

January 24, 2001

Mr. Oliver D. Kingsley
President, Nuclear Generation Group
Commonwealth Edison Company
ATTN: Regulatory Services
Executive Towers West III
1400 Opus Place, Suite 500
Downers Grove, IL 60515

SUBJECT: LASALLE COUNTY STATION - NRC INSPECTION
REPORT 50-373/00-19(DRP); 50-374/00-19(DRP);

Dear Mr. Kingsley:

On December 31, 2000, the NRC completed an inspection at your LaSalle County Station. The enclosed report presents the results of that inspection. The results of this inspection were discussed on December 29, 2000, with Mr. M. Schiavoni and other members of your staff.

The inspection was an examination by the resident inspectors of activities conducted under your license as they relate to reactor safety and to compliance with the Commission's rules and regulations and with the conditions of your license. Within these areas, the inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of this inspection, the inspectors identified two issues of very low safety significance (Green). One of these issues was determined to involve a violation of NRC requirements. However, because of its very low safety significance and because it was entered into your corrective action program, the NRC is treating this issue as a Non-Cited Violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this Non-Cited Violation, you should provide a response with a basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-001, with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at LaSalle County Station.

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Sincerely,

/RA/

Bruce Burgess, Chief
Reactor Projects Branch 2

Docket Nos. 50-373; 50-374
License Nos. NPF-11; NPF-18

Enclosure: Inspection Report 50-373/00-19(DRP);
50-374/00-19(DRP)

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-373, 50-374
License Nos: NPF-11, NPF-18

Report Nos: 50-373/00-19(DRP); 50-374/00-19(DRP)

Licensee: Commonwealth Edison Company

Facility: LaSalle County Station, Units 1 and 2

Location: 2601 N. 21st Road
Marseilles, IL 61341

Dates: November 10 - December 31, 2000

Inspectors: E. Duncan, LaSalle Senior Resident Inspector
P. Krohn, LaSalle Resident Inspector
K. Riemer, Project Engineer, Region III
R. Jickling, Emergency Preparedness Specialist
G. Pirtle, Senior Security Specialist
J. Yesinowski, Illinois Department of Nuclear Safety

Approved by: Bruce Burgess, Chief
Reactor Projects Branch 2
Division of Reactor Projects

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness

Radiation Safety

- Occupational
- Public

Safeguards

- Physical Protection

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

SUMMARY OF FINDINGS

IR 05000373-00-19; IR 05000374-00-19; on 11/10-12/31/2000; Exelon; LaSalle County Station, Units 1 & 2; Permanent Plant Modifications; Surveillance Testing.

The inspection identified two Green findings, one of which was a Non-Cited Violation. The significance of issues is indicated by their color (Green, White, Yellow, Red) and was determined by using Inspection Manual Chapter 0609 "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "no color" or by the severity level of the applicable violation.

A. Inspector Identified Findings

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness

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 significance because an expanded ultrasonic examination detected no flaws in the subject section of piping. (Section 1R17).

Green. The inspectors reviewed videotape documentation of suppression pool inspections accomplished during L2R08 and identified a piece of piping clamped underneath and between two suppression pool downcomers which posed a potential challenge to Emergency Core Cooling System (ECCS) suction strainers in the event that they were forcibly swept away from their installed location during an accident.

The finding was considered to be of very low safety significance because the potential for an impact on the ECCS was small. (Section 1R22).

B. Licensee Identified Violations

No violations of significance were identified.

Report Details

Summary of Plant Status: Unit 1 operated at power for the entire inspection period. Unit 2 operated at power until November 10, when the unit was shut down for refueling outage L2R08. The unit was restarted on November 29 and subsequently synchronized to the grid on November 30. Unit 2 operated at power until December 1, when an automatic shutdown occurred after experiencing abnormally high reactor vessel water level during feedwater manipulations to place the 2B turbine-driven reactor feedwater pump online during power ascension following the completion of refueling outage L2R08. Unit 2 was restarted and synchronized to the grid on December 2. Both units operated at power for the remainder of the inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness.

1R04 Equipment Alignment

a. Inspection Scope

During L2R08, the inspectors performed a walkdown of accessible portions of the Unit 2 Fuel Pool Cooling (FC) system to verify system operability during testing which rendered both trains of shutdown cooling unavailable. The inspectors reviewed documentation to determine correct system lineup. These documents included plant procedures, as well as plant drawings. The inspectors verified critical portions of the system and identified any discrepancies between the existing equipment lineup and the correct lineup.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors walked down the following risk significant areas looking for any fire protection degradations:

- Fire Zone 3D: Unit 2 Reactor Building Elevation 786 Feet
- Fire Zone 2B1: Unit 1 Reactor Building Elevation 820 Feet
- Fire Zone 2B2: Unit 1 Reactor Building Elevation 820 Feet

The inspectors placed emphasis on control of transient combustibles and ignition sources; the material condition, operational lineup, and operational effectiveness of the fire protection systems, equipment, and features; and the material condition and operational status of fire barriers used to prevent fire damage or fire propagation.

In particular, the inspectors verified that all observed transient combustibles were being controlled in accordance with the licensee's administrative control procedures. In addition, the inspectors observed the physical condition of fire detection devices, such as overhead sprinklers, and verified that any observed deficiencies did not impact the operational effectiveness of the system. The inspectors also observed the physical condition of portable fire fighting equipment, such as portable fire extinguishers, and verified that the equipment was located appropriately, and that access to the extinguishers was unobstructed. The inspectors verified that fire hoses were installed at their designated locations and that the physical condition of the hoses was satisfactory and access unobstructed. The physical condition of passive fire protection features such as fire doors, ventilation system fire dampers, fire barriers, fire zone penetration seals, and fire retardant structural steel coatings was inspected and the fire protection features were verified to be properly installed and in good physical condition.

b. Findings

No findings of significance were identified.

1R07 Heat Sink Performance

a. Inspection Scope

The inspectors observed the licensee perform a visual inspection of the 2A Residual Heat Removal (RHR) heat exchanger, which was directed by Work Request (WR) 99013281801B. In addition, the inspectors verified that the eddy current examination results were appropriately categorized against pre-established acceptance criteria, and that the frequency of inspection was sufficient to detect degradation prior to the loss of heat removal capabilities below design values.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed the licensee implementation of the maintenance rule requirements, including a review of scoping, goal-setting, and performance monitoring, short-term and long-term corrective actions, and current equipment performance status. The systems selected for inspection were all classified as risk significant by the licensee's maintenance rule program. The systems evaluated were:

- 125 Volt Direct Current (VDC) Distribution System
- Standby Liquid Control (SBLC) System

The 125 VDC and Standby Liquid Control systems were classified as (a)(2) and were chosen based on their relatively high risk significance. The inspectors independently verified the licensee's implementation of maintenance rule requirements for these

systems by verifying that these systems were properly scoped within the maintenance rule; that all failed structures, systems, or components (SSCs) were properly categorized and classified as (a)(2); that performance criteria were appropriate; and that issues were identified at an appropriate threshold and entered in the corrective action program.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Prioritization

a. Inspection Scope

The inspectors reviewed the licensee's evaluation of plant risk, scheduling, configuration control, and performance of maintenance associated with planned and emergent work activities and verified that scheduled and emergent work activities were adequately managed. In particular, the inspectors reviewed the licensee's program for conducting maintenance risk safety assessments and verified that the licensee's planning, risk management tools, and the assessment and management of online risk were adequate. The inspectors also verified that licensee actions to address increased online risk during these periods, such as establishing compensatory actions, minimizing the duration of the activity, obtaining appropriate management approval, and informing appropriate plant staff, were accomplished when online risk was increased due to maintenance on risk-significant SSCs. The following specific activities were reviewed:

- The inspectors reviewed the maintenance risk assessment for work planned for the week of December 11, 2000. This included work associated with the 1B and 2B High Pressure Core Spray systems, the '0' station air compressor, the 'B' diesel-driven fire pump, the 1A Reactor Building Closed Cooling Water (RBCCW) pump, and the 1B Standby Liquid Control (SBLC) pump, and various surveillance activities.
- The inspectors reviewed the maintenance assessment for work planned for the week of December 18, 2000. This included work associated with the 1A RBCCW pump, breaker inspection impacting the unit cross-tie capability of the safety-related 250 VDC buses, and various surveillance activities.
- The inspectors reviewed the maintenance assessment for work planned for the week of December 25, 2000. This included work associated with the Residual Heat Removal system, Low Pressure Core Spray system, Core Standby Cooling system, SBLC system, and various surveillance activities.

b. Findings

No findings of significance were identified.

1R14 Nonroutine Plant Evolutions

.1 Unit 2 Startup From Forced Outage L2F30

a. Inspection Scope

On December 1, 2000, Unit 2 automatically shut down after experiencing an abnormally high reactor vessel water level. The high reactor water level occurred during feedwater manipulations to place the 2B turbine-driven reactor feedwater pump online during power ascension following the completion of refueling outage L2R08. The inspectors verified that the licensee's root cause evaluation identified and corrected the problem prior to plant startup. The inspectors observed portions of the Unit 2 restart activities, including the approach to criticality, synchronization of the main generator to the grid, startup and operation of the feedwater system, and power ascension.

b. Findings

No findings of significance were identified.

.2 (Closed) Licensee Event Report 50-374/00-05: Inadvertent Start of 2A Emergency Diesel Generator Due to Personnel Error.

On September 13, 2000, during performance of LaSalle Operating Surveillance (LOS) RH-Q1, Attachment 2E, "Unit 2B RHR Service Water Operability Test," the Unit 2 licensed reactor operator inadvertently started the 2A Emergency Diesel Generator (EDG) instead of the Diesel Generator Cooling Water Pump as intended. This error constituted an unplanned Engineered Safeguards Feature (ESF) actuation. The licensee conducted a root cause investigation and determined that the error occurred due to inadequate self-checking practices as well as an inadequate peer check from other licensed personnel in the control room. Licensee corrective actions for this event included a review of verification techniques with all operating crews and issuance of a Daily Order re-emphasizing management expectations for self-checking and peer-checking. The safety significance of the event was minimal. The 2A EDG remained operable during the event, as did the normal offsite power sources and the "0" EDG and 2B EDG. 10 CFR 50, Appendix B, Criterion V, "Instruction, Procedures, and Drawings," requires that activities affecting quality be accomplished in accordance with written procedures. The start of the 2A EDG instead of the Diesel Generator Cooling Water Pump, as directed in LOS-RH-Q1, was an example where the requirements of 10 CFR 50, Appendix B, Criterion V, were not met and was a violation. However, this failure constitutes a violation of minor significance and is not subject to formal enforcement action. This LER is closed.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed selected operability evaluations of degraded and non-conforming conditions affecting mitigating systems and barrier integrity to ensure that operability was properly justified and the component or system remained available,

such that no unrecognized increase in risk had occurred. The following operability evaluations were reviewed:

- OE 95006 2C RHR Water Hammer

This operability evaluation reviewed the impact of a water hammer associated with the Unit 2 'C' RHR train which occurred during cycling of full flow test valve 2RH-021 with the 2C RHR pump secured and the injection valve closed. The inspectors conducted a walkdown of potentially affected portions of the 2C RHR train and verified that no evidence of water hammer damage was present.

- OE 00-008 Degraded Grounding Strap Seals in Diesel Generator Rooms

This operability evaluation reviewed the impact of impaired fire seal penetrations which were part of the 3-hour fire rated barrier separating the diesel generator rooms from adjacent zones and areas as described in Updated Final Safety Analysis Report (UFSAR) sections H.3.7.4, H.3.7.5, H.3.7.6, H.3.8.3, and H.3.8.4. The inspectors reviewed the design basis fire hazards analysis for the affected areas, the effects of the degradation on the carbon dioxide suppression system, and the status and results of the extent-of-condition reviews done for similar grounding strap penetrations.

- OE 00-012 Unit 2 Safety Relief Valve (SRV) Leakage

This operability evaluation reviewed the impact of Unit 2 SRV leakage on plant operations such as the necessity for increased operation in the suppression pool cooling mode of the Residual Heat Removal system. The inspectors also reviewed the potential impact on the capability of plant equipment to mitigate a design basis accident, as well as other initiating events.

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds

a. Inspection Scope

The inspectors reviewed operator workarounds (OWAs) and operator challenges (OCs) to identify any potentially adverse impact on the function of mitigating systems or the ability to implement an abnormal or emergency operating procedure. The following items were reviewed:

- OC87: Offgas Ventilation System Compressor Oil Level Adjustments

Issue Description: Offgas system ventilation compressor adjustments are required following outside air temperature changes. During seasonal temperature changes, the amount of work done by the compressors may vary greatly which may result in an imbalance in the equilibrium oil level. As a result, operator action to raise or lower oil

level is required. If not accomplished, the air compressor may trip, resulting in the loss of offgas ventilation serving the offgas system environment.

The inspectors verified that the offgas system and offgas ventilation system are nonsafety-related and that operation of these systems is not required to respond to an initiating event. No impact on an operator's ability to implement abnormal or emergency operating procedures was identified.

- OC239/OC291: Fire Protection System Pressure

Issue Description: Occasionally, the Type 1 fire protection piping system pressure exceeds the fire protection system supply pressure. The root cause of this condition is believed to be cooler water introduced downstream of system check valves during surveillance testing which, when heated to ambient temperature, causes piping pressure to increase.

The inspectors verified that the increased pressure was within the design limits of the fire protection system piping, sprinkler heads, and other potentially affected components. Therefore, there was no impact on system functionality.

b. Findings

No findings of significance were identified.

1R17 Permanent Plant Modifications

(Closed) Unresolved Item 50-373/200006-01;50-374/200006-01: American Society of Mechanical Engineers (ASME) Class 1 Piping Inspections

As discussed in NRC Inspection Report 50-373/200006-01;50-374/200006-01, as part of Design Change Package (DCP) 990272, the ASME Class 1 pressure boundary associated with Reactor Core Isolation Cooling (RCIC) injection valve 1E51-F013 was extended about 8 feet upstream of the valve. ASME Section IWA-7210(a) and ASME Section XI required that the upgraded portion of piping and any additional material meet all requirements of the original construction code. In this case, the applicable construction code was ASME Section III, Division 1 - Subsection NB, 1974 Edition, which required the section of piping being upgraded be examined by either ultrasonic, eddy current, or radiographic testing of the entire volume, or magnetic particle/dye penetrant testing (MT/PT) testing of external surfaces and accessible internal surfaces. During a review of the piping upgrade evaluation, the inspectors determined that the licensee chose to perform a magnetic particle examination of all external surfaces and accessible internal surfaces. This examination and resultant piping upgrade was completed on May 25, 2000, prior to cutting into the piping to perform the repair activity on May 30. The inspectors questioned the licensee's conclusion that an MT/PT examination of accessible internal surfaces of piping subassembly RI-1048C was not required once the pipe had been cut to install the new 1E51-F013 valve. In the subject evaluation, the licensee concluded that since the upgraded section of piping was intact when the evaluation was completed, and no internal surfaces were accessible during the specific time frame, only an MT/PT

examination of the external surfaces was required. The inspectors questioned this conclusion which essentially reasoned that the upgrade evaluation activities were separate and distinct from the repair effort. However, based on the inspectors observation and questions concerning the ASME Section III NB-2551(a)(3) requirements during the repair activities, the licensee performed an expanded ultrasonic examination of the same area that would have been examined had the MT/PT examination of the internally accessible surfaces of the upgraded section of pipe been performed when the pipe was cut. No flaws were identified during the expanded ultrasonic examination.

To resolve questions regarding whether an internal examination, absent of the ultrasonic examination performed, was actually required to satisfy ASME Code requirements, Task Interface Agreement (TIA) 2000-13, "Request for Technical Assistance - Commonwealth Edison Company's Interpretation of ASME Code Requirements for LaSalle Station," was transmitted to the NRC's Office of Nuclear Reactor Regulation (NRR) for their review. On December 21, NRR completed their review of the subject TIA and concluded that all of the activities associated with installation of the replacement RCIC injection valve should be considered as parts of one repair/replacement activity and not as separate and distinct activities. If a licensee chooses to perform MT/PT testing of external surfaces and accessible internal surfaces, then the intent of the code would be to examine the accessible surfaces of the pipe if they become available.

In determining the significance of the issue, the inspectors concluded that since the potential for a flaw existed at the time that the inspectors brought the issue to the licensee's attention, and because the licensee did not intend to conduct the expanded examination until after questioned by the inspectors, a credible impact on safety existed. As a result, the inspectors utilized the Significance Determination Process which concluded that since the expanded ultrasonic examination detected no flaws in the subject section of piping, the finding screened out as GREEN. Also, since the licensee performed the required examinations following discussions with the inspectors when the design change was completed, the inspectors concluded that no deviation from regulatory requirements occurred. This item is closed.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed and observed the following post-maintenance testing activities involving risk significant equipment:

- Weld IRH-2005-28 and IRH-2005-29 Ultrasonic Examination
- Unit 2 Low Pressure Core Spray Pipe Weld BP5 Flaw Indication Noted During L2R08 In-Vessel Automated Ultrasonic Test Inspections and Associated 10 CFR 50.59 Safety Evaluation Form, L00-1438, and Design Analysis Approval, L-002704

- Work Request 990158938-01, “Unit 1 Division 1 Switchgear Room Ventilation Supply Damper 1VX14Y Actuator Oil Leak”

During post-maintenance testing observations, the inspectors verified that the test was adequate for the scope of the maintenance work which had been performed, and that the testing acceptance criteria was clear and demonstrated operational readiness consistent with the design and licensing basis documents. The inspectors reviewed selected non-destructive examination data and verified that the components were acceptable for continued service. The inspectors also verified that the impact of the testing had been properly characterized during the pre-job briefing; the test was performed as written and all testing prerequisites were satisfied; and that the test data was complete, appropriately verified, and met the requirements of the testing procedure. Following the completion of the test, the inspectors verified that the test equipment was removed, and that the equipment was returned to a condition in which it could perform its safety function.

b. Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities

a. Inspection Scope

The inspectors observed the performance of LaSalle Unit 2 Refueling Outage L2R08 and evaluated licensee outage activities to ensure that the licensee considered risk in developing the outage schedule; adhered to administrative risk reduction methodologies developed to control plant configuration; developed mitigation strategies for losses of key safety functions; and adhered to the operating license and Technical Specification requirements that ensured defense-in-depth. The following specific outage-related activities were accomplished:

- Outage Plan Review

The inspectors reviewed the licensee’s outage control plan and verified that the licensee had appropriately considered risk, industry experience, and previous site-specific problems. The inspectors also confirmed that contingency plans for losses of key safety functions had been established.

- Monitoring of Shutdown Activities

The inspectors observed the Unit 2 shutdown to Refueling Outage L2R08 and verified that the plant was operated in accordance with regulatory requirements and plant procedures. In particular, the inspectors verified that cooldown restrictions were followed.

- Licensee Control of Outage Activities

The inspectors verified that the licensee appropriately managed the configuration of equipment during the outage to ensure that a defense-in-depth commensurate with the outage risk plan for key safety functions and applicable Technical Specifications was maintained. The inspectors also verified that outage activities were appropriately managed. In particular, out-of-service activities were reviewed to ensure that tags were properly hung to support the out-of-service. Reactor coolant system instrumentation was verified to be configured to provide adequate indication of reactor vessel pressure, temperature, and level. In addition, the inspectors routinely observed decay heat removal system parameters and verified that decay heat removal systems were functioning properly. The inspectors verified that the status and configuration of electrical systems met Technical Specification requirements and the licensee's outage risk plan. Switchyard activities were verified to be controlled appropriately. The inspectors verified that flow paths, configurations, and alternative means for inventory addition and decay heat removal were consistent with the outage risk plan. The inspectors verified that the licensee controlled reactivity and maintained secondary containment in accordance with Technical Specifications.

- Refueling Activities

The inspectors verified that fuel handling operations were conducted in accordance with Technical Specifications and approved procedures. The inspectors also verified that the location of fuel assemblies was tracked from core offload through core reload. In particular, the inspectors verified that the five most reactive fuel bundles were correctly loaded into the core.

- Monitoring of Heatup and Startup Activities

The inspectors verified that Technical Specifications, license conditions, and other prerequisites, commitments, and administrative procedure prerequisites for mode changes were met prior to changing modes or plant configurations. The inspectors conducted a walkdown of containment prior to restart and did not identify any conditions that would adversely impact plant startup or operational performance.

- Identification and Resolution of Problems

The inspectors verified that the licensee identified problems related to refueling outage activities at an appropriate threshold and entered them into the corrective action program.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors observed surveillance testing on risk-significant equipment and verified that the structures, systems, and components (SSCs) selected were capable of performing their intended safety function and that the surveillance tests satisfied the requirements contained in Technical Specifications, the Updated Final Safety Analysis Report (UFSAR), and licensee procedures. During surveillance testing observations, the inspectors verified that the test was adequate to demonstrate operational readiness consistent with the design and licensing basis documents, and that the testing acceptance criteria was clear. The inspectors also verified that the impact of the testing had been properly characterized during the pre-job briefing; the test was performed as written and all testing prerequisites were satisfied; the test data was complete, appropriately verified, and met the requirements of the testing procedure; and that the test equipment range and accuracy was consistent with the application, and the calibration was current. Following the completion of the test, the inspectors verified that the test equipment was removed and the equipment returned to a condition in which it could perform its safety function.

The following surveillance testing activities were observed:

- LTS-100-5, "Primary Containment Vent and Purge Inlet Valves Local Leak Rate Test 2VQ026, 2VQ027, 2VQ029, 2VQ030, 2VQ042, and 2VQ043," Revision 17
- LTS-500-209, "Unit 2 Integrated Division 1 Response Time Surveillance," Revision 8
- LTS-600-41, "Primary Containment Inspections for ECCS Suction Strainer Debris Sources," Revision 2

b. Findings

On November 24, 2000, the inspectors reviewed licensee documentation regarding the performance of LTS-600-41, "Primary Containment Inspections for ECCS Suction Strainer Debris Sources," which focused on the identification of materials that, under accident conditions, could pose a challenge to ECCS suction strainer performance. This documentation consisted of a written report regarding the as-found condition of the drywell, as well as videotape documentation of the as-found condition of the suppression pool. During an independent review of the suppression pool videotape, the inspectors identified what appeared to be a lengthy piece of piping clamped underneath and between two suppression pool downcomers. The inspectors also identified what appeared to be a piping clamp attached to a separate downcomer. Neither of these materials appeared to be utilized for any current purpose, and were surmised to pose a potential challenge to ECCS suction strainers in the event that they were forcibly swept away from their installed location during an accident.

The inspectors discussed this issue with engineering personnel and confirmed that the material identified was not a part of the design of the suppression pool. Subsequently,

divers retrieved the material identified by the inspectors, as well as a number of similar piping clamps on other downcomers. These additional clamps were identified as a result of a second, more thorough, licensee review of the suppression pool videotape.

In determining the significance of the issue, the inspectors concluded that this issue had a credible impact on safety. As a result, the inspectors utilized the Significance Determination Process which concluded that because the potential for an impact on the ECCS was low, the finding screened out as GREEN.

10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," requires that conditions adverse to quality be promptly identified and corrected. The failure to identify materials in the suppression pool which represented a potential challenge to ECCS suction strainer performance was an example where the requirements of 10 CFR 50, Appendix B, Criterion XVI, were not met and was a violation. However, this Severity Level IV violation is being treated as a Non-Cited Violation (50-374/2000019-01(DRP)), consistent with Section VI.A.1 of the NRC Enforcement Policy. This item was entered into the licensee's corrective action program as Condition Report (CR) L2000-06818.

1EP4 Emergency Action Level and Emergency Plan Changes

a. Inspection Scope

The inspector reviewed Revision 9 to Sections 1.0, 4, 8, and 9 of the LaSalle Generating Station Emergency Plan, which was submitted by letter dated April 26, 2000, in order to determine whether the changes in Revision 9 might decrease the plan's effectiveness. This emergency plan revision was submitted in accordance with 10 CFR 50.54(q).

b. Observations and Findings

No findings of significance were identified.

3. **SAFEGUARDS**

Cornerstone: Physical Protection (PP)

3PP4 Security Plan Changes (IP 71130-04)

a. Inspection Scope

The inspector reviewed Revisions 62 and 63 of the LaSalle Nuclear Station Security Plans, which were submitted by licensee's letters dated August 2, 2000 and October 10, 2000. The review was completed to confirm that the changes did not decrease the effectiveness of the security plan. The plan revisions were submitted in accordance with 10 CFR 50.54(p).

b. Issues and Findings

The documents were submitted in a timely manner. However, an issue was identified in Revision 62. In Section 1.6 (definitions) the licensee added a new requirement regarding a height limitation to define "bullet resisting". Inspector review determined that this new height limitation is not included in NRC guidance documents. The licensee agreed to submit a security plan change that removes the bullet resisting height limitation.

4. OTHER ACTIVITIES

4OA2 Performance Indicator Verification

Cornerstone: Mitigating Systems

a. Inspection Scope

The inspectors reviewed reported 3rd quarter 2000 data for the Unit 1 and Unit 2 Reactor Coolant System Identified Leakage Rate performance indicator. The inspectors utilized the performance indicator definitions and guidance contained in Nuclear Energy Institute (NEI) 99-02, "Regulatory Assessment Indicator Guideline," Revision 0.

The inspectors reviewed operator log entries and other records of daily measurements of reactor coolant system identified leakage and compared the results to the data reported by the performance indicator.

b. Findings

No findings of significance were identified.

4OA3 Event Followup

a. Inspection Scope

On December 1, 2000, the Unit 2 reactor automatically shut down after experiencing abnormally high reactor vessel water level. The high reactor water level occurred during feedwater manipulations to place the 2B turbine-driven reactor feedwater pump online during power ascension following the completion of refueling outage L2R08. The abnormally high water level initiated trips of the main generator and all online feedwater pumps, resulting in the Unit 2 reactor scram. In response to the event, the inspectors observed plant parameters and status, including mitigating systems and fission product barriers; evaluated the performance of mitigating systems and licensee actions; and confirmed that the licensee properly reported the event as required by 10 CFR 50.72. The inspectors determined that all systems responded to the event as designed, the automatic shutdown was not complicated by material condition deficiencies associated

with mitigation equipment, and that no human performance errors complicated the event response. The inspectors communicated details of the event to the region-based risk analysts who determined that the event was of low risk-significance.

b. Findings

No findings of significance were identified.

4OA5 Other

- a. (Closed) Unresolved Item 50-373/2000009-01;50-374/2000009-01: As discussed in Inspection Report 50-373/2000009;50-374/200009, the inspectors identified Section 9.6 of Revision 61 to the security plan described measures which would allow certain containers to enter the protected area (PA) without being searched if the containers were searched prior to leaving the PA. These measures did not require the containers to be locked while outside of the protected area, and verification of the seal used to initially seal the containers while outside of the protected area was not required before the containers entered the PA. Section 9.6 of Revision 63 to the security plan, submitted by letter dated October 10, 2000, addressed the above concerns and this issue is closed. No violation occurred because the provisions of the measures in Revision 61 of the security plan were not implemented.

4OA6 Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. M. Schiavoni and other members of licensee management at the conclusion of the inspection on December 29, 2000. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

