

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-373/90025(DRP); 50-374/90026(DRP)

Docket Nos. 50-373; 50-374

License Nos. NPF-11; NPF-18

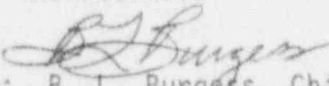
Licensee: Commonwealth Edison Company
Post Office Box 767
Chicago, IL 60690

Facility Name: LaSalle County Station, Units 1 and 2

Inspection At: LaSalle Site, Marseilles, Illinois

Inspection Conducted: October 21 through December 3, 1990

Inspectors: T. Tongue
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Approved By:  B. L. Burgess, Chief
Reactor Projects Section 1B

12/11/90
Date

Inspection Summary

Inspection from October 21 through December 3, 1990 (Report Nos. 50-373/90025; 50-374/90026(DRP)).

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of licensee action on previously identified items; licensee event reports; operational safety; monthly maintenance; monthly surveillance; training effectiveness; report review; events; cold weather preparation; Zion diagnostic evaluation team-followup; occupational safety and health administration; quality assurance; and meetings and other activities.

Results: Of the thirteen areas inspected, no violations were identified. During the inspection period, Units 1 and 2 operated at or near full power. On October 24, 1990 while performing preventive maintenance on the Prime 1 computer, the licensee failed to return the computer to operation in less than two hours. The licensee notified the NRC Operations Center within one hour via the Emergency Notification System as required. On November 29, 1990, an Unusual Event was declared and a shutdown commenced when the Unit 1, Division 1 battery charger became inoperable due to faulty circuit card. The battery charger was repaired, returned to service and the Unusual Event ended later the same day. Performance for each of areas listed is summarily expressed:

Plant Operations

The licensee continues to operate in an above average manner with excellent response to events and transients. During the month of October, a station record was set for monthly electrical generation output. In addition, LaSalle Station has exceeded 1 year and over 1.7 million man hours without a lost time accident.

Maintenance/Surveillance

The number of outstanding work requests in the Radwaste Control Room was reduced this inspection period. This has significantly reduced the amount of distraction to the Radwaste Control Room operators. The licensee continues to perform in an above average manner with no significant trends noted.

Radiation Protection

The licensee has succeeded in reducing the radiological waste inventory from approximately 21,000 cubic feet to below 5,000 cubic feet over the last eleven months. Work continued toward decontamination of radwaste tanks and rooms. Man rem exposure is improving and the station is very close to its yearly goal.

Security

No assessment.

Emergency Preparedness

No assessment.

Engineering and Technical Support

Engineering technical support provided during the Unusual Event resulting from the loss of the Unit 1 Division 1 125 volt dc battery charger failure was excellent.

Safety Assessment and Quality Verification

The onsite Quality Assurance group is in the process of implementing a new policy of increasing time in the field and performing more performance based auditing. More time will be needed to evaluate the effectiveness of this initiative.

DETAILS

1. Persons Contacted

- *G. J. Diederich, Manager, LaSalle Station
- *W. R. Huntington, Technical Superintendent
- *C. W. Schroeder, Production Superintendent
- *J. V. Schmeltz, Assistant Superintendent, Operations
- *J. Walkington, Services Director
- T. A. Hammerich, Regulatory Assurance Supervisor
- W. E. Sheldon, Assistant Superintendent, Maintenance
- W. Betourne, Quality Assurance Supervisor
- J. Hopman, Lead Mechanical Inspector, Quality Control
- *J. Roman, Resident Engineer, Illinois Department of Nuclear Safety

*Denotes those attending the exit interview conducted on December 3, 1990, and at other times throughout the inspection period.

The inspectors also talked with and interviewed several other licensee employees, including members of the technical and engineering staffs, reactor and auxiliary operators, shift engineers and foremen, and electrical, mechanical and instrument maintenance personnel, and contract security personnel.

2. Licensee Action on Previously Identified Items (92701)

(Closed) Violation (373/86046-01; 374/86046-03): Failure of Instrument Mechanics to verify a valve position as required by procedure. This violation was issued with Inspection Report 373/90009; 374/90012 and covered an event on January 17, 1987 when four missing signatures on a procedure checklist were wrongfully filled in after a test was completed. The licensee's response dated September 24, 1990, detailed the corrective actions taken and the followup review performed with the responsible individual. These corrective actions were accepted by the NRC in a letter to the licensee dated November 26, 1990. This violation is considered closed.

(Closed) Open Item (374/88021-03 A, B, and C): Multiple problems associated with a failed high steam flow pressure switch for Reactor Core Isolation Cooling (RCIC). Briefly these were; an isolation intermediate stop valve being shut and not reopened for return to service, and operators failing to properly identify the cause of control room alarms from the failed pressure switch. The correct alarm condition was later identified by the Shift Engineer. The issues addressed were:

- A. The existence of the intermediate stop valves on certain instrument lines were to be specified and addressed in LaSalle instrument surveillances and procedures.

All Instrument Maintenance Department procedures which require valve manipulation were revised to provide specific instruction for the manipulation of only those valves which must be operated to perform a specific instrument test. Any other valve operations are controlled and documented via LIP-GM-909, "Opening Process Instrument Lines and Valve Manipulation." This item is closed.

- B. The Instrument Maintenance Department reviewed practices and considered methods for identification of instrument valves left off normal.

Highlights of this event; valve functions, descriptions, and nomenclatures have been incorporated into the Instrument Maintenance Continuing Training Program. This item is closed.

- C. Unit Nuclear Station Operator shift turnovers were monitored to address the apparently inadequate turnovers. All reviews were to be evaluated and recommendations for improvement were to be made.

Following this event, the operating engineers observed shift turnovers for every crew to assess turnover adequacy. No new problems were identified. This item is closed.

(Closed) Unresolved Item (373/88022-01; 374/88021-04): During an inspection of the Inservice Testing Program (IST), a clarification was needed on the verification of the Remote Position Indication of valves as required by the ASME Code, Section XI, IWV 3300.

Correspondence with the ASME Boiler and Pressure Vessel Committee verified that the intent of IWV 3300 for valves having remote position indication at multiple locations is that only the remote position indicator at the location utilized in exercising, and timing the stroke of the valve be verified to be accurate. This item is closed.

(Closed) Violation (374/89003-01): On July 13, 1987, upon the completion of Modification M-1-2-84-136, Replacement of the Barton Differential Pressure (dp) Switches With Static-O-Ring (SOR) dp Switches, the licensee failed to review and verify completion of Field Change Request (FCR) L85-87 which required the installation of a pulsation dampener on SOR switch 2E31-N012AA. The dampener was not installed, however, the drawing was changed, and approved, reflecting the installation of the dampener.

A list of plant applications containing pulsation dampeners was generated, and an additional walkdown was conducted to ensure similar errors did not exist. The pulsation dampeners were subsequently

installed properly on both units. Training in this event was given to the Instrument Maintenance Department and the Technical Staff. This item is closed.

(Closed) Open Item (373/89012-01; 374/89012-01): During the completion of Temporary Instruction TI2515/99 - Inspection of Licensee's Implementation of Requested Actions of NRC Bulletin 88-07, BWR Power Oscillations, the policy concerning operation in the region of potential instability was questioned.

In a letter dated July 24, 1989 from T. J. Kovach, Nuclear Licensing Manager, Commonwealth Edison, to A. B. Davis, Regional Administrator, Region III, it is documented that during a meeting on April 6, 1989 between NRR, Commonwealth Edison and the Boiling Water Reactor Owners Group, NRR agreed that unintentional entry into regions of potential instability is permissible in response to abnormal operating conditions that may challenge vital equipment or the fuel. This item is closed.

(Closed) Unresolved Item (373/89007-01; 374/89007-01): Documentation of test results, requested by members of an NRC Augmented Inspection Team, was not located on site. The licensee was required to respond in writing with the documentation. In a letter dated May 1, 1989 from W. E. Morgan, the Nuclear Licensing Administrator for Commonwealth Edison and LaSalle Station, to Mr. A. B. Davis, Regional Administrator, NRC, Region III, the requested documentation was provided in whole. This item is closed.

(Closed) Unresolved Item (373/90014-02; 374/90015-02): On June 23, 1990 Unit 2 experienced an unanticipated cooldown rate during a planned reactor shutdown. The inspection report addressed five questions to the licensee which were all addressed in a letter from G. J. Diederich to T. J. Kovach. The root cause of the event was determined to be inadequate procedural guidance. The affected procedures have been revised and the event incorporated into simulator training. This item is considered closed.

(Closed) Open Item (374/89003-03(DRP)): The licensee committed to perform certain actions to justify Unit 2 startup following the loss of a disc insert from the 2B recirculation pump outlet valve. An analysis was performed and recorded in LaSalle Onsite Review, LOSR-89-006 accepting the condition for the fuel cycle following the event. In addition, appropriate procedures were updated to monitor and respond to flow blockage that could be caused by the disc. This item is considered closed.

(Closed) Violation (374/89003-02): Failure to make immediate notification of an Engineered Safety Feature (ESF) Actuation in accordance with 10 CFR 50.72 Section 2 (ii). The licensee has upgraded applicable procedures to avoid recurrence of this violation. This item is considered closed.

(Closed) Violation (374/88021-02): Failure to follow written procedures per Technical Specification 6.2.A. It was noted in the Notice of Violation that "the inspection showed that actions had been taken to correct the identified violation and prevent recurrence." This item is considered closed.

(Closed) Open Item (373/89019-01; 374/89019-02): Calibration sheets did not provide reset values for controlling multiple alarm cards. This led to the spurious runback of a Reactor Recirculation Flow Control Valve (RRFCV). The licensee has begun revising all procedures for calibration of those instruments whose reset points are vital for annunciator indication and control. This item is considered closed.

(Closed) Violation (373/89012-02(DRS)): Failure to promptly identify the root cause of the failure of a reactor building ventilation damper (1VR05YA). The licensee has updated the appropriate procedure to ensure that a member of the technical staff is summoned upon identification of a failed damper test. This item is considered closed.

NRC Region III management has reviewed the existing open items for the LaSalle Station and have determined that the following open items will be closed administratively due to their safety significance relative to emerging priority issues and to the age of the item. The licensee is reminded that commitments directly relating to these open items are the responsibility of the licensee and should be met as committed. NRC Region III will review licensee actions by periodically sampling administratively closed items.

(Closed) Generic Letter (373/88011-GL; 374/88011-GL): NRC position on radiation embrittlement of reactor vessel materials and its impact on plant operations.

(Closed) Generic Letter (373/88014-GL; 374/88014-GL): Instrument air supply problems affecting safety-related equipment.

No violations or deviations were identified.

3. Licensee Event Reports Followup (92700)

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with Technical Specifications.

- a. The following report of a nonroutine event was reviewed by the inspectors. Based on this review it was determined that the event was of minor safety significance, did not represent program deficiencies, was properly reported, and was properly compensated for. This report is closed:

373/90012-00 - Automatic Start of OA Control Room Emergency Makeup Fan Due to Procedural Deficiency

- b. The following report was reviewed and will remain open pending additional review and evaluation by Region III staff.

(Open) 374/90011-00 - Loss of Unit 2 North Bank Automatic Depressurization System Backup (Instrument Nitrogen) Pressure Supply. This event was caused by a personnel error and existed for over four months. It created a situation where three of seven ADS valves may not have functioned if called upon (i.e., loss of Instrument Nitrogen (IN) compressors and IN accumulator supply check valve failures). This resulted in a failure to meet the requirements of Technical Specification 3.5.1 a and b for operability.

Mitigating circumstances were that after a review of all of the technical analysis for the need of ADS valves, it appears that the safety function could have been accomplished and the desired condition achieved. It was noted that during the four months in question, no alarms for low IN ADS accumulator pressure were received and it has been over five years at LaSalle since the last incident of a mispositioned valve in operations due to personnel error.

This LER is being reviewed by Region III for enforcement disposition and will be finalized in a future inspection report.

In addition to the foregoing, the inspector reviewed the licensee's Deviation Reports (DVRs) generated during the inspection period. This was done in an effort to monitor the conditions related to plant or personnel performance, potential trends, etc. DVRs were also reviewed to ensure that they were generated appropriately and dispositioned in a manner consistent with the applicable procedures and the QA manual.

No violations or deviations were identified in this area.

4. Operational Safety Verification (71707)

During the inspection period, the inspectors verified daily, and randomly during back shift and on weekends, that the facility was being operated in conformance with the licenses and regulatory requirements and that the licensee's management control system was effectively carrying out its responsibilities for safe operation. This was done on a sampling basis through routine direct observation of activities and equipment, tours of the facility, interviews and discussions with licensee personnel, independent verification of safety system status and limiting conditions for operation action requirements (LCOs), corrective action, and review of facility records.

On a sampling basis the inspectors daily verified proper control room staffing and access, operator behavior, and coordination of plant activities with ongoing control room operations; verified operator adherence with the latest revisions of procedures for ongoing activities; verified operation as required by Technical Specifications (TS); including compliance with LCOs, with emphasis on engineered safety features (ESF) and ESF electrical alignment and valve positions; monitored instrumentation recorder traces and duplicate channels for abnormalities; verified status of various lit annunciators for operator understanding, off-normal condition, and corrective actions being taken; examined nuclear instrumentation (NI) and other protection channels for proper operability; reviewed radiation monitors and stack monitors for abnormal conditions; verified that onsite and offsite power was available as required; observed the frequency of plant/control room visits by the station manager, superintendents, assistant superintendents, and other managers; and observed the Safety Parameter Display System (SPDS) for operability.

During tours of accessible areas of the plant, the inspectors take note of general plant/equipment conditions, including control room activities in progress (maintenance/surveillance), observation of shift turnovers, general safety items, etc. The specific areas observed were:

a. Engineered Safety Features (ESF) Systems

Accessible portions of ESF systems and components were inspected to verify: valve position for proper flow path; proper alignment of power supply breakers or fuses (if visible) for proper actuation on an initiating signal; proper removal of power from components if required by TS or FSAR; and the operability of support systems essential to system actuation or performance through observation of instrumentation and/or proper valve alignment. The inspectors also visually inspected components for leakage, proper lubrication, cooling water supply, etc.

b. Radiation Protection Controls

The inspectors verified that workers were following health physics procedures for dosimetry, protective clothing, frisking, posting, etc., and randomly examined radiation protection instrumentation for use, operability, and calibration.

On November 29, 1990, the resident inspectors were informed by the Radiation Protection Supervisor that cleanup and repair of the chemistry waste tanks had been completed. This issue was raised during the station ALARA review. Additionally, the waste sludge tank and Ultrasonic Resin Cleaner (URC) sludge tank room had been cleaned (decontaminated). However, the interior of the tanks will not be decontaminated until 1991 in order to help meet the station ALARA man-rem goals. The inspectors were also informed that the licensee plans to commence decontamination of the radwaste discharge tank room early in December 1990. This room has relatively low contamination levels.

The inspectors were also informed that the licensee identified radioactive contamination on the exterior (top and side) of the Unit 1 cycle condensate (CY) storage tank. The CY tanks are in a locked, fenced, and radiologically controlled posted area external to the turbine building. The contamination levels varied between 5000 to 50,000 disintegrations per minute removable by a large area smear test. No contamination was detected on the ground around the base of the tank. In addition, a sludge/water sample from the bottom of the tank indicated about 50 millirem per hour, direct contact reading, on the sample bottle. These levels were not expected, however, similar contamination of condensate storage tanks at other boiling water reactor sites have occurred in the past. The licensee has decontaminated the exterior of the tank and is evaluating options for cleaning of the tank interior.

A noteworthy accomplishment by the licensee has been the reduction of solid radioactive waste stored on site. Since December 1989, the volume has been reduced from a nominal 20,000 cubic feet to less than 5,000 cubic feet, which is a reasonable working quantity.

The inspectors also noted, during the past several months, that the licensee has steadily controlled man-rem exposure such that it was very close to achieving the year-to-date goal at the end of the inspection period.

c. Security

Each week during routine activities or tours, the inspector monitored the licensee's security program to ensure that observed actions were being implemented according to their approved security plan. The inspector noted that persons within the protected area displayed proper photo-identification badges and those individuals requiring escorts were properly escorted. The inspector also verified that checked vital areas were locked and alarmed. Additionally, the inspector verified that observed personnel and packages entering the protected area were searched by appropriate equipment or by hand.

e. Housekeeping and Plant Cleanliness

The inspectors monitored the status of housekeeping and plant cleanliness for fire protection, protection of safety-related equipment from intrusion of foreign matter and general protection of equipment from hazards.

The inspectors also monitored various records, such as tagouts, jumpers, shift logs and surveillances, daily orders, maintenance items, various chemistry and radiological sampling and analysis, third party review results, overtime records, QA and/or QC audit results and postings required per 10 CFR 19.11.

No violations or deviations were identified in this area.

5. Monthly Maintenance Observation (62703)

Station maintenance activities affecting the safety-related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with Technical Specifications.

The following items were considered during this review: the Limiting Conditions for Operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and, fire prevention controls were implemented. Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety-related equipment maintenance which may affect system performance.

The inspector noted that an effective effort was made by management to reduce the number of outstanding work requests existing in the Radwaste Control Room. This has significantly reduced the amount of distraction to the operators.

The following maintenance activities were observed and reviewed:

Unit 1

MCC 135Y-1/E4 Troubleshooting and Loose Wire Repair

Work Request L03131 Equipment Qualification Inspection on Rosemont Pressure Transmitter Division 1, 125V dc Battery Charger Selenium Controlled Rectifier and Firing Circuit Board Replacement

Unit 2

Drywell Equipment Drain Sump (DWEDS) High Speed Flow to Flush the DWEDS Discharge Valve

Rod Worth Minimizer (RWM) Out-of-Service to Load a New Sequence and Cram Array

The inspectors monitored the licensee's work in progress and verified that it was being performed in accordance with proper procedures, and approved work packages, that applicable drawing updates were made and/or planned, and that operator training was conducted in a reasonable period of time.

No violations or deviations were identified.

6. Monthly Surveillance Observation (61726)

The inspectors observed surveillance testing required by Technical Specifications during the inspection period and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that Limiting Conditions for Operation were met, that removal and restoration of the affected components were accomplished, that results conformed with Technical Specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspectors witnessed portions of the following test activities:

Unit 1

- LIS-NB-303 Reactor Vessel Low Low Water Level Recirculation Pump Trip Functional Test
- LIS-NR-103 Power Range Monitor Rod Block and Scram Calibrations

Unit 2

- LST 90-94 I-129 Sample Filter Installation
- LOS-AA-W1 Technical Specification Weekly Surveillance-Rod Operability Check, Turbine Stop Valve and Bypass Valve Surveillances
- LOS-DG-SA-2 2A Diesel Generator Operability Test With Response Time
- LIS-RM-401 RHR (LPCI Mode) Pump Discharge Pressure Permissive and Functional Test
- LIS-MS-404A&B Mainsteam Tunnel High Temperature Isolation Instrument Channel A&C (B&D) Monthly Functional Test

No violations or deviations were identified.

7. Training Effectiveness (41400, 41701)

The effectiveness of training programs for licensed and non-licensed personnel was reviewed by the inspectors during the witnessing of the licensee's performance of routine surveillance, maintenance, and operational activities and during the review of the licensee's response to events which occurred during the inspection period. Personnel appeared to be knowledgeable of the tasks being performed, and nothing was observed which indicated any ineffectiveness of training.

No violations or deviations were identified.

8. Report Review (90713 and 92701)

During the inspection period, the inspector reviewed the licensee's Monthly Performance Report for October 1990. The inspector confirmed that the information provided met the requirements of Technical Specification 6.6.A.5 and Regulatory Guide 1.16.

The inspector also reviewed the following licensee reports:

- . LaSalle County Station Monthly Plant Status Report for October 1990.
- . Weekly Pro-Active Management Reports
- . LaSalle Unit 1 & 2 Error Free Operations Monthly Committee Reviews
- . Event Frequency Reduction Committee Meeting Minutes of November 8, 1990

No violations or deviations were identified.

9. Events (93702)

Prime 1 Computer Down in Excess of Two Hours

On October 24, 1990 at 4:24 p.m. (CDT), the Prime 1 Computer was brought down for preventive maintenance and was expected to stay down for less than two hours. The emergency assessment capability during a plant event is affected by loss of the Prime 1 computer. When, after two hours the computer could not be made operational, the senior resident inspector was informed and the NRC Operations Center was informed via the Emergency Notification System at approximately 7:00 p.m. (CDT). The Prime 1 computer was returned to operability at 4:00 a.m. (CDT) on October 25, 1990.

Unit 1 Division 1 125 Volt DC Battery Charger Failure

On November 29, 1990 at 6:30 a.m., the licensee declared an Unusual Event and commenced a reactor shutdown from full power. The shutdown was commenced in accordance with Technical Specification 3.8.2.3 upon identification that the Division 1 125 volt DC battery charger 1DC09E was displaying voltage and current oscillations and, therefore, was inoperable. The Technical Specifications allows a two hour Limiting Condition for Operation, then requires the licensee to achieve hot shutdown within 12 hours and cold shutdown within the following 24 hours. Investigation indicated a failed B phase selenium control rectifier (SCR), however, after replacement, the associated SCR firing circuit board was found to be the fault. The circuit board was replaced with a qualified board from a spare charger onsite. The repaired battery charger was tested satisfactorily and placed back in service. The Unusual Event was secured at 2:55 p.m., the reactor power ramp was reversed from 70%, and the plant returned to full power.

The resident inspector monitored the troubleshooting and repair, including the verification that the out-of-service and the work request packages were properly administered. The mechanics were properly certified and followed the work packages for troubleshooting and repair. The inspector noted that safety precautions and lifted lead tags were appropriately used.

The response and support of the engineering personnel on the technical staff for troubleshooting and repair, and the support of other station staff in the providing of properly qualified parts was impressive. This contributed to the prompt repair and returning the reactor to full power.

No violations or deviations were identified.

10. Cold Weather Preparation (71714)

The licensee committed itself to a program of protective measures for extreme cold weather in response to IE Bulletin 79-24, Frozen Lines. The objective of this inspection was to determine whether the licensee had maintained effective implementation of the program.

During this inspection period, the inspectors observed portions of operational surveillance LOS-ZZ-A2, Preparation for Winter Operation. The procedure encompasses the items noted in IE Bulletin 79-24. Upon completion of the procedure, the inspectors reviewed the surveillance procedure and results. There were no outstanding observations identified during the inspection, or review of the documentation. The licensee completed the surveillance on September 30, 1990.

No violations or deviations were identified in this area.

11. Zion Diagnostic Evaluation Team-Followup (92701)

During this inspection period, licensee management personnel provided information to the inspectors regarding LaSalle's preliminary followup on the issues identified during the Zion Diagnostic Evaluation Team (ZDET) inspection, conducted in June 1990. At this time, issues pertinent to LaSalle have been identified and evaluated as to their significance.

12. Occupational Safety and Health Administration (OSHA) (93001)

During the inspection period, LaSalle station achieved one year with over 1.7 million manhours without a lost time accident.

13. Quality Assurance (71707)

On November 9, 1990, the resident inspector met with the Onsite Quality Assurance (QA) staff for discussions on areas of expertise, background and current issues. The inspectors found that the station QA group is working on several initiatives, such as; performance based audits, elimination of audit overlap, and improving field time for auditors with a goal of 50% observed activity.

14. Meetings and Other Activities

Illinois Department of Nuclear Safety Memorandum of Understanding

On November 14, 1990, a Memorandum of Understanding (MOU), pertaining to state resident engineers, between the U.S. Nuclear Regulatory Commission and the State of Illinois was approved by the commission and signed by the NRC Executive Director of Operations, and subsequently signed on November 20, 1990 by the Director of the Illinois Department of Nuclear Safety (IDNS).

On November 13, 1990, a meeting was held in the NRC Region III office in Glen Ellyn, Illinois. The meeting was attended by two members of the IDNS staff and Region III Division of Reactor Projects Branch 1 members. Its purpose was to discuss the implementation of the Memorandum of Understanding (MOU) and procedures for the IDNS site resident engineer trial program at LaSalle and Dresden. It was agreed to have a followup meeting in the future to discuss any new developments.

Subsequently, the IDNS staff provided a letter dated November 19, 1990 to the Region III Division of Reactor Projects Chief Branch 1 with a proposed inspection plan for December 1990 at LaSalle. The proposal was for accompaniment of the NRC resident inspectors by the IDNS resident engineer.

15. Exit Interview

The inspectors met with licensee representatives (denoted in Paragraph 1) during the inspection period and at the conclusion of the inspection period on December 3, 1990. The inspectors summarized the scope and results of the inspection and discussed the likely content of this inspection report. The licensee acknowledged the information and did not indicate that any of the information disclosed during the inspection could be considered proprietary in nature.