Commonwealth Edison
LaSalle County Nuclear Station
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Marseilles, Illinois 61341
Telephone 815/357-6761

December 17, 1993

Director, Office of Enforcement
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 and Proposed Imposition of Civil Penalty (NRC Inspection Report 50-374/93025) NRC Docket Number 50-374, and payment of Civil Penalty.

References: 1. W. L. Axelson letter to L. O. DelGeorge, Dated September 27, 1993, Transmitting NRC Inspection Report 50-374/93025.

2. John B. Martin letter to M. J. Wallace, Dated November 17, 1993, Transmitting the Notice of Violation and Proposed Imposition of Civil Penalty.

Enclosed is Commonwealth Edison's response to the subject Notice of Violation and Proposed Imposition of Civil Penalty, and payment of Civil Penalty. The violations related to the September 7, 1993 refuel floor contamination event and involved (1) the failure to adequately evaluate the job and make necessary surveys, (2) failure to use engineering controls to limit airborne radioactivity, and (3) failure of workers to wear respirators. Our response to these specific violations is included in the Attachment. We do not contest your action to classify the violations in the aggregate as a Severity Level III problem or the proposed fine. Accordingly enclosed is a check in the amount of $112,500.

Although the attachment addresses the specific violations, of greater concern to us is our apparent weakness in recognizing all of the precursor events and in establishing and managing a comprehensive plan for performance improvement. The examples cited by the NRC during this inspection and other events at LaSalle led us to commission a special team to review overall station performance, including the Radiation Protection (RP) area. The review methodology was patterned after the NRC's Diagnostic Evaluation module. The team was made up of 27 individuals with 16 members coming from offsite organizations. Several of the team members had recently participated in the Quad Cities Business Development Team which interfaced directly with the NRC DET during that inspection. The team assessed station performance from October 25 through November 12, 1993 and issued their report on November 29, 1993.

The team identified several deficient performance areas, found the existence of common themes throughout, and cited several root causes underlying performance deficiencies including: (1) the lack of a process to increase standards of performance, (2) weak communication of management expectations and sustained accountability for their implementation, and (3) low success at quickly identifying and correcting areas of deteriorating performance. The team's findings were shared with the station staff during information meetings held on December 6 & 7, 1993.

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Recd w/check for $112,500.00. Ck # 1030306

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We are committed to eliminating these underlying problems which are impacting LaSalle's performance. By the end of January, 1994, a comprehensive action plan will be developed to respond to the Team report findings. Accountability for identification of appropriate corrective actions, their implementation, and an effectiveness review will be assigned to station senior managers and will be overseen by myself. Safe plant operation and sustained improved performance are imperative for LaSalle County Station.

In August of 1993 we replaced the Radiation Protection Manager and have planned a significant reorganization of RP personnel which will be in effect January 3, 1994. This transition will place people where they can be most effective and will allow the supervisors to spend more time in the radiation control area of the plant. An aid to the training effort has been the transfer of an experienced degreed Health Physicist to the Training Department. This person will be developing a process for feedback in the functional area which will improve both training and RP performance. We have just recently completed phase one of our team building sessions for the RP Department. We are undergoing many process improvements including the following areas: (1) an efficiency review of the RP procedures, (2) RWP program improvements, (3) pre-job planning process improvements, (4) increasing RP emphasis in NGET training and beginning advanced radiation worker training, and (5) embarking on a pilot customer focus training program. These changes will establish the baseline for future performance improvements in the RP area.

Should you have any questions regarding the specific violation response, please refer them to JoEllen Burns, Regulatory Performance Administrator at (708) 663-7285. If you wish to discuss the team report findings please contact me directly.

Respectfully,

W. P. Murphy
Site Vice President
LaSalle County Station

Signed and sealed on 17th day of December, 1993.

Glenna Bloomfield
Notary Public

OFFICIAL SEAL
GLENNA BLOOMFIELD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 12/05/96

cc: J. B. Martin, Regional Administrator, RIII
A. Gody Jr., Project Manager, NRR
D. Hills, Senior Resident Inspector, LaSalle
D. L. Farrar, Nuclear Regulatory Services Manager, NORS
J. E. Lockwood, Regulatory Assurance Supervisor, LaSalle

ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
50-374/93025

VIOLATION:

During an NRC inspection conducted from September 8 through 14, 1993, 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 Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954 as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

A. 10 CFR 20.201(b) requires that each licensee make such surveys as may be necessary to comply with the requirements of Part 20 and which are reasonable under the circumstances to evaluate the extent of radiation hazards that may be present. As defined in 10 CFR 20.201(a), "survey" means an evaluation of the radiation hazards incident to the production, use, release, disposal, or presence of radioactive materials or other sources of radiation under a specific set of conditions.

Contrary to the above, the licensee did not make surveys to determine that individuals would not be exposed to airborne concentrations exceeding the limits specified in 10 CFR 20.103. Specifically, on September 7, 1993, while performing work in the Unit 2 reactor cavity, breathing zone air surveys were not performed to evaluate the extent of the radiation hazards present during reactor vessel head stud removal. Furthermore, during evaluation of the job the licensee failed to recognize that radiological conditions would likely change in the cavity due to the exhaust of three pneumatic tools. (01013)

B. 10 CFR 20.103(b)(1) states that the licensee shall, as a precautionary procedure, use process or other engineering controls, to the extent practicable, to limit concentrations of radioactive materials in air to levels below those which delimit an airborne radioactivity area as defined in 10CFR 20.203(d)(1)(ii).

Contrary to the above, on September 7, 1993, while performing work in the Unit 2 reactor cavity, the licensee did not use engineering controls such as high efficiency particulate air filter ventilation or pneumatic tool air exhaust diffusers to limit concentrations of radioactive materials in air to levels below those which delimit an airborne radioactivity area. (01023)

C. Technical Specification 6.2.B states, in part, that radiation control procedures shall be adhered to.

Procedure LRP-1310-4, Revision 12, dated August 17, 1992, "Selection, Issuance, and Control of Radiological Respiratory Protective Equipment," Section F.1.a, requires Radiation Protection personnel to evaluate the respiratory protection requirements based on air sampling data and/or contamination surveys per Attachment B. Attachment B states, in part that smearable levels of greater than 100,000 dpm/100cm^2 for beta-gamma emitters will require the use of a full face mask pending air sample results which may relax the requirement.

Contrary to the above, on September 7, 1993, while performing work in the Unit 2 reactor cavity which had contamination levels greater than 100,000 dpm/100cm^2 for beta-gamma emitters in the primary work area, workers did not use full face masks and air samples were not taken. (01033)

This is a Severity Level III problem (Supplement IV).
Civil Penalty - $112,500.

REASON FOR VIOLATION:

A. We agree that the surveys performed were not adequate to completely evaluate radiological hazards and have concluded the reason for this failure was a lack of Radiation Protection (RP) Supervision for the Refuel Floor (RFF) job. This resulted in ineffective pre-job planning and a failure to consider that the crud under the grating would be dislodged by the use of pneumatic tools. Additionally, the Radiation Work Permit (RWP) that was utilized during the RFF event did not have all of the pertinent lessons learned information from past experience and IN 92-75.

B. We agree that we did not use engineering controls to mitigate or limit the creation of an airborne radioactivity area. The incomplete implementation of the Lead Technician concept, including incomplete training, resulted in a failure to consider that crud under the grating would be dislodged by the use of pneumatic tools if no lead/water shielding was used for dose control purposes. We acknowledge that we did not implement adequate corrective actions in response to IN 92-75. Additionally, the RWP that was utilized during the RFF event did not have all of the pertinent lessons learned information and understanding of the ventilation effects on the radiological conditions by personnel involved was limited.

C. We agree that we did not fully comply with radiation protection procedures. The procedure on non-use of respirators required the taking of an air sample whenever any smear in the work area exceeds 100K dpm/100cm^2. The procedure did not address the definition of work area. Contrary to the procedure, workers were permitted to initiate work without full face respirators and air samples were not obtained in this case due to inadequate supervision, lack of a questioning attitude, poor pre-job planning, limited information in the RWP for the RFF, and poor Radiation Protection Technician (RPT) performance.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

A Radiation Protection Technician (RPT) performed a complete survey of the reactor cavity, studs, and vessel head prior to any workers reentering the cavity. The survey included the tools and hoses. The results were below 100K dpm/100cm^2, however, as a conservative measure, respirators were worn for the remainder of work in the cavity. Other RFF workers reviewed the Radiation Work Permit (RWP) and RP Supervisors instructed workers on when and where to use a respirator. To aid in the air exchange and minimize airborne radioactivity within the cavity a HEPA filter system was set up and used at each stud as it was being extracted.

A RP Supervisor was assigned full time to refuel floor activities for the duration of the outage.

A two-person RP team, one Corporate and one offsite station person, reviewed work package preparation for the remaining LaSalle Unit 2 Refueling Outage 5 (L2R05) jobs involving high dose and/or contamination. Special emphasis was placed on inclusion of previous lessons learned information in the applicable RWP packages which aids in the pre-job planning process and was included in the appropriate work packages.

CORRECTIVE ACTIONS TO BE TAKEN TO AVOID FURTHER VIOLATIONS:

The Radiation Protection Manager (RPM) has been conducting one-on-one discussions with the RPTs. In these discussions, the RPM is reviewing this event with each RPT, emphasizing points where management expectations were not met and detailing what our future expectations are. These coaching sessions began the week of September 20, 1993 and will be completed by January 28, 1994.

Review of this event has been added to RPT initial and continuing training for the 1994 cycle. Continual Training will be completed by February 28, 1994.

A Corporate Health Physicist reviewed the effectiveness of the entire process for rad work planning. This included reviewing the method in which lessons learned are incorporated, including related history files, the alara review, and the pre-job planning process. Recommendations for general program improvement will be provided by January 14, 1994.

A RP guidance document, with job specific data for the RFF will be developed by February 28, 1994. Included in this document will be RP directions for all RFF activities, including the use of HEPA units or other engineering controls to be placed in the reactor cavity. In addition this RFF guidance document will include precautions on RFF ventilation effects.

Plant procedure LRP 1310-4 will be revised by January 10, 1994, removing the criteria on when respirators are required. This criteria will be included in LRP 5500-1 which is LaSalle's new 10CFR20 procedure on the Radiological Respiratory Program, which will be revised by January 10, 1994.

During the October 5, 1993 Enforcement Conference we stated that the Lead Technician program would be used to control RFF activities. Subsequent to the conference, we had determined that a better alternative for RFF activity control was to use a member of RP supervision who has responsibility for oversight of all activities on the RFF.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved on September 7, 1993 when the situation was rectified allowing workers to return to the job site.