U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-373/90009(DRP); 50-374/90012(DRP)

Docket Nos. 50-373; 50-374 Licenses No. NPF-11; NPF-18

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

Facility Name: LaSalle Nuclear Power Station

Inspection At: Marseilles, IL 61341

Inspection Conducted: May 3-4, 1990

Inspector: R. D. Lanksbury 8/22/90
Date

Approved By: W. D. Shafer, Chief 8/22/90
for Reactor Projects Branch 1 Date

Inspection Summary

Inspection on May 3-4, 1990 (Reports No. 50-373/90009(DRP); 50-374/90012(DRP))
Areas Inspected: Unannounced, special inspection to followup on concerns regarding a test engineer who falsified another individuals initials in January 1987. An Office of Investigations investigation confirmed the record falsification.
Results: The inspector interviewed the individual involved in the record falsification and his immediate supervisors from the time of the event to the present, reviewed the individuals personnel records, and reviewed the licensee's deficiency tracking system, in order to ascertain the performance of the individual subsequent to the record falsification. The inspector also reviewed the licensee's corrective action subsequent to the event. Based on interviews and the record reviews, the inspector determined that no additional examples of negative performance had been detected by the licensee. The inspector had no concerns with the individuals current work status or on the actions taken by the licensee with returning him to a normal work status. The inspection showed that actions had been taken to correct the violation identified in Inspection Reports No. 50-373/86046 and No. 50-374/86046 and to prevent recurrence.

A Notice of Violation (NOV) is contained in this report for this event. The NOV was not originally issued because of ongoing investigation of the event. Because record falsification is an activity that cannot be tolerated in the nuclear industry, and considering the willful nature of the violation, a response to this violation is required.

DETAILS

1. Persons Contacted

*G. J. Diederich, Manager, LaSalle Station
*W. R. Huntington, Technical Superintendent
*J. C. Renwick, Production Superintendent
*J. Walkington, Services Director
*H. L. Massin, Engineering Project Manager, LaSalle Station

*Denotes personnel attending the exit interview on May 4, 1990.

Additional licensee technical and administrative personnel were contacted by the inspector during the course of the inspection.

2. Background

A. Purpose

This was a special inspection to followup on the performance of an individual (test engineer) involved in record falsification, in January 1987, relating to work activities conducted in his area of responsibility. This event was originally discussed in Inspection Reports No. 50-373/86046 and No. 50-374/86046 and resulted in an apparent violation (373/86046-01(DRP); 374/86046-03(DRP)). A Notice of violation was not issued at that time because the event was under consideration for escalated enforcement action. A recently completed Office of Investigation investigation confirmed the record falsification.

B. Event Details

On January 22, 1987, the licensee reported to the resident inspector that a verification had been improperly performed on a valve lineup for a local leak rate test (LLRT). During the evening of January 17, 1987, a technical staff engineer performed a LLRT on a Unit 2 Low Pressure Core (LPCI) Injection Testable Check valve (2E12-F042A). Upon completion of the test, the Test Engineer reviewed the valve lineup sheet and found a stop valve to a pressure switch (2E12-F350A) had not been verified during the test nor during return of the valve to the original position. The Test Engineer was in the drywell for the test and had requested that an operator position three valves outside the drywell. The instrument stop valve was one of the three valves he requested to be repositioned. The operator outside the drywell did not understand that the stop valve was to be positioned and failed to position the stop valve in accordance with the procedure. The Test Engineer and an operator in the drywell, upon completion of the test, exited the drywell to perform the post test valve lineup. The drywell operator did not realize the instrument stop valve needed to be checked and did not verify or reposition it. The Test Engineer checked the stop valve as being open and

assumed the operator who exited the drywell with him had positioned it after the test. Later in the evening, the Test Engineer discovered the missing signature for positioning of the valve during the test and after the test. He then initialed as the first verifier and falsely initialed another engineer as the second verifier. On January 18, the second engineer was reviewing the valve lineup and noted his initials for the valve which he did not verify. He confronted the Test Engineer on January 19, 1987, with the facts and the Test Engineer lined out the improper initials and requested another engineer to go out and verify the proper valve position. This third engineer proceeded to verify the current valve position as being open, which was the correct position; however, he was also talked into verifying that the valve was closed during the test which he had not witnessed and backdated both initials to Saturday the 17th. The preceding discussion of events was uncovered as a result of the licensee's review of this issue.

The instrument checkoff sheet for LTS-900-4, "Low Pressure Coolant Injection (LPCI) Pressure Isolation Valves Water Leak Test," required the instrument stop valve (2E12-F350A) to be closed and verified by two people. Technical Specification 6.2.A requires the licensee to adhere to detailed procedures, including checkoff lists. Item 7 in the lists of procedures of Technical Specification 6.2.A was for surveillance and testing requirements. Contrary to the above, the checkoff sheet for LTS-900-4 was not adhered to in that the instrument stop valve was not closed and verified closed by two people. This was considered a violation (373/86046-01(DRP); 374/86046-03(DRP)). This violation was under consideration for escalated enforcement action and, therefore, was not cited in the Notice of Violation accompanying the original report.

3. Followup Inspection (92701)

The inspector interviewed the individual involved in the record falsification and his immediate supervisors (a total of three) from the time of the event to the present, reviewed the individual's personnel records, and reviewed the licensee's deficiency tracking system, in order to ascertain the performance of the individual subsequent to the record falsification. The inspector also reviewed the corrective actions taken by the licensee subsequent to the event.

Information obtained during the interviews and during the review of the individuals personnel records did not indicate that any examples of negative performance had occurred. Information was obtained that indicated that the individual in fact went out of his way to ensure that his work and his associates work would not be questioned. The inspector determined that the individual is not designated as a supervisor and has not served as a supervisor from the time of the event to the present. However, he does perform some functions that are supervisory in nature. These include coordinating and directing work activities, signing time cards for contractors, occasionally writing appraisals of contractors, and having supervisory signature authority for

review of leak test results. This last function has only been for the last 9 to 12 months.

The inspector also reviewed Deviation Reports (DVRs) to determine if any instance of negative performance regarding this individual had been documented. The licensee's computerized tracking system yielded six DVRs associated with Technical Staff personnel errors. The inspector reviewed all six DVRs and found one which potentially could have involved the individual. This DVR dealt with a missed surveillance on the Loose Parts Monitoring (LPM) system (a system that at one time had been assigned to the individual). The documented contact person was the same as one of the individuals former supervisors. The interview with the supervisor determined that the individual had not been involved in this DVR.

After the event occurred in January 1987 the licensee implemented a six month monitoring plan for the individual to ensure that the negative work performance did not continue. The monitoring program consisted of two weeks of not allowing any safety-related work to be performed without 100% supervision. The remaining 5½ months of the monitoring period consisted of a spot sampling of a minimum of 20% of his work activities. Periodically during the monitoring period status reports were issued to the plant manager. At the conclusion of the monitoring period a final report making a recommendation to return the individual to normal duties was issued to the plant manager. The basis for the recommendation for returning the individual to a normal work status was based on having not found any negative performance examples during the previous six months. This recommendation was accepted by the station manager. The inspector reviewed these reports and confirmed that no negative performance issues had been identified.

Based upon the above record reviews and the interviews with the individual and his supervisors the inspector had no concerns with the individual's current work status or on the actions taken by the licensee with returning him to a normal work status.

4. Licensee Corrective Actions

The licensee took the following actions in response to this event:

a. The LLRT in question was successfully re-performed.

b. Recent tests and other quality documentation performed by the individual were reviewed. No abnormalities were found.

c. The licensee took disciplinary action against the individual.

d. The Technical Staff individual who back-dated the valve verifications was counseled and trained on the accepted methods for performing double verifications and documentation.

e. The licensee discussed this event at tailgate sessions with the Technical Staff and the other station departments.

f. The licensee issued Procedure LAP-100-30, Independent Verification, to provide specific guidance for second verifications.

g. The licensee implemented a six month monitoring program of the individual to ensure that the negative work performance did not continue. Under this program a sampling of all activities was performed by the Technical Staff supervision and the results reported periodically to the station manager.

5. Conclusion

This followup inspection determined that the event was of minor safety significance, that it was detected by the licensee, that it was reported to the NRC by the licensee, that the licensee took corrective actions to re-perform the test and to prevent recurrence of the event, and that the individual was truthful from the beginning with both the licensee and the NRC when confronted with the falsified initials. The inspector has also reviewed the licensee's corrective actions and consider them appropriate to the circumstances. The inspector has no further concerns in this area. Based upon this inspection, the original violations are being issued with a Notice of Violation (NOV) in this inspection report. Because record falsification is an activity that cannot be tolerated in the nuclear industry, and considering the willful nature of the violation, a response to this violation is required. This response should include the licensee's basis for concluding why they currently have confidence in the individual's activities.

6. Exit Interview (30703)

The inspector met with licensee representatives (denoted in Paragraph 1) at the conclusion of the inspection and summarized the scope and findings of the inspection activities. The licensee acknowledged these findings. The inspectors also discussed the likely informational contents of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any such documents or processes as proprietary.

SYNOPSIS

After reviewing staff inspection results forwarded to the NRC Office of Investigations (OI:RIII) from the NRC Region III Regional Administrator on April 27, 1987, OI:RIII self-initiated an investigation at the LaSalle County Station (LaSalle) on September 29, 1987. The decision to self-initiate evolved from allegations that a test engineer willfully falsified records indicating that he had performed a required independent valve position verification, when in fact he had not, and that he willfully falsified records indicating that another engineer had performed a second verification when that engineer had not performed the verification. It was also alleged that since similar incidents of falsification of verification records were discovered at two other Commonwealth Edison Company (CECo) facilities, there could have been management involvement in the training, approving, or authorizing the falsification of verification records.

Following the completion of a water Local Leak Rate Test (LLRT) at LaSalle on January 17, 1987, and while reviewing the procedure checklists, a test engineer discovered four missing signatures required to verify the position of a valve during the test. One signature was required to verify the pre-test lineup position, one signature was required to verify the post-test lineup position, and a second signature verifying each of the above was required.

The test engineer admitted that he falsified the valve lineup checklist during the LLRT by initialing a valve verification that he had not performed. He admitted that he knew it was wrong to initial a verification that he had not performed, but he was concerned that the procedural paperwork was incomplete. The test engineer also admitted that he again falsified the same valve lineup checklist when he signed another test engineer's initials on the checklist, indicating that this engineer had performed a second verification, when he had not. The test engineer admitted that he had used poor judgement and knew that he should not have signed another engineer's initials in order to complete the checklist.

When confronted by the other test engineer, the test engineer then persuaded a technical staff person to initial and backdate the checklist, indicating that the technical staff person had been the second verifier for both the pre-test and post-test valve lineup on the date of the test. While the technical staff person admitted that he felt that it was against procedure to backdate the entry and to initial a valve lineup that he had not actually verified, there had not been any proceduralized guidelines established for second verifications at LaSalle at the time of the LLRT.

This investigation established that the test engineer acknowledged willfully falsifying an LLRT lineup verification checklist. Despite a history of verification problems at LaSalle and other CECo plants, the investigation did not establish any CECo management involvement by CECo management in the falsification of the verification records.