection Report# : [2005012\(pdf\)](#)

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## Mitigating Systems

**Significance:**  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Promptly Repair a Degraded Condition Associated with the 2B EDG Day Tank Room Structure**

A finding of very low safety significance was identified by inspectors during a quarterly fire protection zone inspection of the 2B Emergency Diesel Generator (EDG) day tank room. Specifically, the inspectors identified a section of structural steel that was missing its requisite fireproof coating and had not been repaired in a timely manner. A non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was also identified for failure to assure that a condition adverse to quality associated with the design of the day tank room structure was promptly identified and corrected.

The performance deficiency, identified during review of the event, involved the work planning for the repair of the structural steel fireproof coating. Specifically, in processing the work request, licensee work planners failed to recognize that the missing fireproof coating constituted a design deficiency for a safety-related structure, and was, therefore, required to be corrected in a prompt manner under NRC regulations. The finding was of more than minor significance in that it had a direct impact on the cornerstone objective. Specifically, the inspectors determined that the licensee's failure to enact proper corrective action and restore the structural steel fireproof coating in the 2B EDG day tank room for multiple years resulted in a reduction of the reliability and capability of the safety-related structure's ability to perform its designed function in the event of a fire. Because of the limited size and location of the missing fireproof coating, and because the EDG rooms at LaSalle Station are protected by an automatic carbon dioxide suppression system, the inspectors determined that the finding was of very low safety significance (Green) and within the licensee's response band. Licensee corrective actions included a review of all open fire protection work orders to ensure their proper coding in accordance with their significance, and scheduling the immediate repair of the structural steel fireproof coating in the 2B EDG day tank room. The finding was also determined to involve the cross-cutting area of problem identification and resolution.

Inspection Report# : [2006005\(pdf\)](#)

**Significance:**  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Procedure Used for GL 89-13 Program Thermal Performance Tests on RHR Heat Exchangers**

A finding of very low safety significance was identified by inspectors during observation of a GL 89-13 residual heat removal system heat exchanger (RHR HX) thermal performance test. Specifically, the inspectors identified that the licensee's engineering staff failed to develop and use an adequate test procedure to implement the RHR HX performance monitoring program in accordance with docketed commitments and the established NRC Generic Letter (GL) 89-13 program basis. A non-cited violation of 10 CFR 50, Appendix B, Criterion V, for an inadequate RHR HX thermal performance test procedure was also identified.

The inspectors determined that the licensee's failure to establish and maintain an adequate GL 89-13 RHR HX thermal performance testing procedure represented a performance deficiency on the part of licensee engineering personnel. The issue was determined to be of more than minor significance in that it directly affected the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, this finding impacted one of the key attributes of this objective, which is to ensure the quality of maintenance and test procedures for systems that must respond to initiating events. The inspectors determined that the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," and conducted a Phase 1 characterization and initial screening. Despite the widespread issues the inspectors identified with the licensee's GL 89-13 program and associated bases, the licensee's engineering staff was able to provide the inspectors with sufficient maintenance and testing records to permit the inspectors to conclude that each RHR HX remained fully capable of performing its design basis and safety functions. As a result, because the finding did not represent a actual loss of operability or safety function and was not potentially risk significant with respect to a seismic, flooding, or severe weather initiating event, the inspectors determined it to be of very low safety significance (Green) and within the licensee's response band. Corrective actions by the licensee included: performing evaluations to document the basis for the 4-year HX clean and inspection interval; evaluating the material condition of the 2B RHR HX, conducting an analysis to determine how the current performance monitoring program meets the intent of GL 89-13; revising commitments to the NRC to be consistent with the current GL 89-13 program; and revising LTS-200-17, the RHR HX test procedure, per the recommendations of that analysis.

Inspection Report# : [2006005\(pdf\)](#)

**Significance:**  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Promptly Correct Identified Issues Associated with the GL 89-13 Program for RHR Heat Exchangers**

A finding of very low safety significance was identified by the inspectors. The inspectors determined that the licensee did not fully evaluate problems and properly prioritize corrective actions with respect to the RHR HX thermal performance test procedure and GL 89-13 HX performance monitoring program. An associated non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was also identified by the inspectors.

The inspectors determined that there was a performance deficiency associated with the corrective actions taken by the licensee. Specifically, the inspectors determined that the licensee had not thoroughly evaluated, nor given proper priority to, identified deficiencies in the RHR HX test procedure as identified in Issue Report 98176. Further, the inspectors also determined that the licensee had failed to complete the GL 89-13 bases review and revision called for under Apparent Cause Evaluation 263535 in 2004. The inspectors determined that the finding was of more than minor significance in that it directly affected the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, this finding impacted one of the key attributes of this objective which is to ensure the quality of maintenance and test procedures for systems that must respond to initiating events. The inspectors conducted a Phase 1 characterization and initial screening in accordance with the SDP. Because the finding did not represent a actual loss of operability or safety function and was not potentially risk significant with respect to a seismic, flooding, or severe weather initiating event, it was determined to be of very low safety significance (Green) and within the licensee's response band. Licensee corrective actions planned include review of GL 89-13 program Corrective Action Program documents to determine if any other identified issues were not fully dispositioned or resolved and to confirm that all corrective actions have been implemented and documented. The finding was also determined to involve the cross-cutting area of problem identification and resolution.

Inspection Report# : [2006005\(pdf\)](#)

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

**Significance:** SL-III Jan 27, 2006

Identified By: Licensee

Item Type: VIO Violation

### **Contractor Pipefitters Enter Condenser Pit HRA Without Required RP Briefing**

On February 13, 2005, a contractor pipefitter foreman and two contractor pipefitters entered a posted HRA in the Unit 2 condenser pit to conduct repairs to a sprinkler head and did not sign the required HRA radiation work permit (RWP) or receive the radiation protection technician (RPT)-provided HRA briefing required for work in a HRA. The HRA was properly posted and barricaded with a fence gate and with a swing gate to preclude inadvertent entry. A licensee contractor RPT identified the contractor pipefitter foreman and pipefitters inappropriate entry into the HRA. The contractor pipefitter foreman and pipefitters actions were an apparent violation of Technical Specification 5.4.1.a and Exelon Procedure RP-AA-460, Revision 4.

The NRC Office of Investigations (OI) conducted an investigation of the event involving an apparent violation of the Technical Specifications on February 13, 2005, at LaSalle County Station, Unit 2. The purpose of the OI investigation was to determine if a contractor pipefitter foreman and two contractor pipefitters willfully entered a posted high radiation area (HRA) without receiving the required HRA briefing. The OI investigation was completed on October 27, 2005. (OI Case 3-2005-007) Based on the results of the inspection and investigation, one apparent violation with wilful aspects was identified and is being considered for escalated enforcement action in accordance with the NRC Enforcement Policy.

Based on the information developed during the OI investigation and the information provided in the licensee's February 27, 2006 letter, the NRC has determined that a SL III violation of NRC requirements occurred.

Inspection Report# : [2005002\(pdf\)](#)

Inspection Report# : [2006005\(pdf\)](#)

Inspection Report# : [2006008\(pdf\)](#)

Inspection Report# : [2006010\(pdf\)](#)

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## Public Radiation Safety

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## Physical Protection

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

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## Miscellaneous

Last modified : December 21, 2006