

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-373/90026(DRP); 50-374/90027(DRP)

Docket Nos. 50-373; 50-374

License Nos. NPF-11; NPF-18

Licensee: Commonwealth Edison Company
Opus West III
1400 Opus Place
Downers Grove, IL 60515

Facility Name: LaSalle County Station, Units 1 and 2

Inspection At: LaSalle Site, Marseilles, Illinois

Inspection Conducted: December 2 through January 12, 1991

Inspectors: T. Tongue
C. Phillips
T. Laughton
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Illinois Department of Nuclear Safety

Approved By: B. L. Burgess
Reactor Projects Section 1B

Date _____

Inspection Summary

Inspection from December 2 through January 12, 1991 (Report Nos. 50-373/90026(DRP); 50-374/90027(DRP))

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors, a regional inspector and an Illinois Department of Nuclear Safety inspector of licensee action on previously identified items; licensee event reports; regional requests; operational safety; monthly maintenance; monthly surveillance; training effectiveness; report review; events; safety assessment and quality verification; response to inspection inquiries; meetings and other activities; and site visits by NRC staff.

Results: Of the thirteen areas inspected, no violations were identified in ten areas. In the remaining areas, two violations were identified. One noncited violation was identified in paragraph 7 for a missed surveillance of containment isolation valves where the requirements for cycling the valves had been placed in the wrong procedure. A second violation was identified with two examples of failure to follow procedures as described in paragraphs 10 and 11. The first example occurred on December 17, 1990, when an Instrument Maintenance Technician performed steps of a surveillance procedure out of order, which resulted in an unplanned group I primary containment isolation

signal. The second example was discovered on December 19, 1990. A clerk had failed to follow an administrative procedure to replace a reactor startup procedure with a new revision. This resulted in a commencement of a reactor startup using the wrong revision to the procedure. This citation had minimal safety significance by itself; however, the cause if uncorrected could have had more serious affects. In addition, these examples add to the growing concern of procedure adequacy and adherences at LaSalle.

Two events occurred during the report period. On December 22, 1990, the licensee reported a fire in the 2A turbine driven feed pump room that required 12 minutes to extinguish with negligible damage from the fire. On December 25, 1990, the licensee reported finding the Unit 2 250 volt d.c. battery electrolyte at 62 degrees F (Technical Specification requires 65 degrees F or above) thus, making the battery and Reactor Core Isolation Cooling (RCIC) inoperable. The licensee promptly placed space heaters in the room and secured the outside air dampers to raise the temperature. The situation was corrected in approximately eighteen hours.

Plant Operations

Performance continues to be above average. Operation during off-normal conditions such as events described in paragraph 10 remain excellent.

Maintenance/Surveillance

Performance in this functional area was mixed. Repair of a leaking feedwater heat exchanger was performed in approximately half of the original estimated time. This was offset, however, by a missed Inservice Inspection surveillance and the failure of a technician to follow procedures during a surveillance which resulted in a primary containment isolation.

Radiological Protection

Performance in this area was good. The licensee implemented a new Radiation Work Permit program and new access control procedures to the radiologically controlled areas.

Emergency Preparedness

This functional area was not assessed this period.

Security

This functional area was not assessed this period.

Safety Assessment and Quality Verification

Performance in this functional area remained steady with some negative indicators. A special inspection of overtime policy was conducted this period. The results showed that greater attention could be given to controlling overtime usage; however, there have been no events caused by overtime abuse. Continued procedure adherence and adequacy problems were noted in several areas.

Engineering and Technical Support

Performance in this area continues steady to improving. An example of well coordinated team work was observed between corporate and site engineering, operations and maintenance personnel during the evaluation and repair of the Unit 2, 23C feedwater heater.

DETAILS

1. Persons Contacted

- *G. J. Diederich, Manager, LaSalle Station
- *W. R. Huntington, Technical Superintendent
- *C. W. Schroeder, Production Superintendent
- D. S. Berkman, Assistant Superintendent, Work Planning
- J. V. Schmeitz, Assistant Superintendent, Operations
- J. Walkington, Services Director
- *T. A. Hammerich, Regulatory Assurance Supervisor
- *M. Santic, Assistant Superintendent, Maintenance
- *W. Betourne, Quality Assurance Supervisor
- *J. Borm, Quality Assurance Engineer
- *J. Giesaker, Technical Staff Supervisor
- *J. Atchley, Operating Engineer
- *J. Roman, Resident Engineer, Illinois Department of Nuclear Safety

*Denotes those attending the exit interview conducted on January 10, 1991, 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, electrical, mechanical and instrument maintenance personnel, and contract security personnel.

2. Licensee Action on Previously Identified Items (92702)

(Closed) Allegation (AMS No. RIII-90-A-0110): Falsification of records and an uncertified radiographer at LaSalle.

a. Background

On October 25, 1990, an individual alleged that records had been falsified by having a certified radiographer sign reports for a radiographer whose certifications had expired.

b. NRC Review

The NRC inspector reviewed radiographic examination reports and certification records identified by the allegor. Radiography was performed by three radiographers on two condenser pots in the turbine building heater bay as a result of Modification Number 1-2-88-021, Work Request Number 79463. The condenser pots are balance-of-plant items that are not safety-related.

Two incidents involving radiographers were identified by the inspector as being of a questionable nature. The first involved a radiographer whose certification expired on May 6, 1990, but took his recertification tests on May 4, 1990. However, his recertification based on these tests was not issued until May 25,

1990. The radiographer's name appears on two radiography reports dated May 7 and 8, 1990, as both the radiographer and interpreter.

The second incident involved a radiographer whose certification expires in 1991. His name also appears to be signed on the May 7 and 8, 1990 radiography reports; however, he did not sign the reports. The radiographer performed the work, but gave his boss permission to sign the report in his absence.

c. Conclusion

This allegation was substantiated. However, in the first incident, the radiographer's competence was not in question since his recertification was based on tests successfully taken prior to the May 6, 1990 expiration date of his certification. While the second incident is not an accepted practice, it had no significant impact on the hardware. In both cases, the licensee's secondary radiographic review had no findings. No further action is considered necessary in this area.

(Closed) Unresolved Item (373/90021-01; 374/90022-01(DRP)): NRC to evaluate the need for a Technical Specification change to address the sampling for the isotopic concentration of the boron solution in the Standby Liquid Control (SBLC) system. By letter, dated December 17, 1990, the NRC provided a response to the licensee's submittals of May 24, 1988 and October 25, 1990. This was regarding only the response to 10 CFR 50.62 (c) (4) for SBLC portion of the Anticipated Transient Without Scram (ATWS) rule (10 CFR 50.62). The licensee's proposal addressed the (a) use of isotopically enriched boron in the form of sodium pentaborate solution and (b) the proposed surveillances in lieu of a Technical Specification change. The licensee committed to use isotopically enriched boron and to perform periodic surveillance of Boron 10 enrichment at least once per fuel cycle and whenever solution from the SBLC system storage tank is used through the spray to ensure equivalent control capacity. NRC determined this to be acceptable. This matter is considered closed.

(Closed) Unresolved Item (373/89007-02; 374/89007-02): The licensee had no formal policy to ensure that when one unit's process computer was on alternate power for Uninterruptable Power Source (UPS) maintenance, that the other unit computer was not out of service for maintenance or on its alternate power supply.

The licensee has changed the shiftly operator rounds package to include the status of both the process computer and Hathaway UPS. The policy change is documented in the rounds package page. This item is 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 low 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 (373/85003-HH): Clarification of Equivalent Control Capacity for SLC Systems.

(Closed) Generic Letter (373/85013-HH): Transmittal of NUREG-1154 Regarding Davis Besse Loss of Main and Aux FW.

(Closed) Generic Letter (373/85022-HH): Potential for Loss of Post-LOCA Recirculation Due to Insulation Debris Blockage.

(Closed) Generic Letter (373/88001-GL, 374/88001-GL): NRC Position on Intragranular Stress Corrosion Cracking in Boiling Water Reactor Austenitic Stainless Steel Piping.

(Closed) Unresolved Item (373/87024-01; 374/87024-01): LaSalle Technical Specifications Do Not Comply With Generic Letter 84-11 Guidelines on Reactor Coolant Leakage Detection Systems.

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:

373/90007-01 Reactor Core Isolation Cooling Trip on Mechanical Overspeed Due to Contaminated Oil

- b. The following report of a nonroutine event involved a violation of regulatory requirements. This report is considered closed.

373/90013-00 Missed Inservice Testing Surveillance on Residual Heat Removal Heat Exchanger Vent Valves to Procedural Deficiency Caused by Incomplete Review. This is addressed in more detail in paragraph 7.

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.

4. Regional Request (71707)

In accordance with a memorandum from the Director, Division of Reactor Projects, a formal inspection was conducted to characterize the sites' practices and programs for the use of overtime by departments other than operations. The primary references used as guidance for this inspection were Generic Letters (GL) 82-12, GL 83-14, and LaSalle Station Technical Specifications (TS).

Technical Specification 6.1.C.7 adopts the guidelines given in GL 82-12 in that Administrative Procedures shall be developed and implemented to limit the working hours of unit staff who perform safety-related functions; and that:

An individual should not be permitted to work more than 16 hours straight, excluding shift turnover time.

An individual should not be permitted to work more than 16 hours in any 24-hour period, nor more than 24 hours in any 48 hour period, nor more than 72 hours in any seven day period, all excluding shift turnover time.

In addition, the TS also states that any deviation from the guidelines shall be authorized by the Production Superintendent or Technical Superintendent for their individual departments. The TS also states that the Production or Technical Superintendents shall review individual overtime monthly to assure that excessive overtime hours have not been assigned.

A review of the documentation records of overtime for the mechanical, electrical and instrument maintenance departments revealed that it was not uncommon for individuals, that were not perceived to be involved in safety-related work, to exceed the TS time guidelines. There were several occurrences of deviations from the TS guidelines of individuals that were involved with safety-related work; however, all were approved by their supervisors as required in the administrative procedures. For example, during the period May 1, 1990 to July 1, 1990, there were 34 deviations from TS guidelines, only 7 of which were approved prior to the deviation. The other 27 were approved after the fact. This is allowed under site administrative procedures.

The inspectors interviewed the Technical Superintendent and the Production Superintendent. It was learned that overtime for management staff and technical staff is not tracked because it is perceived that they do not meet the definition of key maintenance personnel as defined in GL 83-14. The Technical Superintendent did say that since the recent event at the Braidwood Station, new guidance had been given to the technical staff not to exceed the TS guidance without prior approval if the work was safety-related.

Finally, since technical staff overtime is not tracked, a small sample of engineers were selected and the computer data for gate entrance and exit times were examined during times of plant outages. The engineers selected were the snubber coordinator and the motor operated valve

coordinator during the month of April 1990. The feedwater heater system engineer was also selected for the period December 12-19, 1990, during which time Unit 2 was shutdown for repairs to the 23C feedwater heater. During this shutdown, the feedwater system engineer exceeded the 16 out of 24 hour guidance, the 24 out of 48 hour guidance, and the 72 hour in 7 day guidance. This work was not considered by the licensee to be safety-related.

In conclusion, the administrative aspects of overtime control can be improved upon. However, through review of previous inspection reports and inspection of recent events, there have been no problems that can be related to fatigue caused by overtime abuse.

No deviations or violations were identified.

5. 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 made note of general plant/equipment conditions, including control of 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.

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 also verified that observed personnel and packages entering the protected area were searched by appropriate equipment or by hand.

d. 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.

As requested by regional management, a review of control room visits during the month of November 1990, by Station Senior Management was performed. The table below was summarized from security computer data obtained.

<u>Position</u>	<u>Days on Site</u>	<u>Number of Visits</u>	<u>Total Time (min)</u>
Station Manager	15	2	9
Technical Supt.	18	2	28
Production Supt.	19	3	7
Asst. Supt. Oper.	19	32	236
Asst. Supt. Scheduling & Planning	21	10	121.5

The above information reveals that in November management spent less than 1% of its time in the control room. However, the licensee is still performing at the SALP 1 level in plant operations. It has been observed that during plant evolutions management presence is evident.

No violations or deviations were identified in this area.

6. 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 following maintenance activities were observed and reviewed:

Unit 1

WR L 02065 Replacement of Drywell Rosemont Pressure Transmitter
 WR L 00633 Preventive Maintenance Inspection of Motor Operated Valves
 WR L 04655 Outboard Main Steam Isolation Valve Leak Control System Upstream Depressurization Valve Repair

Unit 2

WR L 97022 Replace RCIC Turbine Trip and Throttle Valve Motor
 23C Heater Drain Planning and Repair

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.

7. 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 was 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-NR-303B	APRM Rod Block and Scram Functional Test
LOS-DG-M1	Diesel Generator Operating Test
LOS-DG-M4	Diesel Generator Monthly Fuel Oil Sample MSIV Leakage Control Steam Line Bleed Off Flow Functional Test
LIS-AR-305	Main Control Room Radiation Monitor Functional Test
LIS-PC-101	High Drywell Pressure Scram and Isolation Functional Test

Unit 2

LIS-MS-406	Condenser Vacuum MSIV Isolation Functional Test
LTP-600-4	ASME Section XI Inservice Tests of Pumps and Valves

On December 7, 1990, during a routine Technical Staff audit of the Inservice Testing Program (IST), it was discovered that quarterly surveillances, to cycle and time manually controlled motor operated Residual Heat Removal (RHR) heat exchanger (HX) vent valves (1(2)E12-F073A&B and F074A&B), had not been performed. The surveillance on the Unit 2 valves had been missed for two quarters and the Unit 1 valves for one quarter. The surveillances had been missed because the requirement to test these valves had been placed in the wrong procedure (LOS-RH-Q3 RHR and RHR Service Water Valve Inservice Test for Cold Shutdown or Refuel Condition vs LOS-RH-Q2 RHR and RHR Service Water Valve Inservice Test for Operating, Startup, and Hot Shutdown Conditions). The root cause as to why the valves were added to the wrong procedure was considered to be a personnel error. The licensee's conclusion also considered the following contributing factors:

- A short time frame for a major IST revision
- The IST administrative procedure should have included a requirement to perform an independent review of the applicable procedures following a major IST program revision

The safety significance of the missed surveillances is minimal. The valves function to vent non-condensable gases from the HX to the suppression pool should the HX be used to condense main steam. Leak rate tests proved that the valves were in the shut position during the time between surveillances.

Technical Specification (TS) 4.0.5.a requires that inservice testing of ASME Code Class 1, 2, and 3 pumps and valves shall be performed in accordance with Section XI of the ASME Boiler and Pressure Code and applicable Addenda except where specific written relief has been granted by the Commission pursuant to 10 CFR 50, Section 50.55a(g) (6) (1). The failure to perform the surveillances as required by the Inservice Test Program is a violation of TS 4.0.5a.

As corrective action, the licensee immediately performed the required surveillances on all four of the valves satisfactorily. In order to prevent recurrence, the licensee is taking the following additional actions:

- The procedures are being revised to delete the valves from the shutdown procedure and to add them to the operating procedure.
- An audit from outside the Technical Staff from an organization with IST experience, the Nuclear Quality Program Department, was requested and performed. The results of this report have yet to be reviewed by the inspectors.

This violation was identified by the licensee and meets the tests of 10 CFR 2, Appendix C, Section V.G.1.. Consequently, no notice of violation will be issued and this matter is considered closed.

No deviations were identified in this area. However, one violation, for which a Notice of Violation was not issued, was identified in this area.

8. 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.

The inspector observed required licensee training on the implementation of the Radiation Work Permit program. The training was considered to be comprehensive and well presented.

No violations or deviations were identified.

9. Report Review (90713 and 92701)

During the inspection period, the inspector reviewed the licensee's Monthly Performance Report for October and November 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's report:

- LaSalle County Station Monthly Plant Status Report for November 1990.

No violations or deviations were identified.

10. Events (93702)

- a. On December 17, 1990, at 1:17 p.m. C.D.T., while performing LIS-MS-405, Condenser Low Vacuum Main Steam Isolation Functional Test, on Unit 2, an Instrument Maintenance Technician (IMT) performed steps of the procedure out of sequence resulting in a Primary Containment Isolation System (PCIS) Group I isolation. Unit 2 was shutdown for maintenance at the time. The licensee made an Emergency Notification System phone call within four hours as required.

The inspector interviewed the IMT and reviewed the procedure. The IMT performed step 3.j. of the procedure which says to request the operator to place the "Cond Low Vac Trip BypS S24A" keylock switch on panel 2H13-P609, to the "BYPASS" position. The IMT then performed step 3.m. which says to request the operator to place the "Cond Low Vac Trip BypS S24B" keylock switch on panel 2H13-P611 to the "NORM" position. After this was done, the PCIS Group I auto isolation occurred. The IMT stated that he assumed that when the S24A keylock switch was taken to BYPASS, the system logic was automatically reset. Step 3.k. of the procedure clearly states that the valve isolation logic must be reset by depressing reset push buttons for the inboard and outboard isolation logic on panel 2H13-P601. Step 3.l. of the procedure clearly states to verify that two alarms are extinguished prior to proceeding to the next step. The procedure clearly states in a note prior to step 3.m. that the next step will initiate alarms and give a 1/2 main steam isolation valve signal. Because Unit 2 was shutdown at the time of this event, the safety significance of this event was considered minimal.

The IMT, when interviewed, indicated that he had not been working overtime, that he was not being rushed and that to his knowledge this was the first time he had performed this particular procedure.

The root cause of the event was the failure to adhere to the procedure which is a violation of 10 CFR 50 Appendix B, Section V (374-90027-01a(DRP)).

The proposed corrective actions for this event are to first, review this event with the personnel/departments involved emphasizing the importance of referencing the procedure, not just the attachments. Second, current job turnover practices in the control room concerning jobs in progress and assisting other departments will be reviewed. Finally, the procedure will be rewritten incorporating sign off steps into the body of the procedure. The Instrument Maintenance Department (IMD) has a program in place that began in 1988 to review and update all IMD procedures. This program is expected to be completed by 1995.

- b. On December 22, 1990, at approximately 7:45 a.m. (CDT), smoke was discovered coming from the outboard turbine bearing of the 2A Turbine Driver Reactor Feed Pump (TDRFP). The smoke was coming from oil soaked lagging around a vibration probe which was leaking oil. The fire brigade was dispatched but later dismissed and replaced with a fire watch. At approximately 9:25 a.m., the lagging ignited. It took approximately 12 minutes to extinguish the flames. There was no automatic initiation of the sprinkler system in the room. The licensee declared an Unusual Event at approximately 9:40 a.m., due to a fire lasting longer than ten minutes. There were no injuries and no contaminated individuals. The shift foreman was present and in charge at the scene. The Unusual Event was secured at 10:25 a.m. The licensee's response was considered excellent and minimized the danger of a potentially significant event.
- c. On December 25, 1990, at approximately 11:40 a.m., while performing a quarterly surveillance on the Unit 1 250 volt batteries, the average electrolyte temperature was found to be 62 degrees F. Station procedures require the battery to be declared inoperable should the average electrolyte temperature drop below 65 degrees F. The 250 volt battery supplies power to the Reactor Core Isolation Cooling System (RCIC) which was also declared inoperable.

The licensee secured ventilation to the battery room and used heaters to raise room temperature. An outside air supply damper was leaking which caused the low temperature. A work request was generated to repair the damper. The NRC duty officer was notified via the Emergency Notification System at 1:15 p.m. The Unit 1 250 volt battery and RCIC operability were restored at 3:45 a.m. on December 26, 1990. The safety significance of this event was minimal due to the administrative nature of the inoperability.

No deviations were identified in this area; however, one violation was identified.

11. Safety Assessment and Quality Verification (71707)

On December 19, 1990, while observing the startup for Unit 2, just prior to the commencement of pulling rods, it was observed by the inspector that the Nuclear Station Operator (NSO) and the Shift Control Room Engineer (SCRE) were using different revisions to LGP 1-1, Unit Startup. This was pointed out to the Unit Operating Engineer by the inspector. It was discovered that the record copy of the procedure used by the NSO was not the latest revision. The SCRE stopped the progress of the startup and personally conducted a review of the two procedure revisions up to that point to ensure that no steps had been left out. It must be noted that a licensee Quality Assurance inspector was present to observe the startup and did not discover the procedure problem.

It was later discovered that a clerk had failed to replace copies of LGP 1-1, Unit Startup, in a file drawer, from which the procedure was taken, with the new revision, even though it had previously been identified to be replaced by attachment B of LAP-820-3, "Procedure Distribution". This is a violation of 10 CFR 50 Appendix B, Section V (374/90027-01b(DRP)).

The licensee's corrective action was to immediately perform an audit of the file cabinet drawer to verify the correct revisions of all the procedures stored inside. The root cause of this problem was the personnel error of the clerk. The safety significance of this event was small; however, operating with superseded procedures has the potential for much more serious consequences.

No deviations were identified in this area; however, one violation was identified.

12. Response to Inspector Inquiries (92701)

During inspections, the inspectors may note various matters and request explanations and/or responses from the licensee. Some of the responses may require more research and time to respond and a summary of those identified are listed below.

A Technical Issue Summary, dated June 8, 1990, described a problem at the Ginna plant with a single block switch that could block both trains of an ECCS function upon switch failure. The inspectors found that there are no block/unblock switches in ECCS initiation circuits at LaSalle. Control switches can be placed in "pull-to-lock" and separation criteria prevents single switch control. Some containment isolation logic features have bypass switches; however, there is only one switch per logic division.

A NRC Technical Summary, dated July 26, 1990, discussed potential reactor coolant leakage from worn movable incore neutron flux monitoring thimble tubes in Pressurized Water Reactors (PWRs). The inspector inquired as to whether the same condition could exist in a Boiling Water Reactor (BWR) Transient Incore Probe (TIP).

After evaluation of the licensee response, the inspector found that the TIP system on a BWR is not a containment pressure boundary as in a PWR and they are part of the Local Power Range Monitoring (LPRM) string. The LPRM strings are changed at every fourth fuel cycle and TIP drive friction measurements are measured at each refuel outage.

The foregoing responses were verified, evaluated, and found to be acceptable.

No deviations or violations were identified.

13. Meetings and Other Activities (30702)

Illinois Department of Nuclear Safety (IDNS) Meeting at Dresden

On January 4, 1991, a meeting was held at the Dresden Station between the members of the staffs of the NRC and IDNS for the purpose of continuing to develop the coordinated inspections between the NRC and IDNS. During the meeting, proposed coordinated inspection plans for LaSalle during February, March and April 1991 were discussed.

During this inspection period, the NRC inspectors were accompanied by the IDNS Site Resident Engineer as the first step in developing this program.

14. Site Visits by NRC Staff

Commissioner James R. Curtiss' Site Visit

On December 11, 1990, Commissioner James R. Curtiss was onsite. He was accompanied by Mr. Kevin Connaughton, Technical Assistant, Mr. Charles Norelius, Region III, Director of the Division of Radiation Safety and Safeguards and the resident inspectors. The purpose of the visit was an opportunity to become more familiar with LaSalle through meetings with the licensee and resident inspectors and, a tour of the plant. During the tour, the Commissioner used the occasion to tour areas of particular interest in the plant, interview a number of personnel and observe presentations by the licensee. At the close of the tour, he offered a number of comments to the licensee and the resident inspectors and, expressed appreciation to all who assisted in the success of his visit.

15. Violations For Which A "Notice of Violation" Will Not Be Issued

The NRC uses the Notice of Violation as a standard method for formalizing the existence of a violation of a legally binding requirement. However, because the NRC wants to encourage and support licensee's initiatives for self-identification and correction of problems, the NRC will not generally issue a Notice of Violation for a violation that meets the requirements set forth in 10 CFR 2, Appendix C, Section V.A. A violation of regulatory requirements identified during the inspection for which a Notice of Violation will not be issued is discussed in paragraph 7.

16. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in paragraph 1) during the inspection period and at the conclusion of the inspection period on January 10, 1991. 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.