Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

June 2, 1993

U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Attention: Document Control Desk

Subject: LaSalle County Station Units 1 and 2
Response to Notice of Violation
Inspection Report Nos. 50-373/93010; 50-374/93010
NRC Docket Numbers 50-254 and 50-265

Reference: G.C. Wright letter to L.O. DelGeorge dated April 20, 1993 transmitting NRC Inspection Report 50-373/93010; 50-374/93010

Enclosed is Commonwealth Edison Company's response to Notice of Violation (NOV) which was transmitted with the referenced letter and Inspection Report. The violations concerned inadequate corrective actions.

Based on a teleconference between D. Schrum and Sara Reece-Koenig on 5/17/93 an extension to June 2, 1993 for the response due date was granted.

If there are any questions or comments concerning this letter, please refer them to Sara Reece-Koenig, Regulatory Performance Administrator at (708) 663-7250.

Respectfully,

Dennis L. Shamblin for

D.L. Farrar
Nuclear Regulatory Services Manager

cc: J. B. Martin, Regional Administrator, RIII
R. Stransky, Project Manager, NRR
D. Hills, Senior Resident Inspector, LaSalle

IE01 1/1

ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
373(374)/93010

VIOLATIONS: 373(374)/93010-01 (examples a and b), and 02

During an NRC inspection conducted on March 22 through 29, 1993, two violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violations are listed below:

1. 10 CFR 50, Appendix B, Criterion XVI, states, in part, that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

   a. Contrary to the above, on March 29, 1993, conditions adverse to quality had not been promptly corrected. Three fire doors remained inoperable for an extended period of time: fire door 406 since October 31, 1990, and fire doors 262 and 393 since April 11, 1991 (373/374/93010-01a(DRS)).

   b. Contrary to the above, the licensee's corrective actions on March 15, 1991, were not effective at precluding repetition of a condition adverse to quality that occurred when welding and grinding sparks fell down a shaft and caused a fire. On January 31, 1993, a fire ensued from grinder sparks when the licensee failed to remove or protect combustibles within 35 feet of grinding activities (373/374/93010-01b(DRS)).

   This is a Severity Level IV violation (Supplement I).

2. 10 CFR 50, Appendix R, Section III.J, states that emergency lighting units with at least an 8-hour battery power supply shall be provided in all areas needed for operation of safe shutdown equipment and in access and egress routes thereto.

   Contrary to the above, as of March 22, 1993, emergency lighting units were not provided in all areas needed for operation of safe shutdown equipment when work was stopped on Modification M-1-2-89-031 in November 1992 (373/374/93010-02(DRS)).

   This is a Severity Level IV violation (Supplement I).

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REASON FOR THE VIOLATION: Example 373(374)/93010-01a

Commonwealth Edison agrees that the doors involved in this violation example could have been replaced in a more timely manner. The doors needed to be replaced and were declared inoperable by us as part of our surveillance/work request program. Appropriate compensatory action was taken in accordance with the Technical Specifications. A review of the history indicates two basic causes for the extensive time involved. First, the process for specifying, purchasing, inspecting, and issuing fire doors prior to 1993 did not address a feedback or follow-up mechanism to the requestor for items which encountered problems. An evaluation of the process, which was in place by the beginning of 1993, revealed that this process had been improved. A feedback/follow-up mechanism now exists, but no provision was made to review material the request backlog to ensure this type of problem was found and incorporated into the improved process for similar items. Second, a process to ensure the initial priority of a request was appropriate and to resolve or evaluate the priority if problems were encountered was not clear. Priorities were based on "need" as defined by Operations, Technical Specification LCOs, or other commitments. In the case of the fire doors, LCO actions were being met through the allowed compensatory measures.

CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED:

1) The three doors identified in this violation have been replaced and the required compensatory measures have been terminated.

2) The process for specifying, purchasing, inspecting, and issuing requested material, including fire doors, had been improved prior to 1993, and no further action is necessary for the process.

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THE CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:

1) A review of the computerized material data base for items not having an identified "needed by" date will be conducted. Respective departments will be notified of the omission and requested to provide an appropriate date. The computerized data base will be updated with the requested dates. These activities will be completed by October 10, 1993.

2) An evaluation of the current prioritization process for material request will be conducted to determine any needed improvements. Identified improvements will be in place and necessary training conducted by August 10, 1993.

THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved with the installation of the fire doors.

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373(374)/93010

REASON FOR THE VIOLATION: Example 373(374)/93010-01b

Commonwealth Edison does not dispute the facts presented in the examples of the violation, and agrees that a violation occurred. We view the two events as having different causes.

The March 15, 1991 event revealed weak procedural guidance. The corrective actions for this event addressed the issue of combustibles below a work area which may be ignited. The corrective actions required removal of combustibles located below a work area and/or provide protective covers to prevent sparks from falling. These actions were adequate to prevent further problems of this nature.

The January 31, 1993 event was a result of the Maintenance Supervisor's failure to thoroughly survey the job site area as required by LAP-900-10, "Fire Prevention Procedure For Welding and Cutting." This requirement existed prior to the 1991 event, and was not related to the corrective actions of that event. A survey was conducted, but it was not thorough enough.

CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED:

Relative to the March 15, 1991 event, no additional corrective actions were necessary.

The corrective actions taken for the January 31, 1993 event, involved the Fire Marshal conducting a review of the procedure with the work group involved, specifically stating that combustibles within 35 feet of a "hot work" job shall be removed or covered. The supervisor involved was counselled on performance expectations involving the January event.

THE CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:

No additional corrective actions are necessary.

THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved with the counselling of the supervisor.

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NRC INSPECTION REPORT
373(374)/93010

REASON FOR THE VIOLATION: 373(374)/93010-02

Commonwealth Edison does not dispute the facts presented in this violation, however the status of modification M-1-2-89-031 between November 1992 and April 1993 needs to be clarified. This modification is the final phase of plant wide enhancements to the emergency battery pack lighting at LaSalle station to bring our standards above the minimum safe shutdown requirements. This project was developed from the lessons learned by the reviews of other CECO station inspection reports, upgrading to Emergency Operating Procedures (EOP) requirements, and as a result of plant/procedure changes. This effort has spanned approximately four years with an investment exceeding $5,000,000. This project has included periodic reviews of the design details and lessons learned from previous installation activities to aid in completing the project in the most timely and efficient manner. The construction field activities of this project were temporarily suspended in November of 1992. A review of the remaining design was performed to enhance constructability and obtain additional funding. Scope review continues to ensure lighting benefits are balanced with ALARA.

CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED:

Field work recommenced in early April 1993 as planned.

THE CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:

No additional corrective action is planned.

THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance will be achieved upon completion of modification M-1-2-89-031 by December 31, 1993.