Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

October 18, 1991

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Subject: LaSalle County Nuclear Station Units 1 and 2
Response to Notice of Violation
Inspection Report Nos. 50-373/91015; 50-374/91015
NRC Docket Nos. 50-373 and 50-374

Reference: W.D. Shafer letter to Cordell Reed dated September 19, 1991 transmitting NRC Inspection Report 50-373/91015; 50-374/91015

Enclosed is Commonwealth Edison Company's (CECo) response to the subject Notice of Violation (NOV) which was transmitted with the referenced letter and Inspection Report. The NOV cited two Severity Level IV violations. The first violation concerned the use of an inadequate procedure during testing. The second violation was regarding the failure to properly report an event. CECo's response is provided in the following attachment.

If your staff has any questions or comments concerning this letter, please refer them to Annette Denenberg, Compliance Engineer at (708) 515-7[illegible].

Very truly yours,

PL Barnes for

T.J. Kovach
Nuclear Licensing Manager

Attachment

cc: A. Bert Davis, NRC Regional Administrator - RIII
B. Siegel, Project Manager - NRR
T. Tongue, Senior Resident Inspector

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RESPONSE TO LEVEL IV VIOLATIONS
INSPECTION REPORT
50-373/91015; 50-374/91015
ATTACHMENT A

VIOLATION: (50-373/91015-01)

10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality shall be prescribed and accomplished by documented instructions, procedures, or drawings of a type appropriate to the circumstances.

Contrary to the above, on July 30, 1991, the test procedure for the Unit 1 reactor core isolation cooling (RCIC) system was inappropriate to the circumstances in that the procedure did not require shutting the discharge valve to the lubricating oil cooler and barometric condenser to prevent draining the pump discharge line upon shutdown and did not provide for venting the pump discharge line upon restart.

REASON FOR THE VIOLATION:

On July 31, 1991 at 1655 hours, Operating and Tech Staff were performing special procedure LLP-91-083, "Reactor Core Isolation Cooling (RCIC) System Start in Conditions 1, 2, and 3". This procedure was being performed to troubleshoot the RCIC system in response to a July 29, 1991 overspeed trip that occurred during the system cold quick start.

During the portion of the procedure where RCIC had been running and was subsequently shutdown, it was determined that a procedure step to close 1E51-F046, RCIC Lube Oil Cooler Stop, was not included in the procedure.

In preparing this special procedure, the step to close 1E51-F046 was inadvertently omitted. Had the step been properly incorporated, the Lube Oil Cooler Stop (1E51-F046) would have been closed at the appropriate point in the evolution and there would have been no need to include a requirement to fill and vent the RCIC system.

CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED:

The RCIC Lube Oil Cooler Stop 1E51-F046, was closed and, as a conservative measure prior to restarting the system, the fill and vent procedure was performed. Execution of the procedure was continued following a conference between the Nuclear Station Operator and the Station Control Room Engineer. Appropriate notations were made to the LLP-91-083 procedure package documenting justification for continuing the evolution.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS:

LLP-91-083, "Reactor Core Isolation Cooling (RCIC) System Start in Conditions 1, 2, and 3", was a special procedure which was specifically written to duplicate certain plant conditions that had occurred previously. It was written as a "single use" procedure and was not used again after July 31, 1991. The special procedure formally expired on August 31, 1991.

LaSalle is currently performing a study to ascertain the effectiveness of the methods used during the preparation and approval of special tests and special procedures. Completion of the study is expected by February 29, 1992.

In order to notify appropriate personnel of the details of this event, General Information Notice GIN 91-74 was issued informing the appropriate departments of the situation and increasing their awareness during Special Procedure and/or Test preparation and review. Completion of this GIN is expected by December 11, 1991.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved upon identification and correction of the condition caused by the procedural deficiency.

RESPONSE TO LEVEL IV VIOLATIONS
INSPECTION REPORT
50-373/91015; 50-374/91015
ATTACHMENT A

VIOLATION: (50-374/91015-02)

10 CFR 50.72 (b)(2)(iii)(c) requires the licensee to notify the NRC as soon as practical and in all cases, within four hours of the occurrence of any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to control the release of radioactive material.

Contrary to the above, on March 21, 1991, notification of the NRC was not made within four hours when LaSalle Unit 2 experienced an unplanned breech of containment resulting in the loss of control over the release of radioactive material.

REASON FOR THE VIOLATION:

The cause of the failure to report this event in a timely manner was due to a cognitive error by personnel responsible for event classification. They clearly recognized that, had the duration of the event exceeded one hour, it would have been reportable as a violation of the Technical Specifications. Because the duration was less than one hour, it was believed the event was not reportable. The need to report the event as a condition that could have prevented the fulfillment of a safety function was not properly assessed.

CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED:

Once the failure to notify and report was brought to the attention of the station, the issue was reviewed and discussed. LaSalle Station concluded that this event required notification under 10CFR50.72 and is reportable as an LER in accordance with 10CFR50.73. An ENS notification was made at 1010 hours on July 3, 1991 and a LER was submitted on July 26, 1991.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS:

The Operating Department was tailgated to emphasize the need to closely review the reporting requirements for loss of a safety function even if Technical Specification LCO's are met. Regulatory Assurance personnel who review classifications were also tailgated on these requirements. Additionally, LaSalle Emergency Procedure LZP-1310-1, "Notifications", was revised on July 24, 1991 to include more specific examples of notification requirements for events including those affecting primary containment integrity. This revision reorganized the procedure to help facilitate proper identification of reporting requirements.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was attained on July 26, 1991 upon submission of the LER.