

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-373/82-37(DPRP); 50-374/82-07(DPRP)

Docket No. 50-373; 50-374

License No. NPF-11, CPPR-99

Licensee: Commonwealth Edison Company  
Post Office Box 767  
Chicago, IL 60690

Facility Name: LaSalle County Station, Units 1 and 2

Inspection At: LaSalle Site, Marseilles, IL

Inspection Conducted: July 1-30, 1982

Inspectors:	<i>R. D. Walker for</i> W. Guldemond	<u>8-13-82</u>
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	<i>R. D. Walker for</i> M. Parker	<u>8-13-82</u>
	<i>R. D. Walker for</i> S. Stasek	<u>8-13-82</u>
	<i>P. C. Barrett</i> P. Barrett	<u>8-13-82</u>
Approved By:	<i>R. D. Walker</i> R. D. Walker, Chief Reactor Projects Section 1C	<u>8-13-82</u>

Inspection Summary

Inspection on July 1-30, 1982 (Report No. 50-373/82-37(DPRP); 50-374/82-07(DPRP))

Areas Inspected: Routine, unannounced resident inspection. The inspection consisted of Followup on Previously Identified Items, Operational Safety Verification, Monthly Maintenance Observation, Monthly Surveillance Observation, Licensee Event Report Followup, Plant Trips/Safety System Challenges, Part 21 Followup, Power Ascension Test Witnessing, Followup on Regional Requests, and Independent Inspection Effort. The inspection involved a total of 259 inspector-hours on-site including 40 inspector-hours on off-shifts.

Results: Of nine areas inspected, no items of noncompliance were identified in eight areas. One apparent item of noncompliance was identified in the remaining area (use of out-of-calibration test equipment-Paragraph 4).

## DETAILS

### 1. Persons Contacted

R. Holyoak, Superintendent, LaSalle Station  
G. J. Diederich, Operating Assistant Superintendent  
\*R. D. Bishop, Administrative and Support Services Assistant Superintendent  
J. G. Marshall, Operating Engineer  
\*J. C. Renwick, Technical Staff Supervisor  
\*R. Kyrouac, Quality Assurance Engineer

The inspectors also talked with and interviewed members of the operations, maintenance, health physics, and instrument and control sections.

\*Denotes personnel attending exit interviews.

### 2. Followup On Previously Identified Items

(Closed) Unresolved Item (373/79-34-01): Reference IE Reports 79-34, 79-39, 81-32, 81-48 and 82-18. The AE design control measures to verify or check the adequacy of the physical load design for cable tray intersections and control and instrument conduits.

In Letter #SCE-1651 dated June 17, 1982 from Mr. W. G. Schwartz, Sargent and Lundy to Mr. J. W. Giesecker, CECO, the architect engineer (S&L) stated that the cable trays and their supporting stiffeners at these [tray] intersections have been evaluated and found adequate for a 40 pound per square foot (psf) load at the entrances to the intersection and for 80 psf at the center of the intersection.

The letter identified an exception to the type of tray stiffeners which had actually been used at the LaSalle Station Unit 1. V-shaped stiffeners had been used in lieu of the stiffener bars specified in S&L Standard Series EB-700. On July 20, 1982, during a phone conversation, Mr. Giesecker stated that S&L had permitted the change of stiffener type in Purchase Specification J-2560.

Attached to the letter were the calculations for the physical loading of two tray intersections. Intersection 225C, 235C, 249C and 224C, which had been previously selected by the RIII inspector based on the appearance of being highly filled, had a calculated cable load of 32.86 psf. Tray intersection 239C, 226C, 225C, and 250C, which was identified by S&L as the heaviest loaded intersection (worst case), based on the sum of the design indices, had a calculated cable load of 46.68 psf. Both of these intersections were below the design limit of 80 psf.

No items of noncompliance were identified.

### 3. Operational Safety Verification

At 2:15 p.m. on July 25, 1982, the licensee exceeded the allowable heatup rate of Unit 1 during a critical heatup. The problem was caused by faulty heatup rate indication on the control board CRT display. By 3:45 p.m. on July 25, 1982 the licensee, in cooperation with General Electric, had performed the Technical Specification required engineering evaluation of the situation and had determined that no detrimental effects had resulted. As prompt corrective action was taken, this is not considered to be an item of noncompliance at this time.

At 11:50 p.m. on July 26, 1982, Unit 1 reactor was manually scrammed and the licensee declared an Unusual Event in response to drywell pneumatic system problems. At 2:00 p.m. on this date, the flexible supply hose for high pressure ADS activating gas on the "V" ADS valve ruptured. The south drywell high pressure pneumatic header was isolated. In so doing, makeup pneumatic supply to two additional ADS valves was lost. At the time of the event, the plant was in Mode 1 with individual rod scram time testing in progress.

Given these conditions, the Technical Specifications allow operation for up to 12 hours. Scram time testing was continued to completion for rod sequence B.

At 7:45 p.m. on July 26, 1982, low accumulator pressure alarms were received for all four Unit 1 inboard main steam isolation valves. The licensee, recognizing that this could represent a second failure in the drywell pneumatic system elected to conduct a controlled manual reactor scram to place the plant in a condition called for by Technical Specifications and to complete a portion of the required startup testing program. Declarations of the Unusual Event was required by the Emergency Plan as the plant was being shut down to comply with a Technical Specification Action Statement.

The inspector witnessed the reactor scram and subsequent cool down to a pressure less than 122 psig as called for by Technical Specifications. All systems performed as expected. All evolutions were conducted in accordance with approved procedures. The cool down and Unusual Event status were terminated at 5:30 a.m. on July 27, 1982.

During dayshift on July 27th, maintenance personnel entered the drywell to investigate and repair the damaged air hoses. Based on their observations, it appears that the flexible rubber hose supplying high pressure air to ADS valve "V" failed after coming in contact with a main steam line pipe hanger. On July 30th, the licensee decided to replace the flexible rubber hoses on all of the ADS, safety/relief, and main steam isolation valves with braided stainless steel hoses. This was completed on August 1.

No items of noncompliance were identified.

#### 4. Monthly Maintenance Observation

On July 1, 1982, the inspector monitored checks of the structural bolting tightness on valves in the Unit 1 drywell. Included were inspection and adjustments on safety relief valves and motor operated valves.

The work performed on the safety/relief valves was supervised by a Crosby Valve and Gage Company representative. No significant problems were noted. However, several lock tab washers required adjustment to achieve the locking function. All retorquing was performed properly.

Torque checks on motor operated valves were performed in accordance with approved procedures. However, several problems were noted. Work progress was slowed by a failure to bring a complete set of tools to the job site. In the future, such a failure will impact ALARA program requirements. Some bolts could not be checked using a torque wrench because of space limitations. In such cases, an effort was made to check similar bolts with a torque wrench and then have the same person try to apply approximately the same torque using a hand wrench. Some bolts were not checked using a hand wrench of the correct size, indicative of a lack of job planning. In some instances, vice grips or adjustable pliers were used to verify bolt tightness.

No items of noncompliance were identified.

#### 5. Monthly Surveillance Observation

On July 8, 1982, during a routine inspection of the control room, the inspector found a multimeter with a calibration date six months past its due date. This matter was brought to the attention of the control room staff, who agreed that the instrument should not be in use. The instrument was immediately removed from service. A followup discussion with an instrument foreman revealed that the instrument had been listed by the computerized tracking system as requiring calibration and furthermore, listed the instrument as having been returned to OAD for calibration. The system obviously was in error as the instrument had still been in use in the control room.

As a check on the yearly calibration, the instrument mechanics also perform weekly calibration checks identical to the yearly one except for not being done in a controlled environment. Subsequent to the inspector's finding the multimeter, the instrument was found to still be within calibration.

The concern is that the computerized system used to maintain a current listing of instruments requiring calibration was in error, thus causing an instrument to be available for use that had an out-of-date calibration sticker. This violates LAP-300-10. Also, the instrument mechanic performing the work and the ones responsible for the weekly calibration check failed to identify that the calibration date was overdue. This violates LAP-300-9.

This is an item of noncompliance. (373/82-37-01)

5. Licensee Event Report Followup

Through direct observations, discussions with licensee personnel and review of records, the following Unit Event Reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action had been taken, and action to prevent recurrence had been accomplished in accordance with Technical Specifications. These items are closed.

<u>Number</u>	<u>Title</u>
82-20/03L-0	Shorted Contacts on OA Diesel Fire Pump
82-23/03L-0	Control Room HVAC Damper Failure
82-26/03L-0	Failure to Properly Seal Sumps
82-27/03L-0	Spurious Blowdown Valve Radiation Alarm
82-28/03L-0	Failure to Properly Approve a Procedure Change
82-30/03L-0	Failure to Return Vent Stack Sample Valve Lineup to Normal
82-31/03L-0	Overridden Secondary Containment Solenoids
82-32/03L-0	Failed Vent Stack Low Range Monitor
82-33/03L-0	Leak on RHR Service Water Sample Pump
82-34/03L-0	Isolated RHR Pump Suction Flow Switch
82-35/03L-0	Failure to Test Leakage Detection System Prior to Mode 3
82-36/03L-0	Failed Snubber
82-37/03L-0	Overridden Secondary Containment Vent Damper Solenoid
82-38/01T-0	Failed Reactor Vessel Level Switch
82-43/03L-0	Failed Lake Blowdown Flow Transmitter
82-45/01T-0	Failure of Both Control Room Emergency HVAC Trains
82-54/03L-0	Failed Cable Connector on Reactor Building Ventilation Monitor

7. Plant Trips/Safety System Challenges

At 2212 on July 24, 1982, Unit 1 experienced an automatic scram on high pressure. The scram occurred subsequent to receipt of a main steam tunnel high temperature alarm and Group 1 isolation. Followup investigation revealed that two test valves on main steam line "C" were left open following maintenance on main steam isolation valves. This condition allowed steam to be admitted to the main steam tunnel and caused the high temperature alarm. All safety systems functioned normally and the reactor was taken critical at 0940 on July 25, 1982.

8. Part 21 Followup

On June 8, 1982, Region III received notification from Zack Company that fire dampers 18 inches wide and narrower, manufactured by American Warming and Ventilating, Incorporated and shipped prior to March 24, 1981 may not close when the fusible link separates. A manufacturer's suggested repair was provided. It was determined that fire dampers of this type were in use at LaSalle.

As the type of deficiency reported could render the dampers inoperable, the licensee instituted hourly fire watch patrols in accordance with Technical Specification requirements. Work was commenced on replacing the fusible links. The links on all Unit 1 and Unit 2 affected safety related fire dampers was completed on July 1, 1982.

9. Power Ascension Test Witnessing

On July 21 and 22, 1982, the inspector observed portions of the testing program that cycled safety/relief valves and ADS valves. The inspector verified that the tests, initiated from less than 5% power were performed in accordance with approved procedures and that Technical Specification requirements were satisfied. During the course of the testing two valve position indication problems were encountered. Valve position indication by computer functioned properly. The errant valve position indications were subsequently repaired and tested satisfactorily.

On July 22, 1982, the inspector also witnessed portions of RCIC testing. As a result of the testing it was determined that the RCIC turbine controller was malfunctioning and that there were numerous oil leaks in the system.

No items of noncompliance were identified.

10. Followup on Regional Requests

The Resident Inspector was requested by Region III to determine the manufacturers of installed bullet resistant fire doors and determine if the licensee had documentation specifically confirming that the doors had been tested for fire resistance by a nationally recognized laboratory. It was determined that installed doors were manufactured by Pioneer and Chicago Bulletproof. The licensee did not have documentation that specifically confirmed the doors, as supplied, had been tested and approved by a nationally recognized laboratory.

Paragraph 2.C.(25)(d) on Operation License NPF-11 requires that, "Prior to startup after the first refueling outage, the licensee with respect to fire doors shall implement one of the following:

- (a) Perform an engineering review of the manufacturer's certified doors and door frames by a nationally recognized laboratory to certify that the doors and door frames provide the required fire resistance rating, or
- (b) Test a replicate "as installed" door assembly by a nationally recognized laboratory to determine the door rating, or
- (c) Replace the manufacturer's labeled doors and door frames with UL rated items."

The licensee is still pursuing options (a) and (b) above. No date has been established for establishing fire resistance by a nationally recognized laboratory.

11. Independent Inspection Effort

On June 30, 1982, the licensee issued a letter to Mr. J. G. Keppler, Regional Administrator, addressing concerns delineated in IE Inspection Report 50-373/82-08. In this letter, the licensee committed to have the "Burns' General Company Comment" revised by July 6, 1982 to include the following statement, "Anyone found in violation of the Burns' Procedure on Alcohol/Drug Intoxication will be terminated." On July 6, 1982, the inspector verified that Burns had issued a memorandum promulgating this policy.

During a routine plant tour on July 9, 1982, the inspectors discovered three empty beer cans in a storage area adjacent to Unit 2 reactor building. Based on the fact that the cans were completely dry, it is surmised that their discovery does not constitute evidence of recent on-site consumption of alcoholic beverages. However, the situation was brought to the attention of licensee management, and a commitment was made to have the plant and construction superintendents semi-annually issue notices to all department heads stressing the policy on consumption of alcoholic beverages on site. Additional plant tours have failed to produce any additional evidence of on-site alcohol consumption.

12. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) throughout the month and at the conclusion of the inspection period and summarized the scope and findings of the inspection activities. The licensee acknowledged these findings.