

September 17, 2001

Mr. Oliver D. Kingsley, President
Exelon Nuclear
Exelon Generation Company, LLC
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: LASALLE COUNTY STATION
NRC INSPECTION REPORT 50-373/01-10(DRP); 50-374/01-10(DRP)

Dear Mr. Kingsley:

On August 18, 2001, 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 August 20, 2001, with Mr. C. Pardee 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, no findings were identified.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Sincerely,

Original signed by
Bruce Burgess

Bruce Burgess, Chief
Branch 2
Division of Reactor Projects

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

Enclosure: Inspection Report 50-373/01-10(DRP);
50-374/01-10(DRP)

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J. Skolds, Chief Operating Officer
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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: 50-373/01-10(DRP); 50-374/01-10(DRP)

Licensee: Exelon Generation Company

Facility: LaSalle County Station, Units 1 and 2

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

Dates: July 1 through August 18, 2001

Inspectors: E. Duncan, LaSalle Senior Resident Inspector
G. Wilson, LaSalle Resident Inspector
C. Brown, Clinton Resident Inspector
K. O'Brien, Reactor Inspector
J. Yesinowski, Illinois Department of Nuclear Safety

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

SUMMARY OF FINDINGS

IR 05000373-01-10(DRP), IR 05000374-01-10(DRP), on 07/01-08/18/2001, Exelon, LaSalle County Station, Units 1 & 2, Routine Resident Inspection.

This report covers a 7-week routine resident inspection. The inspection was conducted by the resident inspectors. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609 "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>. 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

No findings of significance were identified.

B. Licensee Identified Violations

Two violations of very low significance, which were identified by the licensee, have been reviewed by the inspectors. Corrective actions taken or planned by the licensee appear reasonable. These violations are listed in Section 4OA7 of this report.

Report Details

Summary of Plant Status: Both units operated at or near full power for the entire inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R04 Equipment Alignment (71111.04)

a. Inspection Scope

On July 25, 2001, the inspectors performed a walkdown of accessible portions of the Unit 2 High Pressure Core Spray (HPCS) system to verify system operability during emergent maintenance activities associated with the Unit 2, 250 Volt Direct Current (VDC) Battery which impacted the availability of the Unit 2 Reactor Core Isolation Cooling (RCIC) system.

On August 7, 2001, the inspectors performed a walkdown of accessible portions of the Unit 1 Residual Heat Removal (RHR) system to verify system operability and low pressure injection capability during maintenance activities associated with the Unit 1 Low Pressure Core Spray (LPCS) system.

The inspectors reviewed documentation to determine the correct system lineup. These documents included plant procedures, such as abnormal and emergency operating procedures, as well as plant drawings. The inspectors verified critical portions of the redundant or backup 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 (71111.05)

a. Inspection Scope

The inspectors walked down the following risk-significant areas to identify any fire protection degradations:

- Fire Zone 2D: Unit 1 Reactor Building General Area - Elevation 786'
- Fire Zone 3H4: Unit 2 Reactor Building - RCIC/LPCS Cubicle
- Fire Zone 3I3: Unit 2 Reactor Building - RHR Pump "B" and "C" Cubicle
- Fire Zone 8C1: Unit 2 HPCS - Diesel Fuel Tank Room

Emphasis was placed 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 and mitigation devices (such as overhead sprinklers) and verified that any observed deficiencies did not impact the operational effectiveness of the system. The physical condition of portable fire fighting equipment, such as portable fire extinguishers, was also observed and verified to be located appropriately, and that access to the extinguishers was unobstructed. Fire hoses were verified to be installed at their designated locations and the physical condition of the hoses was verified to be 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 verified to be properly installed and in good physical condition.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification (71111.11)

a. Inspection Scope

On August 8, 2001, the inspectors observed the following licensed operator requalification training simulator scenarios:

- ESG00C5-01: "A" Turbine-Driven Reactor Feedwater Pump (TDRFP) Flow Transmitter Failure/Station Air Rupture/"A" Reactor Recirculation (RR) Discharge Rupture/Anticipated Transient Without Scram
- ESG00C5-03: Trip of Division 2, 125 VDC Battery Charger/"B" RR Flow Control Valve Fails Closed/1A TDRFP Lube Oil Leak and TDRFP Trip/Feedwater Leak in the Drywell with a RCIC Automatic Flow Controller Failure
- ESG00C5-14: Loss of Bus 111X/Stator Cooling Loss/Bus Undervoltage/Loss-of-Coolant-Accident/Emergency Depressurization/"0" Emergency Diesel Generator Failure to Automatically Start

The inspectors verified crew performance in terms of clarity and formality of communication; the ability to take timely action in the safe direction; the prioritizing, interpreting, and verifying of alarms; the correct use and implementation of procedures, including alarm response procedures; timely control board operation and manipulation, including high-risk operator actions; the oversight and direction by the shift manager,

including the ability to identify and implement appropriate Technical Specification actions such as reporting and emergency plan actions and notifications; and the group dynamics.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

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 following systems were evaluated:

- Residual Heat Removal Service Water (RHRSW) System
- Residual Heat Removal (RHR) System
- Standby Gas Treatment (SBGT) System

The RHR and RHRSW systems were classified as maintenance rule (a)(2) systems and were selected based upon their relatively high core damage frequency contribution. The Standby Gas Treatment System was also classified as a maintenance rule (a)(2) system and was selected based upon its classification as a high-risk system.

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; and that established performance criteria were appropriate. The inspectors also verified that issues were identified at an appropriate threshold and entered into the corrective action program. The inspectors verified that the availability and functional failure data were accurate through a review of operator log entries, out-of-services, and work request documentation. The inspectors conducted walkdowns of accessible portions of the systems reviewed to verify that the material condition of the system supported availability.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation (71111.13)

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 was 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 July 9, 2001. This included work associated with the Unit 1 and Unit 2 Service Water system, the Unit 1 Spent Fuel Pool Cooling system, and the Unit 2 Primary Containment Vent and Purge system. Emergent work associated with 2E12-F024A, the 2A RHR Full Flow Test Valve, was also reviewed for the impact on plant risk. Planned surveillance activities were reviewed to ensure that they did not adversely impact the availability of the respective systems.
- The inspectors reviewed the maintenance risk assessment for emergent work which occurred during the week of July 23, 2001. This included the unexpected risk impact of a failed 1B Emergency Diesel Generator during routine monthly surveillance testing and the failure of the Unit 2, 250 VDC battery during its scheduled 18-month intercell resistance verification surveillance test.
- The inspectors reviewed the maintenance risk assessment for work planned for the week of August 6, 2001. This included work associated with the Unit 1 LPCS system and the 2A Condensate/Condensate Booster pump. Emergent work associated with the Unit 1, Division 2, RHRSW system was also reviewed for the impact on plant risk. Planned surveillance activities were also reviewed to ensure that they did not adversely impact the availability of the respective systems.

b. Findings

No findings of significance were identified.

1R14 Personnel Performance During Nonroutine Plant Evolutions (71111.14)

(Closed) Licensee Event Report (LER) 50-374/01-02: Reactor Scram Due to High Turbine Vibration During Testing.

On May 27, 2001, the Unit 2 reactor automatically shutdown after experiencing abnormally high vibration associated with main turbine bearing #1. The high bearing vibration occurred during the performance of LaSalle Operating Surveillance (LOS) RP-M5, "Turbine Control Valve Monthly Surveillance." The main turbine bearing #1 high vibration condition initiated an automatic shutdown of the main turbine, resulting in the Unit 2 automatic reactor shutdown. 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 results of that inspection are documented in NRC Inspection Report 50-373/01-08; 50-374/01-08.

The licensee determined that the root cause of the event was electro-hydraulic control (EHC) fluid contamination of a connector for Turbine Control Valve (TCV) #3 in combination with higher than normal baseline vibration during TCV testing. The inspectors reviewed the subject LER. No new issues were identified. This LER is closed.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed selected Operability Evaluations (OEs) and Condition Reports (CRs) concerning degraded and non-conforming conditions to ensure that operability was properly justified and the system remained available, such that no unrecognized increase in risk had occurred. The following Operability Evaluations and CRs were reviewed:

- OE00-009 Revision 2: Unit 1 and Unit 2 Leaking Safety Relief Valves (SRVs)

This revised operability evaluation identified that LaSalle Unit 1 and Unit 2 each have six leaking SRVs. The impact of this issue has been an increase in suppression pool level as well as a slow heatup of the suppression pool. To address suppression pool temperature issues, operators run the RHR system in the suppression pool cooling (SPC) mode to cool the suppression pool to maintain the suppression pool temperature below the Technical Specification 3.6.2.1 limit of 105°F.

The operating time of the RHR system in the SPC mode is dependent upon the heat input into the pool and the LaSalle cooling lake temperature. Recently, the Unit 1 SRV leakage rate and lake temperature increased to the point that RHR operation on a daily basis was required. As a result, licensee management made a decision to operate one train of the Unit 1 RHR system in the SPC mode continuously and implemented this action on June 6, 2001. The technical basis for this decision was documented in Analysis L-002766, "GE NEDC & Continuous Operation of RHR in the Suppression Pool Cooling Mode," Revision 0, dated May 10, 2001, and reviewed and approved by the Plant Onsite Review Committee (PORC) on June 8, 2001.

The inspectors reviewed OE00-009, Revision 2, and verified that the RHR system would automatically re-align from the suppression pool cooling mode to the injection mode within the time required to satisfy design basis assumptions.

- CR L2001-03950 Low Discharge Pressure on 2A RHR Following Shutdown From Suppression Pool Cooling

This CR identified that on July 8, 2001, following the shutdown of the 2A RHR system from suppression pool cooling, operators received the 2A RHR low discharge pressure alarm. Operability of the system was then verified by observing water flow through the system high point vents. The inspectors reviewed the subject CR and identified that no

discussion regarding the impact of potential leakage on the low pressure coolant injection (LPCI) mode of RHR was documented. The inspectors were subsequently informed that a verbal discussion of this matter had taken place and that the CR would be revised to reflect this aspect of the operability decision. Operations also subsequently issued a standing order to re-enforce expectations regarding the amount of detail expected in CRs which address operability. The operability evaluation is still under review by the inspectors due to the concern for potential water hammer conditions when the LPCI mode of RHR is initiated. This is considered an Unresolved Item (URI 50-373/2001010-02)

- CR L2001-04182 Ultimate Heat Sink (UHS) Temperature Limits

This CR identified that the peak condenser inlet temperature was approaching the Technical Specification limit for the UHS. The inspectors reviewed the subject CR and verified that the method employed by licensee personnel to measure plant inlet water temperature was consistent with that required to satisfy the design basis and therefore support operability of the UHS.

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds (OWAs) - Cumulative Effects Assessment (71111.16)

a. Inspection Scope

The inspectors reviewed the cumulative effects of all documented OWAs and operator challenges (OCs) on reliability, availability, and potential for mis-operation of a system; the potential for increasing initiating event frequency or impact on multiple mitigating systems; and the ability of operators to respond in a correct and timely manner to plant transients and accidents.

The majority of documented OWAs and OCs reviewed had only a negligible potential impact on initiating event frequency, the functional capability of a mitigating system, or the potential to impact human reliability in responding to an event. Operator Challenge OC322 regarding reactor water level control problems which have led to a number of plant transients, and OC324 regarding multiple Unit 1 and Unit 2 SRVs which leaked excessively were reviewed for an aggregate impact since in the first case an initiating event frequency impact existed, and in the second case, the reliability of the RHR and LPCS systems could be impacted by the additional required operating time of these systems.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing (71111.19)

a. Inspection Scope

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 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.

The inspectors reviewed work orders (WOs) and observed the following post-maintenance testing activities involving risk-significant equipment:

- WO 00337716-01-01: Investigate Incomplete 2E12-F024A Valve Closure

During the performance of routine surveillance testing on July 10, 2001, maintenance personnel identified that 2E12-F024A, the 2A RHR Full Flow Test Valve, failed to stroke fully closed. The inspectors reviewed signature traces following maintenance activities to clean torque switch contacts and verified that acceptable motor-operated valve currents were developed to ensure that the valve was fully seated.

- WO 99282195-01: Unit 1 High Pressure Core Spray (HPCS) Minimum Flow Bypass Switch Replacement

The inspectors observed the performance of LaSalle Instrument Surveillance (LIS) HP-105, "Unit 1 High Pressure Core Spray Minimum Flow Bypass Calibration," associated with the replacement of switch 1E22-N006. The review evaluated the surveillance acceptance criteria and the adequacy of the post-maintenance testing.

- WO 99187910-01: 1B Emergency Diesel Generator Failure to Start

During the performance of routine surveillance testing on July 25, 2001, the 1B Emergency Diesel Generator failed to start. The inspectors observed the analysis of the governor oil, the actuation of the governor shutdown solenoid, and the replacement of the pneumatic booster pump after the diesel failed to start for monthly testing. The inspectors also observed the performance of LOS-DG-M3, "1B Diesel Generator Operability Test," following the failure. The review evaluated the results of the governor troubleshooting and the surveillance acceptance criteria for the adequacy of the post-maintenance testing.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed surveillance testing on risk-significant equipment and verified that the 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 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 were 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 that the equipment was returned to a condition in which it could perform its safety function.

The following surveillance testing activities were observed:

- LOS-RH-Q1, "RHR(LPCI) and RHR Service Water Pump and Valve Inservice Test for Modes 1, 2, 3, and 5," Attachment 2A, "Unit 2A RHR System Operability and Inservice Test"
- LaSalle Technical Surveillance (LTS) 200-28, "1A DG [Emergency Diesel Generator] Division 2 Flow Balance Test"
- LOS-DC-Q2, "Battery Readings for Safety-Related 250 VDC and Division 1, 2, and 3, 125 VDC Batteries"

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors reviewed Temporary Modification 9900401 which bypassed channel 17 of 1PL15J, the Unit 1 Primary Containment Air Particulate Sample Panel, to address a solenoid valve that would not open to allow sampling the suction for channel 17 and resulted in a system low flow alarm and automatic system shutdown. The inspectors reviewed the associated 10 CFR 50.59 safety evaluation against the system design basis documentation, including the UFSAR and Technical Specifications. The inspectors also conducted a walkdown of the temporary modification and compared the installed configuration against the configuration prescribed in design drawings.

b. Findings

No findings of significance were identified.

1EP6 Drill Evaluation (71114.06)

a. Inspection Scope

The inspectors evaluated the adequacy of the licensee's conduct of drills and critique of performance through the observation of their annual emergency preparedness exercise on August 15, 2001. The inspectors reviewed the exercise scenario to identify the timing and location of classification, notification, and protective action measure activities, and for licensee expectations and response. The inspectors verified that these actions were accomplished in a timely manner.

During the exercise scenario, a simulated Unit 2 Loss-Of-Offsite-Power (LOOP) was properly classified as an Unusual Event and then upgraded to an Alert when power to the engineered safeguard feature (ESF) buses was reduced to a single source. Following a Unit 1 manual reactor scram due to high steam tunnel temperatures following the loss of reactor building ventilation and a subsequent Anticipated Transient Without Reactor Scram (ATWS), a Site Area Emergency was properly identified.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification

Cornerstone: Mitigating Systems

a. Inspection Scope

The inspectors reviewed reported 2nd quarter 2001 data for the Safety System Functional Failure and the Emergency Alternating Current (AC) Power Unavailability performance indicators for Unit 1 and Unit 2 utilizing the performance indicator definitions and guidance contained in Nuclear Energy Institute (NEI) 99-02, "Regulatory Assessment Indicator Guideline," Revision 0.

The inspectors reviewed Licensee Event Reports (LERs) and operator log entries to identify the number of safety system functional failures that occurred during the previous four quarters and compared that number to the number in the performance indicator. The inspectors also reviewed the licensee's basis for excluding events and conditions identified in LERs from reporting as a safety system functional failure.

The inspectors reviewed operator log entries for periods of Emergency AC Power system unavailability. The inspectors verified that planned and unplanned unavailability

hours were characterized correctly in determining performance indicator results. The inspectors verified performance indicator data through independent calculations.

b. Findings

No findings of significance were identified.

40A5 Other

.1 (Closed) URI 50-373/200003-01; 50-374/200003-01 (DRP): Resolution of Appendix J Moderate Energy Line Break (MELB) Discrepancies

During 1998, the licensee identified discrepancies between the as-built configuration of in-plant MELB mitigation features and the overall MELB design as described in Appendix J of the Updated Final Safety Analysis Report (UFSAR). The licensee entered these findings into their corrective action program and had an independent assessment of the findings completed by an outside contractor. At the time the initial corrective action program report was issued, the licensee determined that the condition was not reportable. The NRC Resident Inspectors reviewed the licensee's resolution of the discrepancies and could not determine the regulatory basis for the licensee's acceptance of the as-found conditions and could not determine how the as-found conditions were consistent with previous licensing correspondence with the NRC. As a result, the licensee initiated a second review of the initial findings which was tracked as PIF L2000-01182. Results of the second review included a reevaluation of the as-found conditions.

The inspectors reviewed the results of the licensee's reevaluation of the MELB design basis as documented in Design Analysis No. L-002702, Revision 0, dated February 6, 2001, and in UFSAR Change No. LU2000-152, dated March 7, 2001, using the information included in the NRC's Safety Evaluation Report (SER) (NUREG 0519) and the guidelines included in NRC Branch Technical Position (BTP) SPLB (formerly ASB) 3.1, "Protection Against Postulated Piping Failures in Fluid Systems Outside Containment," and BTP MEB 3-1, "Postulated Rupture Locations In Fluids Systems Inside and Outside Containment." Based upon the reference materials, the inspectors concluded that the licensee staff had properly identified the current licensing basis, as described in the SER, and had identified those portions of the BTPs which prescribed the appropriate acceptance criteria for demonstrating compliance with the licensing requirements.

Based upon a review of the design analysis methodology and a sampling comparison of the design analysis results against the basic requirements of the BTPs, the inspectors determined that the analysis included a method for complying with the licensing requirements. The analysis relied upon a separation of components and the availability of three trains of components to ensure safe shutdown of the plant following a MELB. The inspectors also noted that the MELB response, proposed in the design analysis, was different from the MELB response described in Appendix J of the UFSAR. The inspectors compared the design analysis results with the plant configuration and determined that none of the previously installed MELB-specific response design features, such as spray shields, would be required using the revised analysis. As a

result, the licensee could demonstrate, using the revised design analysis, that the previous failure to install some of the MELB-specific design features did not affect the staff's ability to safely shutdown the plant following a MELB.

Using the results of Design Analysis No. L-002702, the licensee initiated a change to the UFSAR as a final corrective action to the issues identified in the 1998 and 2000 CRs. The inspectors reviewed the completed change to the UFSAR and the associated 10 CFR 50.59 evaluation and did not have any questions.

The inspectors evaluated the licensee's failure to maintain the plant configuration consistent with the UFSAR MELB description between initial licensing and the 2001 update to the UFSAR using the Significance Determination Process (SDP). This issue was screened out from further review as being a minor issue using the Group 1 screening questions of the SDP because the as-found plant was sufficient to allow for a safe shutdown of the plant following a MELB event. See Section 4OA7 for further discussion.

4OA6 Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. C. Pardee and other members of licensee management on August 20, 2001. 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.

On July 11, 2001, the NRC presented the End of Cycle Assessment results to licensee management in a public meeting. Handouts used during the meeting are included as an attachment to this report.

4OA7 Licensee-Identified Violations

The following finding of very low significance was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Policy, NUREG 1600 for being dispositioned as a Non-Cited Violation (NCV).

If you deny this noncited violation, you should provide a response with the 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 20555-0001; 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.

NCV Tracking Number

Requirement Licensee Failed to Meet

50-373/374/2001010-01

10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality be prescribed by adequate procedures.

Adequate plant conditions were not prescribed in LTS-200-28, "1A DG Division 2 Flow Balance Test," which potentially impacted safety-related cooler flow. This issue was entered into the licensee's corrective action program as CR L2001-04480.

The following issue was identified by the licensee and was a violation of NRC requirements which meet the criteria of Section IV of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as minor violations. The minor violation was corrected by the licensee and is being documented in the inspection report because it involved the extenuating circumstances criterion for closing an URI.

N/A

Criterion III of 10 CFR Part 50, Appendix B, requires the licensee to verify and control the design basis of systems, structures and components to ensure their ability to meet the prescribed functional goals. Contrary to this, prior to February 2001, the licensee failed to ensure that the Moderate Energy Line Break design basis, as described in the Updated Final Safety Analysis Report, was verified and controlled. Upon discovery of the failure, the licensee developed, approved, and controlled a revised methodology for the Moderate Energy Line Break design which demonstrated that the functional goals continued to be met (Section 4OA5).

PARTIAL LIST OF PERSONS CONTACTED

Exelon

- D. Bost, Site Engineering Manager
- D. Enright, Operations Manager
- F. Gogliotti, Design Engineering Supervisor
- C. Pardee, Site Vice President
- J. Pollock, System Engineering Manager
- W. Riffer, Regulatory Assurance Manager
- M. Schiavoni, Station Manager
- R. Tjernlund, Design Engineer

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-373/2001010-01;50-374/2001010-01 50-373/2001010-02	NCV URI	Procedure LTS-200-28 Inadequate Potential Water Hammer when LPCI Mode of RHR Initiated
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Closed

50-373/2001010-01;50-374/2001010-01 50-374/01-02 50-373/200003-01;50-374/200003-01	NCV LER URI	Procedure LTS-200-28 Inadequate Scram Due to High Turbine Vibration Resolution of Appendix J Moderate Energy Line Break Discrepancies.
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Discussed

None

LIST OF INSPECTIONS PERFORMED

The following inspection-area procedures were used to perform inspections during the report period. Documented findings are contained in the body of the report.

<u>Number</u>	<u>Title</u>	Inspection Procedure	<u>Report Section</u>
92903	Follow-up Engineering		OA5

LIST OF DOCUMENTS REVIEWED

Condition Reports

L1998-00665	UFSAR Appendix J Drawings Found to be Out of Date During UFSAR Search	January 27, 1998
L1998-02970	Spray Shielding Requirements for Moderate Energy Line Break on SR Equipment	April 20, 1998
L2001-02400	Historical Moderate Energy Line Break Reportability Question	April 18, 2001

Other Documents

	Engineering Evaluation on LaSalle Unit 1 and 2 Moderate Energy Line Break (MELB) UFSAR Appendix J	Revision 0 May 1, 1998
Design Analysis No. L-002702	Moderate Energy Line Break (MELB) Analysis	Revision 0 February 6, 2001