November 1, 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 50-373/01-16(DRP); 50-374/01-16(DRP)

Dear Mr. Kingsley:

On October 2, 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 October 2, 2001, with Mr. Pardee and other members of your staff.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection involved a selected examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of the inspection, we concluded that your corrective action program adequately identified and resolved conditions adverse to quality. Station management established a safety conscious work environment where people are not reluctant to raise issues due to harassment or chilling concerns. The inspectors did not identify any issues that questioned the operability of safety-related or risk significant plant equipment. The significance threshold for entering issues into your corrective action program appeared appropriate.

Notwithstanding the program's overall acceptability, the inspectors identified one area where the station is potentially missing opportunities to identify issues. Specifically, several plant staff interviewed by the inspectors indicated a reluctance to write condition reports against their peers, potentially depriving the station of the opportunity to identify and resolve human performance and procedural adherence concerns.

While the overall program allowed the station to identify and resolve problems, we did note several weaknesses in the station's overall implementation and use of the program. One "No Color" and one "Green" finding were identified during this inspection. The "No Color" finding involved the failure to follow station procedures associated with Corrective Action program requirements (failure to adhere to station procedural requirements to initiate a Condition Report subsequent to validating a common cause or trend). The "Green" finding involves the failure to take timely corrective action to address operator knowledge deficiencies of the Technical Specification entry requirements for RCIC injection check valves. These findings were determined to be violations of NRC requirements. However, because of their very low safety significance and because the findings have been entered into your corrective

action program, the NRC is treating these issues as Non-Cited Violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny these Non-Cited Violations, 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 the LaSalle County Station.

In addition, since September 11, 2001, your LaSalle County Station has assumed a heightened level of security based on a series of threat advisories issued by the NRC. Although the NRC is not aware of any specific threat against nuclear facilities, the heightened level of security was recommended for all nuclear power plants and is being maintained due to the uncertainty about the possibility of additional terrorist attacks. The steps recommended by the NRC include increase patrols, augmented security forces and capabilities, additional security posts, heightened coordination with local law enforcement and military authorities, and limited access of personnel and vehicles to the site.

The NRC continues to interact with the Intelligence Community and to communicate information to Exelon Generation Company, LLC. In addition, the NRC has monitored maintenance and other activities which could relate to the site's security posture.

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,

/RA/

Bruce Burgess, Chief
Branch 2
Division of Reactor Projects

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

Enclosure: Inspection Report 50-373/01-16(DRP);
50-374/01-16(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:	50-373/01-16(DRP); 50-374/01-16(DRP)
Licensee:	Exelon Generation Company
Facility:	LaSalle County Station, Units 1 and 2
Location:	2601 N. 21st Road Marseilles, IL 61341
Dates:	September 4 through October 2, 2001
Inspectors:	K. Riemer, Project Engineer, Team Lead P. Prescott, Senior Resident Inspector, Duane Arnold G. Wilson, Resident Inspector B. Palagi, Operator Licensing (observer)
Approved by:	Bruce Burgess, Chief Branch 2 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000373-01-16(DRP), IR 05000374-01-16(DRP), on 09/04/2001-10/02/2001, Exelon, LaSalle County Station, Units 1 & 2, annual baseline inspection of the identification and resolution of problems.

The inspection was conducted by a regional project engineer and resident inspectors. One "No Color" and one "Green" finding were identified which were the subject of Non-Cited Violations. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (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.

Identification and Resolution of Problems

The inspectors concluded that the licensee adequately identified, evaluated, and resolved problems within the requirements of the corrective action program (CAP). The inspectors found that station personnel identified and entered problems into the CAP using condition reports. The significance threshold for entering issues into the corrective action program appeared appropriate. Overall, the station adequately identified and resolved problems. Station management established a safety-conscious work environment where people were not reluctant to raise issues due to potential harassment or chilling concerns. While the overall program allowed the station to identify and resolve problems, there were several weaknesses in the station's implementation of the program.

Cross-Cutting Issue: Problem Identification and Resolution

No Color. During this inspection, several examples of procedural non-compliance were identified that were associated with the station corrective action program procedure. An adverse performance trend in procedural compliance appeared to be developing in several cornerstone elements. The specific procedural adherence issues were associated with AD-AA-106 "Corrective Action Process Program Procedure", Section 4.6.2.2, Class B Evaluations where the licensee had not implemented the requirement to initiate new condition reports following a class B Common Cause Analysis when a potential adverse trend was validated. One non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified.

The issue was of very low safety significance based on the inspector risk significance screening of this finding in accordance with NRC Inspection Manual Chapter 0610*, "Power Reactor Inspection Reports," Appendix B, "Thresholds for Documentation." Because the failure to initiate Condition Reports (CRs) when common causes or trends were identified did not have an actual or credible impact on safety, the issue was not evaluated using NRC Manual Chapter 0609, "Significance Determination Process". However, the finding was more than minor based on extenuating circumstances (Group 3 Questions). The finding was considered to be a substantive cross-cutting

issue because the issue was captured in a number of examples noted in the different functional areas examined during the inspection and across plant departments which indicated an adverse performance pattern.

Cornerstone: Mitigating System

Green. Following the April 6, 2001, reactor scram, licensed operators entered the wrong Technical Specification associated with the reactor core isolation cooling system (RCIC) discharge check valves. The licensee established and implemented corrective actions to improve operator understanding of Technical Specification 3.4.6, "Reactor Coolant System (RCS) Pressure Isolation Valve (PIV) Leakage." During similar circumstances following the September 3, 2001 reactor scram, licensed operators again demonstrated poor understanding of the Technical Specification requirements for the RCIC system. The corrective actions implemented for the failure on April 6, 2001, to properly recognize and enter the appropriate technical specifications, were not performed in a timely manner. One non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," was identified.

The event was of very low safety significance based on the inspectors risk significance screening of this finding in accordance with the guidance contained in Appendix B, "Thresholds for Documentation," of Inspection Manual Chapter (IMC) 0610*, "Power Reactor Inspection Report." The inspectors evaluated the issue with the SDP Group 1 questions and concluded that the failure to correct the operator understanding of Technical Specification requirements was more than minor in that, if left uncorrected, the issue could under the same condition become a more significant safety concern. Using the Group 2 questions, the inspectors concluded that the issue could credibly affect the availability, reliability, or function of a mitigating system. The Group 3 question, item 6, was addressed and the issue was determined to be greater than minor during review of Group 1 questions, resulting in the issue being screened Green.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors conducted a review of the station process for identifying and correcting problems at the plant. The inspectors reviewed previous licensee and inspector identified issues related to the seven safety cornerstones in the Reactor Safety, Radiation Safety, and Safeguards strategic performance areas to determine if problems were appropriately identified, characterized, and entered into the corrective action program. The problem identification program and its effectiveness was evaluated by reviewing issues identified in previous NRC inspections, selected corrective action program documents and records, and discussions of the program with licensee personnel.

In order to determine if problems were being identified at the proper threshold and entered into the corrective action process, the inspectors reviewed the following documents: inspection reports issued over the past year, selected plant procedures and program description handbooks, licensee completed effectiveness reviews and common cause analysis (CCAs), various Condition Reports (CRs) and corrective action documents, and industry operating experience documents.

The inspectors also reviewed records of internal audits and self-assessments completed by the LaSalle corrective action program organization. The inspectors conducted the review to determine whether the audit and self-assessment programs were effectively managed, adequately covered the subject areas, and to determine whether the associated findings were appropriately captured in condition reports. The effectiveness of the audits and assessments was evaluated by comparing the licensee's audit and assessment results against self-revealing and NRC-identified issues. In addition, the inspectors interviewed licensee staff regarding the audit and self-assessment programs.

A listing of the specific documents reviewed is attached to the report.

b. Findings

The station effectively identified and entered problems as Condition Reports (CRs) into the corrective action program (CAP). There were no risk significant problems identified in this area. However, the inspectors noted several examples where problem identification was not always effective. While the station demonstrated the ability to identify problems (as evidenced by the thousands of CRs initiated each year) the inspectors noted some weakness in identifying specific issues and potential adverse trends concerning those issues. Previous NRC inspection reports have also identified issues associated with problem identification.

Identification of Deficiencies Associated with Technical Specification Understanding

The inspectors reviewed operator actions following the September 3, 2001, Unit 2 reactor scram. Specifically, the inspector interviewed on-shift licensed operators concerning Technical Specification (TS) limiting condition for operation (LCO) entry requirements associated with the reactor core isolation cooling (RCIC) system. During the interviews, the inspectors identified that some of the operators did not clearly understand the requirements. These operators were the same crew that was on shift for the April 6, 2001 reactor scram. The problem associated with poor operator understanding of the requirements for the RCIC system Technical Specification requirements was similar to problems identified by inspectors following the April 6, 2001, Unit 2 reactor scram. The inspectors identified that licensee corrective actions implemented after the April 6, 2001 reactor scram were not timely enough to prevent recurrence of the problem on September 3, 2001 (see Section 4OA2.3 of this report for additional details concerning this item).

Trending of Issues

During the inspection, the inspectors identified examples where licensee trending of issues was weak. While the station identified individual, specific deficiencies and entered those deficiencies into the corrective action program database, the items were not always evaluated collectively to determine the extent of the problem. Specific examples of adverse trends identified by the inspectors are listed below.

Emergency Preparedness

During review of data associated with the emergency preparedness (EP) cornerstone, the inspectors determined that during EP drills and exercises, six errors in completing Nuclear Accident Reporting System (NARS) forms had been made since January 2001. Three of the six errors were identified by NRC inspectors. The errors were minor and administrative in nature and were individually captured in CRs. The inspectors questioned whether a trend CR had been written to identify a potentially adverse trend associated with filling out the forms. The licensee did not write a trend CR until after questioning by the inspectors.

Procedural Adherence Concerns

During the review of docketed material, the inspectors identified a negative trend associated with procedural adherence. The resident inspectors reviewed or observed the performance of 25 procedures since March 2001. Of the 25 procedures, the inspectors identified six examples of procedural noncompliance. The inspectors determined that station personnel had also identified specific examples of procedural noncompliance; however, the station had not written a trend CR to capture the full extent of the problem. Examples of procedural non-compliance are listed below:

* CR L2001-02357 - A temporary modification was not installed on the Unit 2, Division 2, 125v Battery in accordance with the procedure.

* CR L2001-02931 - The licensee was not properly recording the oil level for LPCS motor.
* CR L2001-03119 - Problems with Instrument Maintenance Department (IMD) procedural adherence was identified.
* CR L2001-05501 - licensee documented the circumstances associated with the self-revealing procedural noncompliance associated with procedure LIS-RD-403 resulting in an inadvertent trip of one reactor protection system channel.

Technical Specification Concerns

The inspectors identified a negative trend associated with licensed operators understanding of, and compliance with, Technical Specification requirements. The licensee had not captured or documented this adverse trend in operator performance. Examples of Technical Specification implementation concerns are:

* Inspection Report 2001-07; CR L2001-02043 - NRC inspectors identified that operators failed to enter Technical Specification 3.4.3.1 as required when containment particulate and gaseous radiation monitors were inoperable

* Inspection Report 2001-07; CR L2001-03162 - Station personnel identified that operators failed to verify the performance of the hi setdown function of the APRM channel checks, as required by Surveillance Requirement 3.3.1.1.4.

* Inspection Report 2001-09 - NRC inspectors identified that operators entered the incorrect LCO (and failed to enter the correct LCO) associated with RCIC system injection check valves

* September 3, 2001 Unit 2 Reactor Scram - NRC inspectors again identified deficiencies associated with operators' understanding of the Technical Specification entry requirements for RCIC system injection check valves.

Effectiveness of Licensee Audits and Assessments

The inspectors determined that the Nuclear Safety Review Board (offsite committee) reports were effective at identifying concerns. The inspectors also determined that licensee audits were generally effective at identifying specific issues. However, the audits were not effective in identifying or document several broad themes, trends, or concerns identified by the PI&R team.

Individual items identified in the Nuclear Oversight quarterly data were entered into the CR database. However, there were no requirements for the specific departments to either formally respond to the audit results or evaluate the data for potentially adverse trends. While the inspectors did not identify any specific safety significant issues resulting from the station's actions associated with the Nuclear Oversight Assessments, the team concluded that this represented a weakness in the licensee's process.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors reviewed inspection reports and corrective action documents to verify that identified issues were appropriately characterized and entered into the licensee's problem identification and resolution program.

The inspectors attended management meetings to observe the assignment of CR categories for current issues and the review of root cause analyses and corrective actions for existing CRs.

The inspectors conducted an independent assessment of the prioritization and evaluation of selected CRs. The assessment included a review of the category assigned, the operability and reportability determinations, the extent of condition evaluations, the cause investigations, and the appropriateness of assigned corrective actions. Other attributes reviewed by the inspectors included the adequacy of the root cause analyses and the corresponding corrective actions. The inspectors also assessed licensee evaluations of Non-Cited Violations (NCVs). The review included the controlling procedures, selected records of activities, and attendance of meetings. In addition, the functions, activities, and findings of the groups were discussed with cognizant licensee personnel.

The inspectors also reviewed the licensee staff's efforts to capture industry operating experience (OPEX) issues in the corrective actions program. Documents reviewed included the licensee's assessment of industry operating event reports, NRC, and vendor generic notices. The inspectors reviewed information recorded since July 2000.

A listing of the specific documents reviewed is attached to the report.

b. Findings

One "No Color" inspection finding was identified which was determined to be a Non-Cited Violation involving the failure to follow the station procedure for actions required during the conduct of a common cause analysis (CCA).

The inspectors determined that, in general, issues were appropriately characterized and classified, and appropriate evaluations were conducted for significant conditions adverse to quality. The inspectors reviewed the licensee's proposed corrective actions for NCVs issued during the last year and noted no concerns with the proposed corrective actions. Likewise, the inspectors' review identified no significant concerns associated with the licensee's operating experience (OPEX) program.

The inspectors reviewed licensee root cause reports (RCRs) generated since July 2000. While the inspectors did not identify any significant concerns with the root causes identified in the RCRs, the inspectors did note weaknesses associated with the licensee's risk analyses. Licensee procedures required that the root cause report should identify the plant-specific risk consequences of the issue. The risk analyses were weak and often contained little or no quantitative data. By not quantitatively

evaluating plant events or conditions, the licensee may be missing opportunities to more effectively use its resources in addressing the issues. The following are examples of RCR risk analysis documented in licensee reports which provided little quantitative assessment of the deficient condition:

* CR L2001-00701 (LaSalle U1 Automatic Rx Scram due to an Electrical Fault on Transformer Yard 345kV Line C0 Insulator Buildup of Foreign Deposits) - "The plant response to the event are as expected within the bounds of the safety analysis."

* CR L2001-05114 (RCA of Inadvertent Start of 2A EDG During Surveillance Due to Human Performance Error of Inattention to Detail) - "This particular error did not result in any damage to equipment or reduction in plant safety."

* CR L2001-06981 (LaSalle U2 Automatic Rx Scram and Turbine Trip Caused by High Rx Water Level due to Human Performance, Design Deficiency and Material Condition) - "The reactor and fuel are protected from level transients by automatic actions."

* CR L2001-02667 (RCA of Trip of LaSalle 1B EDG due to Failure to Self-check and Inadequate Knowledge of Human Performance Tools) - "This event did not have any significant adverse effect on safety."

Corrective Action Program (CAP) Procedure Non-compliance

The team identified concerns with the corrective action program implementation where the station practices were not consistent with procedural guidance. The licensee's corrective action program governing document (AD-AA-106, "Corrective Action Program (CAP) Process Procedure") made numerous references to the Condition Review Group's (CRG) responsibilities and functions. However, the CRG had been disbanded some time earlier. The inspectors did not identify any significant concerns as a result because it appeared, to the inspectors, that the CRG's functions and responsibilities were implemented by other station personnel. Nonetheless, the inspectors were concerned that while it was apparently well known that the CRG no longer existed, station personnel did not modify procedure AD-AA-106 to match actual practices at the station. This issue was evaluated as a violation of minor safety significance with no further action required.

During this inspection, multiple examples of failure to follow procedure were identified and reviewed (reference Section 4OA2.1 of this report). An adverse performance trend in procedural compliance appeared to be developing in several cornerstone elements. The inspectors also noted examples of procedural adherence issues associated with AD-AA-106 "Corrective Action Process Program Procedure", Section 4.6.2.2, Class B Evaluation. Step 4.6.2.2 of AD-AA-106 "Corrective Action Process Program Procedure" required that "**If** the CR identifies a potential trend, **then** a class B CCA shall be performed to further review the data to determine whether the trend is valid. **If** the potential trend is validated (i.e., common causes are identified), **then** a new CR shall be initiated." The inspectors were unable to locate CRs generated as a result of licensee personnel validating a common cause or trend. Interviews with station personnel

revealed that they were not writing the required subsequent CRs when common causes were identified. In contrast to the procedural requirements, the licensee failed to initiate new condition reports following a Class B Common Cause Analysis when a potential trend was validated. The licensee documented the procedural adherence issue in Condition Report L2001-05717.

Significance Evaluation

The inspectors performed a risk significance screening of this finding in accordance with NRC Inspection Manual Chapter 0610*, "Power Reactor Inspection Reports," Appendix B, "Thresholds for Documentation." Because the failure to initiate CRs when common causes or trends were identified did not have an actual or credible impact on safety, the issue was not evaluated using NRC Manual Chapter 0609, "Significance Determination Process". However, the finding was more than minor based on extenuating circumstances (Group 3 questions). The finding was considered to be a substantive cross-cutting issue because the issue was captured in a number of examples noted in the different functional areas examined during the inspection and across plant departments which indicated an adverse performance pattern.

Enforcement Actions

This finding was a substantive cross-cutting issue. However, since no significant performance issues occurred from the procedural adherence issue, the finding was considered to be of very low safety-significance (No Color). 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires that activities affecting quality be prescribed by documented procedures of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions. The failure to adequately comply with the procedure to further evaluate common cause analysis outcomes did not allow the licensee to fully identify further recommendations for evaluation and associated corrective actions. The procedural adherence issue was an example where this criteria was not met and was a violation. However, because of the very low safety-significance of the item and because the licensee has included this item in their corrective action program (Condition Report L2001-05717), this violation is being treated as a Non-Cited Violation (NCV 50-373/2001016-01).

.3 Effectiveness of Corrective Action

a. Inspection Scope

The inspectors reviewed selected CRs and associated corrective actions to evaluate the effectiveness of corrective actions. The inspectors reviewed Condition Reports, operability determinations, and root cause reports to verify that corrective actions, commensurate with the safety significance of the issues, were identified and implemented in a timely manner, including corrective actions to address common cause or generic concerns. The inspectors also verified the implementation of a sample of corrective actions. The samples were selected based on their importance in reducing operational risks. The inspectors reviewed information recorded since July 2000.

A listing of the specific documents reviewed is attached to the report.

b. Findings

One Green finding and an associated Non-Cited Violation were identified for ineffective corrective actions associated with understanding of Technical Specification LCO entry requirements.

The station adequately corrected most identified issues. The inspectors' review of licensee event reports (LERs) identified no significant concerns. Additionally, the inspectors' review of NCV corrective actions indicated that the licensee's proposed actions were completed as scheduled and the actions appeared appropriate in most cases as evidenced by lack of repeat items. Some of the self-revealing and long standing material condition concerns, and trends in some of the human performance areas (Technical Specification compliance and procedure adherence) indicated that corrective actions were not effective in all cases. For example, the licensee's corrective actions associated with operator understanding of the RCIC injection check valve Technical Specification requirements were narrowly focused, not timely, and did not prevent recurrence of the issue.

RCIC System Technical Specification Requirements

Operators failed to appropriately enter Technical Specification 3.4.6, "Reactor Coolant System (RCS) Pressure Isolation Valve (PIV) Leakage" following the Unit 2 scram on April 6, 2001 (reference Special Inspection report 2001-09). A similar event involving operator understanding of the implementation and entry requirements for the same Technical Specification occurred during the September 3, 2001 reactor scram.

Both scrams resulted in a RCIC system injection and the associated testable check valves indicating open after the RCIC system was secured. Following an evaluation of operator performance during the April 6 scram, the licensee implemented corrective actions to address the operators knowledge deficiency. Following the September 3, 2001 scram, five months after the April event, the inspectors identified that while the crew on shift during the event entered the appropriate Technical Specification they failed to properly implement the associated procedure. Further, in discussions with the on-coming crew, the NRC identified that they were not aware of the entry conditions for Technical Specification 3.4.6.

Even though the two events were separated by five months, the licensee's corrective actions to address the operator knowledge deficiency were not performed in a timely manner to prevent recurrence of the event. The licensee documented the Technical Specification issue in Condition Report L2001-05119 and concluded that the issue was due to a knowledge deficiency on the applicability of Technical Specification 3.4.6 to the Reactor Core Isolation Cooling (RCIC) System testable check valves.

Significance Evaluation

The inspectors performed a risk significance screening of this corrective action finding in accordance with the guidance contained in Appendix B, "Thresholds for Documentation," of Inspection Manual Chapter (IMC) 0610*, "Power Reactor Inspection Report." The inspectors evaluated the issue with the SDP Group 1 questions and

concluded that the failure to correct the lack of understanding of the RCIC Technical Specification requirements was more than minor in that, if left uncorrected, the issue could under the same condition become a more significant safety concern. Lack of operator knowledge has the potential for placing the facility in a condition outside the technical specifications. Using the Group 2 questions, the inspectors concluded that the issue could credibly affect the availability, reliability, or function of a mitigating system. The lack of knowledge by licensed operators had the potential to compromise the containment isolation system's function. The Group 3 question, item 6, was addressed and the issue was determined to be greater than minor during review of Group 1 questions, resulting in the issue being screened Green.

Enforcement Actions

10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," required that measures shall be established to assure that conditions adverse to quality, such as deficiencies, are promptly identified and corrected. The failure to promptly correct the deficiency in operators' understanding of Technical Specifications requirements was an example where the requirements of 10 CFR 50, Appendix B, Criterion XVI, were not met and was a violation. However, because of the very low safety significance of the item and because the licensee has included this item in the corrective action program (Condition Report L2001-05119), this corrective action violation is being treated as a Non-Cited Violation (NCV 50-373/2001016-02).

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The inspectors interviewed plant staff to assess whether there were impediments to the establishment of a safety conscious work environment.

During the conduct of interviews, document reviews and observations of activities, the inspectors looked for evidence that suggested plant employees may be reluctant to raise safety concerns. The inspectors also discussed the implementation of the Employee Concerns Program (conducted per EI-AA-101, "Employee Concerns Program") with the station's program owner and the corporate point of contact. Additionally the inspectors reviewed a recent outside audit of the station's Employee Concerns Program.

b. Findings

There were no significant issues or findings identified.

No "chilling" effect was noted by the inspectors and employees were free to raise issues for entry into the corrective action program. However, during interviews with station personnel, some individuals indicated a reluctance to initiate a CR against their peers. The inspectors concluded that the station was missing potential opportunities to identify and enter issues into the corrective action program as a result. The inspectors also

noted the potential for this reluctance to initiate CRs to possibly impact the station's ability to identify and document human performance and procedure adherence concerns.

4OA6 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. C. Pardee and other members of licensee management on October 2, 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.

PARTIAL LIST OF PERSONS CONTACTED

Exelon

K. Bartes, Nuclear Oversight
B. Bartlett, Security
R. Bellettini, Regulatory Assurance, Corrective Action Program
D. Bost, Site Engineering Manager
D. Czufin, Engineering
A. Duncan, Regulatory Assurance
S. DuPont, Regulatory Assurance
D. Enright, Operations Manager
F. Gogliotti, Design Engineering Supervisor
G. Graff, Operations
J. Henry, System Engineering Manager
G. Kaegi, Training Director
P. Lucky, Work Control
R. McConuaughy, Work Management
M. Okopny, Operations
C. Pardee, Site Vice President
G. Randle, Maintenance
W. Riffer, Regulatory Assurance Manager
M. Schiavoni, Station Manager
S. Taylor, Radiation Protection Manager

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-373/200116-01;50-374/200116-01	NCV	Failure to Follow Procedure adequately comply with procedural requirements to further evaluate common cause analysis outcomes.
50-373/200116-02;50-374/200116-02	NCV	Failure to promptly correct condition adverse to quality (operators' lack of recognition of Technical Specification entry requirements).

Closed

50-373/200116-01;50-374/200116-01	NCV	Failure to Follow Procedure adequately comply with procedural requirements to further evaluate common cause analysis outcomes.

50-373/200116-02;50-374/200116-02	NCV	Failure to promptly correct condition adverse to quality (operators' lack of recognition of Technical Specification entry requirements).

Discussed

None

LIST OF ACRONYMS USED

CAP	Corrective Action Program
CFR	Code of Federal Regulations
CR	Condition Report
DRP	Division of Reactor Projects
EDG	Emergency Diesel Generator
HPCI	High Pressure Coolant Injection
IR	Inspection Report
LCO	Limiting Condition for Operation
LER	Licensee Event Report
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
OPEX	Operating Experience
PI&R	Problem Identification and Resolution
PMT	Post-Maintenance Testing
RCR	Root Cause Report
SDP	Significance Determination Process
SRO	Senior Reactor Operator
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report

LIST OF BASELINE INSPECTIONS PERFORMED

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

Inspection Procedure		
Number	Title	Report Section
71152	Problem Identification & Resolution	4OA2
(none)	Meetings, Including Exit	4OA6

LIST OF DOCUMENTS REVIEWED

The following is a list of licensee documents reviewed during the inspection. Inclusion of a document on this list does not imply that NRC inspectors reviewed the entire document, but, rather that selected sections or portions of the document were evaluated as part of the overall inspection effort. In addition, inclusion of a document on this list does not imply NRC acceptance of the document, unless specifically stated in the body of the inspection report.

Corrective Action Program (CAP) Description

CAP-3	Root Cause Investigation and Report Handbook, Revision 4
CAP-4	Common Cause Analysis Handbook, Revision 1
CAP-5	Effectiveness Review Handbook, Revision 1
CAP-6	Coding and Trending Handbook, Revision 3
CAP-8	Apparent Cause Evaluation (ACE) Handbook, Revision 2
CAP-9	CAPSYS Process Instruction Handbook, Revision 1
CAP-10	Corrective Action Program (CAP) Guidance and Expectations Handbook, Rev. 2

Procedures

AD-AA-106	Corrective Action Program (CAP) Process Procedure, Revision 3
LS-AA-127	Passport Action Tracking Management Procedure, Revision 0
CWPI-NSP-AP-1-1	Corrective Action Program Process Manual of Common Work Practice Instructions; Instruction One Event Response Guidelines, Revision 1
LAP-200-7	Event Frequency Reduction Post Event Review Program, Revision 7
EI-AA-101	Employee Concerns Program
RS-AA-115	OPEX Reviewer's Guidelines

Condition Reports (CRs)

L2001-05119	ITS Applicability Issue
L2001-02897	NOS Identified: No formal tracking of standard administrative expiration date
L2001-02912	Ineffective CAPR identified during EFR #000114221-14
L2001-01646	LER and Root Cause Report Corrective Actions Do Not Correlate
L2001-01528	Mid Cycle Assessment Identified Deficiencies in CAP Program
L2001-01205	Regulatory Assurance and D.G. Collegial Review of LaSalle Root Cause Report
L2001-00641	N.O. Identified: (ENRE Issue) Corp. Reactor Engineering ACE Quality Issues
L2001-00594	Incorrect Revisions of Root Cause Reports Submitted to NSRB
L2001-00143	N.O. Identified: (RP): A SAC Voting Member Not Attending Meetings on a Reg. Basis
L2001-00155	Trending Data in CAPSYS Not Valid
L2001-00010	Regulatory Assurance Manager and Downers Grove Review of Root Cause Report
L2000-07460	N.O. Identified: System Engineering Accelerated Investigation Concerns

L2000-07205	N.O. Focus on Human Performance During Observations in the Plant Needs Improvement
L2000-07349	N.O. Identified: Chemistry, RCR,TIR, and ACE Corrective Action Issues
L2000-07348	N.O. Identified: Chemistry, RCR,TIR, and ACE Corrective Action Issues
L2000-07340	N.O. Identified: Class B (ACE) Evaluation Corrective Actions Overdue
L2000-07370	N.O. Identified: Radiation Protection ACE Quality Issues
L2000-07381	N.O. Identified Missed Opportunity - Unit 2 Scram
L2000-06969	Thermocouple for Cavity Temperature Measurement During ADHR Was in the Wrong Unit's Fuel Pool
L2000-06983	Failure to Meet RCIC Pump Inservice Test Conditions During LOS-RI-Q3
L2000-07041	Corrective Action Not Created From a Completed Trend Investigation AR00020130
L2000-06953	N.O. Identified: Incomplete Closure Documentation to a Corrective Action by Radiation Protection
L2000-06036	NSRB Sub-Committee Raised Question on Root Cause Report for P-bypass Extent of Condition
L2000-06720	Unit 2 Division 1 Gross Gamma Failed to Re-energize During Response Time Testing
L2000-00886	Part 21 Transfer of Info SC 00-01 on GE AK and AKR Circuit Breakers
L2000-06719	Corrective Action Program Fails to Assign Work Appropriately
L2000-06760	MRC Rejected AR 22713-18 Effectiveness Review
L2000-06752	D.G. Nuclear Oversight Review of Recent LaSalle Root Cause Report #35031
L2000-04284	Adverse Trend in MRM Report
L2000-04962	CAP Trend Review of Engineering Plant Observations/Walkdowns
L2000-03918	N.O. (CAP) Identified:Potential Adverse Trend :Inattention to Detail Errors
L2000-04133	N.O. (CAP) Identified: Potential Adverse Trend :Management Leadership Effectiveness
L2000-04330	NRC Identified: Adverse Trend of Low Level Scrams (Feedwater Concerns)
L2000-04345	N.O. (CAP) Identified: Potential Adverse Trend with Personnel Injuries
L2000-06732	N.O. Identified: Root Cause Report Corrective Action Overdue
L2000-06731	N.O. Identified: Class B (ACE) Evaluation Corrective Action Overdue
L2000-06653	Exceeded Maximum Interpass Temperature During Welding of Spec Flange Replacement
L2000-06907	Component Failure During L2R08 Exams
L2000-06906	Failed Component During L2R08 FAC Inspections
L2000-06904	Component Failure During L2R08 FAC Exams
L2000-06899	Increased Leakage From RBCCW Heat Exchanger WS TCV's
L2000-06741	UT & VT Indication in LP Core Spray Piping Inside the Reactor
L2000-07067	Potential Adverse Trend in RP
L2000-05982	Potential Adverse Trend with Personnel Injuries
L2001-00445	Lack of Radiography for the Bonnet Repair of 2B21-F508A
L2001-00574	Pre-Service VT-1 Exam not Performed on New CRD Capscrews
L2001-00304	Recommend Additional Corrective Actions for Inoperable IST Valve
L2001-04912	NRC Identified Potential Operability Issue Portable Fan on 1A D/G CWP Suction Piping
L2001-00444	N.O. Identified: (RA, MULT Depts.) Potential Adverse Trend in (CAP) Issues

L2001-05433	NOS Identified: Unnecessary Shipping/Packing Materials Found in RWTB Filter Aisle
L2001-05431	NOS Identified: (RP) Discrepancies Identified with Calibration Facility Documents
L2001-05432	NOS Identified: (RP) Daily Source Check Instrument Sticker Discrepancies
L2001-05430	NOS Identified: (RP) In-Field dose Rate Instrument Found Out-of-Calibration
L2001-05436	NOS Identified: (RP) Radiological Labeling Discrepancies
L2001-03823	Adverse Trend Identified with NEI Indicator - “Unplanned Scrams”
L2001-00069	Adverse Trend Identified with NEI Indicator - “Unplanned Scrams”
L2001-00768	Adverse Trend Identified withNEIIndicator - “Unplanned Power Changes”
L2001-02894	Adverse Trend Identified for Low Level Human Performance Errors
L2001-05247	Potential 10CFR21 for Bussmann JCW-1E Fuses
L2001-02357	NRC Identified U2 Div 2 125 V Battery Cable Not Tie-Wrapped
L2001-04341	NRC Identified 2B EDG “B” Air Compressor Running with Normal Air Pressure
L2001-02079	NRC Concern About U-1/2 DWEDS
L2001-01314	NRC Identified Nylon Contamination Barrier
L2001-04968	Deficiencies Found on the Vendor Supplied
L2001-04541	NRC Identified U1 Issues Spring Can Support
L2001-03804	NRC Identified Loose U-Bolt
L2001-03494	NRC Resident Housekeeping Tour
L2001-03383	NRC Identified Material Condition
L2001-01928	NRC Identified Air Leak
L2001-00074	NRC Identified Incomplete Evaluation
L2000-06427	APRM GAF Adjustments Needed
L2000-06280	NRC Identified Undocumented Material in Plant
L2000-04935	NRC Identified U1 Div 1 Battery Support Loose
L2000-04934	NRC Identified 1A Supply Switch Partially Closed
L2001-03119	IMD Procedural Adherence is Poor LPRM Gain Adjustments
L2001-02225	LIP-6M-964 Stopped Due to Procedure WRGM (SPING) Procedure
L2001-0931	NRC Identified Failure to Record LPCS Motor Oil Level
L2001-02357	NRC Identified U2 Div 2 125V Battery Not Performed IAW TMOD
L2001-01552	NRC Identified Documentation Not Signed FME Paperwork
L2001-02237	Portions of LOS-RH-Q1 IC Were Repeated
L2001-01750	Missed OOT on Review
L2001-01413	Level Correction on Specific Gravity Signing of Steps Before Complete
L2001-00238	GSEP Exercise Comments and Improvements
L2001-00389	Recommendations Identified During GSEP Tabletop
L2001-00737	GSEP Table Top Critique Items
L2001-04949	Emergency Preparedness Drill Critique Items

Action Requests (ARs)

AR00050588	Perform OPEX Review of NRC Information Notice 2001-04
AR00052012	Perform OPEX Review of NRC Information Notice 2001-07
AR00041943	Perform OPEX Review of NRC Information Notice 2000-21
AR00035767	Perform OPEX Review of NRC Information Notice 2000-14

AR00032280	GE SIL 630 Physical Separation of Circuits for Low Pressure Emergency Core Cooling systems
AR00042415	GE SIL 631 Zinc Injection Following NobleChem Application
AR00042149	GE SIL 632 Pressure Drop due to LPCI Flow Deflector
AR00050570	GE SIL 635 Reactor Core Isolation Cooling System Water Hammer

Effectiveness Reviews

AR00001898	Perform an Effectiveness Review For Improving Safety Culture
AR00002245	Perform an Effectiveness Review For Corrective Actions
AR00004039	L1999-01301 Radioactive Tool Found Outside the RPA
AR00007845	L2000-00241 failure of 1A DG to Start During LOS-DG-M2 Idle
AR00018109	L1999-04953 New Fuel Assembly Orientation Inconsistencies
AR00019292	L1999-05608 Fuel Bundle Mis-Oriented
AR00022713	L2000-00355 Level Indication Change When Selecting C Level
AR00030675	L2000-03414 Unit 2 Scrammed Due to Low Reactor Water Level

Common Cause Analysis (CCA) Action Requests

AR00019230	L2000-05982 Potential Adverse Trend with Personnel Injuries
AR00031989	L2000-03918 N.O. Identified Potential Adverse Trend
AR00035042	L2000-05070 Superceded RS-AA-104.02 Form (50.59 Screening Form)
AR00040268	L2000-07067 Potential Adverse Trend in RP
AR00041164	L2000-07366 FME Work Practice Weaknesses
AR00043101	L2001-00411 Body to Bonnet Leak On Another HD Valve
AR00043633	L2001-00529 Electrician Shocked While Performing Modification
AR00043753	L2001-00478 Inadequate Information Provided on Op Evaluation
AR00053835	L2001-03288 NEI Indicator R.IE.01 Unplanned Scrams
AR00055031	L2001-03582 HPCS Cable Fire Protection Separation
AR00056617	L2001-03972 Rework Issue - Relief Valve Leaks by Seat

Root Cause Reports

L2000-04349	NRC Identified: Concerns Regarding Configuration Control of Replacement HVAC Filters
L2000-05114	2A Diesel Control Switch Mispositioning
L2000-06981	U-2 RX Automatic Scram From Hi Rx Water Level
L2001-00604	Unit 1 Scram
L2001-00701	Unit Scram Due to 345 kV Phase to Ground Fault
L2001-01299	Framatome (Siemens) Notification of Code Error That Caused Non-Conservative Thermal Limits
L2001-02137	U-2 Reactor Scram
L2001-02667	1B DG Shutdown Due to Operator Error
L2001-04537	Unit 2 Potential Overpower

Licensee Event Reports (LERs)

L2000-03414	Unit 2 Scrammed Due to Low Reactor Water Level

L2000-04909	Unit 2 Division 2 RCIC Isolation
L2000-05114	2A Diesel Control Switch Mispositioning
L2000-06981	U2 Reactor Automatic Scram From Hi Reactor Water Level
L2001-00604	Unit 1 Scram
L2001-02137	U-2 Reactor Scram

LaSalle Audits and Assessments

LaSalle Nuclear Safety Review Board Meeting; October 24 and 25, 2000
LaSalle Nuclear Safety Review Board Meeting; January 30 - 31, 2001
LaSalle Nuclear Safety Review Board Meeting; April 10 - 11, 2001
LaSalle Nuclear Safety Review Board Meeting; July 16 and 17, 2001
Nuclear Oversight Audit; NOA-01-00-ES09 CAP Assessment Report
Nuclear Oversight Audit; LOS-LS-00-4Q Fourth Quarter 2000 Report
Nuclear Oversight Audit; LOA-LS-01-1Q First Quarter 2001 Report
Nuclear Oversight Audit; LOA-LS-01-2Q Second Quarter 2001 Report
Nuclear Oversight Audit; Common CAP Assessment Multi-Site Roll-Up
Operations Department Focus Area Self-Assessment; March 01, 2001 to March 26, 2001
Operations Department Focus Area Self-Assessment; May 01, 2001 - June 25, 2001
Maintenance Monthly Assessment; April, 2001
Maintenance Monthly Assessment; May, 2001
Maintenance Monthly Assessment; June, 2001
Maintenance Monthly Assessment; July, 2001
Maintenance Monthly Assessment; August, 2001
First Quarter 2001 Focus Self Assessment; Operations Comprehensive Assessment
First Quarter 2001 Focus Self Assessment; Operator Rounds
First Quarter 2001 Focus Self Assessment; Corrective Action Program Implementation
First Quarter 2001 Focus Self Assessment; Lesson Learned Review of Continuous Assessment
Second Quarter 2001 Focus Self Assessment; Technical Specification Compliance
Second Quarter 2001 Focus Self Assessment; Self Identification of Maintenance Issues
Second Quarter 2001 Focus Self Assessment; Effectiveness of Using Performance Indicators to Improving Performance
LaSalle Station Self-Assessment Report Security Department 1st Quarter 2001
LaSalle Station Security Areas 2nd Quarter 2001
LaSalle Station Self-Assessment Report Radiation Department 1st Quarter 2001
LaSalle Station Radiological Protection Areas 2nd Quarter 2001

Non-Cited Violations

50-373/200011-02;50-374/200011-02	Inadequate Suppression Pool Temperature Correction Design Basis
50-373/200012-01;50-374/200012-01	Failure to Identify, Correct, and Prevent Recurrence of Delinquent ASME Code Requirements
50-373/200012-02;50-374/200012-02	Failure to Identify and Correct Discrepancies Regarding Replacement Air Intake Filters Associated with the 2B EDG
50-373/200013-01;50-374/200013-01	3-Hour Fire Barrier Degradation
50-373/200018-01;50-374/200018-01	Failure to have Adequate Procedure

50-373/200019-01;50-374/200019-01	Suppression Pool Debris
50-373/200102-01;50-374/200102-01	Inadequate Temporary Modification
50-373/200102-02;50-374/200102-02	Unit 2 Div 2Post-LOCA Monitoring
50-373/200102-03;50-374/200102-03	Unit 2 Offgass Radiation Monitor Isolated
50-373/200103-01;50-374/200103-01	1RFO12 Primary Containment Isolation Valve Leakage
50-373/200107-01;50-374/200107-01	Inoperable Containment Radiation Monitors
50-373/200107-03;50-374/200107-03	Dampers Open Without HELB Review
50-373/200107-04;50-374/200107-04	Inadequate Gamma TIP Modification

NRC Inspection Reports

IR 50-373/00-11(DRP);50-374/00-11(DRP)
IR 50-373/00-12(DRP);50-374/00-12(DRP)
IR 50-373/00-13(DRP);50-374/00-13(DRP)
IR 50-373/00-14(DRS);50-374/00-14(DRS)
IR 50-373/00-15(DRS);50-374/00-15(DRS)
IR 50-373/00-16(DRS);50-374/00-16(DRS)
IR 50-373/00-18(DRP);50-374/00-18(DRP)
IR 50-373/00-19(DRP);50-374/00-19(DRP)
IR 50-373/00-20(DRS);50-374/00-20(DRS)
IR 50-373/01-01;50-374/01-01(Annual Assessment Letter)
IR 50-373/01-02(DRP);50-374/01-02(DRP)
IR 50-373/01-03(DRP);50-374/01-03(DRP)
IR 50-373/01-04(DRS);50-374/01-04(DRS)
IR 50-373/01-05(DRS);50-374/01-05(DRS)
IR 50-373/01-06(DRS);50-374/01-06(DRS)
IR 50-373/01-07(DRP);50-374/01-07(DRP)
IR 50-373/01-08(DRP);50-374/01-08(DRP)
IR 50-373/01-09(DRP);50-374/01-09(DRP)