U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-373/84-03(DPRP); 50-374/84-02 (DPRP)

Docket Nos. 50-373; 50-374 License No. 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, IL

Inspection Conducted: April 16 through May 11, 1984

Inspectors: W. G. Guldemond — A M Tongue for — 5/30/84 Date

S. C. Guthrie — A M Tongue for — 5/30/84 Date

C. D. Evans — A M Tongue for — 5/30/84 Date

M. J. Jordan — A M Tongue for — 5/30/84 Date

Approved By: N. J. Chrissotimos, Chief
Reactor Projects Section 2C — 5-31-84 Date

Inspection Summary

Inspection on April 16 through May 11, 1984 (Report Nos. 50-373/803(DPRP); 374/802(DPRP))

Areas Inspected: Routine, unannounced inspection conducted by resident inspectors of licensee actions on previous inspection findings; operational safety; operating events; surveillances; review of reports, Licensee Event Reports; Part 21 Reports; independent inspection; information notices; regional requests, and assistance to headquarters. The inspection involved a total of 183 inspector-hours onsite including 28 inspector-hours onsite during off-shifts.

Results: In the eleven areas inspected, no items of noncompliance or deviations were identified in nine areas. Two items of noncompliance were identified in the remaining two areas (failure to follow procedures - Paragraph 3; and failure to meet Technical Specification requirements on RWCU - Paragraph 7).

DETAILS

1. Persons Contacted

R. Holyoak, LaSalle Project Manager
G. J. Diederich, Superintendent, LaSalle Station
*R. D. Bishop, Administrative and Support Services Assistant Superintendent
*C. E. Sargent, Operating Assistant Superintendent
J. Schmeltz, Operating Engineer
*P. Manning, Assistant Technical Staff Supervisor
*R. Kyrouac, Quality Assurance Supervisor
*W. Sheldon, Assistant Superintendent of Maintenance

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

*Denotes personnel attending exit interview.

2. Licensee Actions on Previous Inspection Findings

(Open) Open Item (373/84-02-18(DPRP)): This open item tracked receipt of three and nine month Unit 1 drywell cable inspections. These inspections were committed to by the licensee following a drywell overtemperature condition. By letter dated April 4, 1984, the licensee transmitted the results of the three month inspection. No degradation was found on safety related cables or snubbers. Three temporary temperature monitoring cables were found to have suffered some thermally-induced insulation degradation; however, there was no safety related equipment located in the areas where degradation was observed. This item will remain open pending receipt of the nine month inspection results.

No items of noncompliance or deviations were identified in this area.

3. Operational Safety Verification

The inspectors observed control room operations, reviewed applicable logs, and conducted discussions with plant operators during the inspection period. The inspectors verified the operability of selected emergency systems, reviewed tagout records, and verified proper return to service of affected components. Tours of Unit 1 and Unit 2 reactor buildings and turbine buildings were conducted to observe plant equipment conditions, fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been expeditiously initiated and resolved for equipment in need of maintenance.

The inspector, by observation and direct interview, verified that the physical security plan was being implemented in accordance with the station security plan, and that radiation protection controls were being implemented.

During the inspection period, the inspector walked down the accessible portions of the following systems to verify operability:

Unit 2	Unit 1
Emergency Diesel Generating System	HPCS
Residual Heat Removal (RHR) Service Water	LPCS
A.C. Electrical Distribution	Area Radiation Monitors
D.C. Power Supplies	Control Rod Drive
High Pressure Core Spray (HPCS)	
Low Pressure Core Spray (LPCS)	
Low Pressure Coolant Injection/RHR System	
Reactor Core Isolation Coolant (RCIC)	
Post Accident Containment Monitoring	
Control Rod Drive (CRD)	
Primary Containment Vacuum Relief	

At 8:15 a.m. on April 19, diesel generator 1A was declared inoperable due to line blockage that restricted oil flow to the diesels upper rocker arm bearings. The inspector monitored the licensee's testing of offsite power distribution and other diesel generators to verify compliance with Technical Specifications. Diesel generator 1A was returned to service at 5:30 p.m. on April 19.

At 4:00 p.m. on May 9 the inspector was notified by the licensee that grab samples to monitor main condenser offgas treatment system hydrogen concentration as required by Action Statement 3.3.7.11.b were not performed within the required time limit. The hydrogen analyzers had been declared inoperable at 10:30 p.m. on May 8 and grab sampling was conducted. However, at 10:00 a.m. on May 9 licensee personnel discovered that the sample point on the system prefilter was totally isolated, voiding the validity of the earlier samples. The first valid sample of offgas system hydrogen concentration was obtained at 10:40 a.m. May 9, approximately eight hours beyond the required sample deadline. Contributing to the incident was the failure of radiation-chemistry personnel to verify the prefilter being on line as required by LaSalle Radiological Procedure LRP-1360-9, Step F.1. This failure to follow procedural requirements and the resultant violation of Technical Specifications is an item of noncompliance (373/84-03-01(DPRP)). Immediate corrective action involved establishing the correct sampling lineup and meeting the sampling requirements of Technical Specifications. In addition, the licensee has commenced a revision to LRP 1360-9, Off Gas System Four Hour Hydrogen Sampling, to revise the required data sheet in a manner that the technician must identify the prefilter then on line. Training sessions were conducted immediately with rad chem foremen and training on this issue is scheduled for all rad-chem technicians. The corrective actions by the licensee were adequate to address the concerns of the inspector. The licensee has committed to complete all corrective actions by June 30, 1984.

No others items of noncompliance or deviations were identified in this area.

4. Onsite Followup of Operating Events

At 7:05 p.m. on April 14, Unit 1 experienced a reactor scram on low reactor vessel water level. The scram occurred from 558 MWe while conducting tests of the Turbine Driven Reactor Feed Pump (TDRFP) 1B that involved matching the output of 1B with control in manual with that of the automatically controlled 1A TDRFP, then placing the 1B TDRFP in automatic for parallel pump automatic operation. During the first attempt to perform this operation at normal vessel level, the resultant high feed rate from both pumps at a relatively low power level resulted in rapidly rising levels that required securing of the oncoming 1B pump. In anticipation of the rising level, the operator, prior to his second attempt to parallel the pumps, used the level controller to lower level to the vicinity of 22-25 in. At 22 in. indicated level a miscalibrated level indication instrument inserted a half scram signal for low vessel water level, occurring as the operator was placing the 1B control into automatic. The operator was unable to readjust the level controller before level fell to the low level scram setpoint. Factors contributing to the scram included the miscalibrated level instrument and the instability of the feed control system while attempting to place both feed pumps in parallel automatic operation. At this relatively low level this evolution is characterized by TDRFP oscillations and vessel level changes. The operator restored level manually from its lowest level of -15 in. and no ECCS systems were actuated. Following verification of accurate calibration of reactor vessel level instrumentation startup was commenced and the reactor was critical at 2:30 p.m. on April 15. This incident occurred during the inspection period covered by Report No. 50-373/84-10(DPRP) but occurred to close to the end of the inspection period to be documented in that report.

At 5:05 a.m. on April 26 Unit 2 was manually scrammed from below 1% power after having reduced power from approximately 25% by control rod insertion. The action was taken to protect the units condensate pumps which were experiencing suction problems resulting from suction blockage. The blockage resulted from rust, sediment, and possible debris in the condensate and feed water systems that was knocked loose when steam was admitted for the first time to the feed water heaters several hours earlier. The Reactor Core Isolation Cooling (RCIC) System was manually initiated prior to scramming the reactor to assure the operators of a means of maintaining vessel level when there was reason to believe condensate/feed flow might be lost. There was no level loss and RCIC did not inject water into the vessel. No ECCS systems were activated.

At 11:40 p.m. on May 3 Unit 2 was manually scrammed from 10% power in response to a trip of the Motor Driven Reactor Feedwater Pump (MDRFP) on low lubricating oil pressure. No Turbine Driven Reactor Feedwater Pumps (TDRFP) were in operation. Investigation revealed that the MDRFP lubricative oil loss resulted from the incorrect closure of the MDRFP downstream balancing stop valve 2CB037 which eliminated the balancing effect of feedwater pressure on the pump shaft and forced the full thrust of the shaft against the thrust bearing. The rapid decomposition of the thrust bearing babbitt face caused that material to accumulate in the lube oil strainer, blocking lube oil flow. The inadvertent closure of 2CB037 resulted from confusion between that valve and the numbering of the MDRFP

Warmup Line Upstream Stop Valve, 2FW037, which the operator had been instructed to close. The two valves are similar in size and appearance and are physically located approximately six feet apart at the MDRFP. All systems responded normally following the scram. Water level was restored and maintained by manual initiation of Reactor Core Isolation Cooling System (RCIC). No Emergency Core Cooling Systems were activated. Following thrust bearing repair, lube oil system flushing, and inspection of all journal bearings on the pump and motor, the MDRFP was returned to service. Unit 2 was returned to operation on May 6 and increased to 22% power for continuation of startup testing, including calibration of the recently replaced 2A TDRFP controller.

Immediate licensee corrective action included the installation of red signs affixed to 2CB037 and the upstream stop valve in the same line warning operators against valve manipulation unless the MDRFP is out of service. Training of personnel to alert them to the cause and significance of the event commenced immediately and continues beyond the date of this report to other crews. Other corrective action includes revision of all station procedures from requiring the manipulation of valve 2FW037 to instead operate valve 2FW115, which is located in the same line but outside the MDRFP room, thereby reducing the potential for confusion over nearly identical identification numbers and close physical locations. Adding 2CB037 to the locked valve checklist was considered and rejected by the licensee.

Subsequent to Unit 2 startup it was discovered that the MDRFP shaft driven lube oil pump had been incorrectly reassembled, requiring the operation of the electric driven auxiliary lube oil pump to maintain oil pressure. Projections for repair time required the MDRFP to be out of service for 16 hours, leaving only the 2A TDRFP to meet feed flow demands during startup testing at approximately 22% reactor power. During earlier phases of startup testing 2A TDRFP had demonstrated its inability to respond reliably to changes in feed demand. Further, the Electrical Hydraulic Control (EHC) system used for control of turbine stop values and by pass valves had earlier demonstrated erratic behavior. The EHC had just been declared fully operational and turbine vibration problems were still being addressed. Given the 2A TDRFP's demonstrated inability to reliably cope with transients and the various opportunities for transients to be imposed on the plant by startup testing activities, surveillances, or unplanned events, the inspector expressed to the licensee his concerns that the potential was greatly enhanced for a challenge to the Unit 2 Reactor Protection System (RPS) during the period the MDRFP would be out of service. The inspector maintained that while RCIC was available for manual operation, it was unlikely that an operator could initiate RCIC upon a loss of feed in time to prevent the low water level scram. The licensee committed to provide an additional licensed operator during the MDRFP out of service period, and to avoid performing surveillances or other activities which have the potential to impose a transient on the feedwater system during that period. The inspector verified the licensee's efforts to increase operator awareness of the potential hazards of this operational situation. On May 2 the inspector was informed that computer analysis of data gathered during the calibration of the Traversing In-Core Probe (TIP) System indicated possible reversal of TIP tubes 9 and 10 on Unit 2D. TIP tube 10 was found on each of the five TIP drive units and was used as a calibration channel in LPRM detection assembly 32-33, which was physically located in the center of the core. TIP tube 9, Unit 2D, served LPRM detector assembly 56-17, located on the core periphery. Reversal of TIP tubes 9 and 10, Unit 2D, was confirmed by performance of a specially prepared test. Investigation by maintenance personnel located the tube reversal at the Unit 2D indexer. Repairs were completed by May 4 and reperformance of the special test showed normal and expected values for all TIP data. An investigation by the licensee was unable to determine any work activity involving the TIP indexer that could have resulted in tube reversal during the period following initial unit startup and was unable to locate documentation that would verify proper hookup during the construction phase. The licensee identified other work performed by the Operations Analysis Department subsequent to the construction phase that involved a tube walkdown from indexer to reactor vessel using an audible test of the detector passing through the TIP tube that relied heavily on the expertise of the operator. Unit 1 had used a visual inspection of the TIP detector in the correct TIP tube as a means of tube to indexer alignment verification. This matter is an unresolved item (374/84-02-06(DPRP)) pending further investigation by the licensee.

No items of noncompliance or deviations were identified in this area.

5. Surveillance

a. On April 20, the inspector observed the performance of monthly surveillance 1-LIS-PC-13, Functional Test of Drywell Equipment Drain Sump Discharge Flow instruments by licensee instrument mechanics. The surveillance was performed in accordance with procedural requirements.

b. On Friday, April 27, the inspector observed the licensee's performance of mechanical surveillance LMS-FP-0[illegible], Monthly Inspection of Yard Loop Fire Hose Stations. The surveillance was conducted according to procedure with satisfactory results.

c. On April 20, while observing performance of surveillance 1-LIS-PC-13, Functional Test of Drywell Equipment Drain Sump Discharge Flow, the inspector observed that during the venting process of the differential pressure detector several drops of water fell onto the cell and were wiped up by the mechanic. Discussions with other instrument mechanics and a review of other surveillance procedures pointed out the possibility of instruments becoming contaminated during the procedure performance. After a review of station procedures and interviews with maintenance persons and supervisors to determine the licensee's normal response to minor potential radiological spills, contamination detection and control procedures, and emphasis on craftsmanship and housekeeping, the inspector determined that the licensee adequately addresses the inspector's concerns.

d. On May 2, the inspector observed performance of 2-LIS-NB-03, Reactor Vessel Low Low Water Level Recirculation Pump Trip Calibration and Functional Test. The surveillance was performed in accordance with procedural requirements with the exception of the caution note in Paragraph F requiring the mechanic to consider all water contaminated and follow the appropriate rad/chem procedures. Contrary to instrument maintenance department training and common work practices, the technicians perform the surveillance involving potentially contaminated water without the use of protective rubber gloves. An investigation by the inspector revealed that while use of rubber gloves in this activity would be in keeping with the standards of craftsmanship expected of instrument mechanics, the rad/chem procedures to which the mechanic must adhere, including a procedure that would define exactly what protective clothing would be required of technicians involved with potentially contaminated water, do not exist. Technical Specifications 6.2.A.1 requires that detailed written procedures recommended in Appendix "A" of Regulatory Guide 1.33, Rev. 2, February 1978, be prepared, approved, and adhered to. This Regulatory Guide in section 7.e specifies the preparation of radiation protection procedures for contamination control. Failure to provide a procedure that details requirements for the use of protective clothing during performance of surveillances where potentially contaminated water is expected is considered a programmatic weakness. The licensee has taken the immediate corrective measure of reemphasizing to all instrument mechanics, in their regular weekly safety meeting, the need to wear rubber gloves while performing surveillances where water is involved, and that all water must be treated as contaminated as specified in the procedural caution notes. For long term corrective action, the licensee has, as a minimum, committed to conduct a procedure review and implement changes that specify protective clothing requirements for any work that involves potential radioactive contamination. Followup on the long term corrective actions is an open item (374/84-02-01(DPRP)).

No items of noncompliance or deviations were identified in this area.

6. Review of Periodic and Special Reports

During the inspection period the inspector reviewed the following report and verified that it was submitted in a timely manner and contained the required information. LaSalle Units 1 and 2 Monthly Operating Reports

No items of noncompliance or deviations were identified in this area.

7. Licensee Event Reports Followup

Through direct observations, discussions with licensee personnel, and review of records, the following Event Reports (LER's) 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.

374/84-011 Out Of Specification Water Level Instrument
373/84-020 Reactor Building Ventilation Process Radiation Monitor Failure
373/84-021 Miswired Ammonia Detector
374/84-013 Reactor Water Clean-up (RWCU) Differential Flow Isolation
374/84-014 High Pressure Core Spray Jockey Pump Failure

LER 374/84-010 documented Unit 2 Reactor Water Cleanup System (RWCU) isolations which occurred as a result of ventilation system problems in the RWCU rooms. The LER was submitted in a timely fashion, contained the required information, and is considered closed; however, the corrective actions specified in the LER have yet to be completed. These actions will be tracked as an open item (374/84-02-02(DPRP)).

LER 374/84-009 documented an inadvertent pump down of approximately 60 inches of water from the Unit 2 reactor vessel with the unit in cold shutdown. The cause of the event was a combination of personnel error and a faulty temperature alarm module which generated a spurious Residual Heat Removal (RHR) isolation signal. The LER contains the required information, was submitted in a timely fashion, and is considered closed; however, the licensee has yet to complete the committed-to corrective actions. These actions will be tracked as an open item (374/84-02-03(DPRP)).

LER 373/84-016 documented an event in which two Low Pressure Coolant Injection System permissive pressure switches were left isolated following a surveillance activity. This event resulted in an item of noncompliance (reference IE Inspection Report 373/84-05(DPRP)). The LER contains the required information, was submitted in a timely fashion, and is considered closed. Licensee corrective actions will be tracked by the previously identified item of noncompliance.

373/84-019, RWCU differential flow isolation calibration. The licensee reported that the RWCU inlet flow transmitter had been replaced by a modification and the subsequent data sheet provided by the Architect-Engineer (A&E) firm was not correct, resulting in the station calibration procedures being incorrect. The flow transmitter was calibrated incorrectly and according to this LER resulted in the actual differential flow less conservative than the allowed Technical Specification limit of 87.5 GPM. This condition had existed in both units since their respective licenses were issued.

The inspectors expressed a concern with the excessive length of time the Limiting Condition of Operation (LCO) was exceeded, and requested information as to the significance of the excessive flow setting. Subsequently, the licensee investigated and determined that this problem was an isolated condition by review of 19 other flow indicators in the diesel generators, High Pressure Core Spray (HPCS), Fuel Pool Cooling, and Standby Gas Treatment Systems. The licensee identified this problem as a result of corrective actions to a problem identified during pre-operation testing of the HPCS where the flow orifice was not temperature compensated. The temperature compensation correction of the RWCU outlet flow orifices to the reactor vessel and to the main condenser resulted in the down scale indication in the differential flow reading.

A subsequent licensee investigation determined that correct calibration of the inlet flow transmitter 1E31-N503, (Unit 1); and 1E31-N503 (Unit 2) resulted in the isolation function being within the Technical Specification limits as long as total flow through the system was not to the main condenser. With total flow of the RWCU to the main condenser the isolation differential flow exceeded Technical Specification limits by aoproximately 5 GPM. The licensee contacted General Electric who stated that the 87.5 GPM had no technical bases but was based on a nominal 20% of rated flow. Total flow to the condenser would occur only during startup conditions or cold shutdown which would have minimal safety significance if the pipe ruptured. Other detection methods of line breakage were available such as equipment room temperature indication, which would cause the RWCU system to isolate and level alarms on the containment equipment drain sumps to activate, which also could have been used to indicate a line break inside the containment.

10 CFR 50, Appendix B, Criterion III states in part: "The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Contrary to the above, the RWCU system did not have the capability to isolate in certain configuration on high differential flow required by Technical Specifications. The condition existed for both units since licensing. The safety significance in this case is considered of a minor nature; however, this is considered an item of noncompliance (373/84-03-02(DPRP), 374/84-02-04(DPRP)).

8. Part 21 Reports

a. On April 6, 1984 the NRC was telephonically notified by a representative of Terry Turbine of a deficiency reportable pursuant to 10 CFR Part 21. Specifically, a Reactor Core Isolation Cooling (RCIC) turbine throttle valve stem guide bushing was found loose on the Unit 2 RCIC turbine. The loose bushing prevented the valve from operating properly creating the potential for a turbine overspeed on a quick start. Inspection of the subject part showed it to be made of two pieces which had become separated, allowing movement.

   As a temporary repair the licensee, with the concurrence of Terry Turbine, peened over an exposed surface of one of the two bushing pieces to secure it to the second piece. A replacement bushing was procured and will be installed at the next Unit 2 outage of sufficient duration. This will be tracked as an open item (374/84-02-05(DRPR)).

b. On March 18, 1983 NRC Region IV was notified of a failure of an ITE Gould circuit breaker to meet environmental qualification requirements. In the notification, made pursuant to 10 CFR Part 21, the vendor identified that one application of the subject breaker was in the safety-related hydrogen recombiners at LaSalle Units 1 and 2. The vendor recommended corrective action was to bypass the subject breakers. On April 27, 1984, NRC Region III requested the inspectors to verify that the vendor recommended corrective action had been implemented.

On March 23, 1983 the licensee was also notified of the breaker problem by the vendor. On that same date the breakers were bypassed. Completion of that action was verified at that time by the inspectors as noted in IE Inspection Report 373/83-34. This matter is closed.

No items of noncompliance or deviations were identified in this area.

9. Independent Inspection

a. During this inspection period the inspector reviewed the licensee's revision to the Unit 1 and 2 Locked Valve Position Checklist, Attachments A and B to LAP-240-1. This revision to LAP-240-1 was conducted as part of the licensee's response to a series of unlocked valve incidents detailed in Reports 50-373/84-02(DPRP) and 50-374/84-01(DPRP)). The proposed deletions were evaluated for safety significance against licensee developed criteria, which included:

   1. Deletion of valves in systems having minimal impact on plant safety, such as turbine oil and service water.

   2. Deletion of double-block valves located outside of containment isolation valves.

   3. Deletion of one of the two locks on double-block valves located between Primary Containment Isolation Valves.

   4. Deletion of certain valves associated with the water leg pumps in the Residual Heat Removal (RHR) and Reactor Core Isolation Cooling (RCIC) systems where alarms exist that would directly or indirectly alert the operator to failure or isolation of the water leg pump.

   5. Retention of Emergency Core Cooling System (ECCS) flow path valves, the abnormal position of which would not be annunciated.

   6. Retention of containment boundary valves, located inside containment isolation valves, the abnormal position of which would not be annunciated

   The inspector verified that all valves proposed for deletion from LAP 241 meet the licensee established criteria, and concluded that the removal of these valves does not compromise plant safety. The inspector determined that the licensee's actions are in keeping with the requirements of Criterion 55 to Appendix A, 10 CFR 50, and that the concerns expressed by the inspector in the above referenced report are adequately addressed. This is a followup to noncompliance (374/84-01-01(DPRP)). This item remains open pending licensee actions on key control.

b. On May 7 the inspector toured the facility with the licensee representatives in charge of housekeeping and maintenance of fire fighting equipment. The inspector identified the locations of the newly designated employee smoking areas and concluded that successful implementation of the licensee's plan to restrict smoking to the established areas should contribute significantly to plant cleanliness. The inspector observed the general level of cleanliness throughout the facility to be satisfactory with the exception of the Radwaste Control Room which the inspector has observed on other occasions to be well below normal plant standard cleanliness. Concerns regarding the radwaste area were expressed to the licensee.

c. During the inspection period the inspector reviewed the licensee's actions in regard to Generic Letter 84-12, compliance with 10 CFR Part 61. The inspector verified that the licensee does have an approved Process Control Program (PCP) for solidification of liquid radwaste. The licensee is presently discussing with NRR the interpretation of the new regulations and the degree of upgrading necessary for the present PCP program, if any, to meet the requirements of 10 CFR 61. The inspector will track the developments in this area as an open item (373/84-03-03(DPRP)).

No items of noncompliance or deviations were identified.

10. IE Information Notices (IEN)

(Closed) IE Information Notice 84-34: This IEN described a deficiency in self-contained breathing apparatus (SCBA) hoop-wrapped aluminum air cylinders rated at 4500 psi manufactured by Luxfer Company under Department of Transportation (DOT) Exemption DOT-E 7235. Following failure of a cylinder on February 4, 1984, a Notice was published in the Federal Register by DOT limiting cylinder filling pressure to 4000 psi. On May 1, 1984 the inspector determined that the subject cylinders were in use at LaSalle. It was further determined that the licensee had been notified by INPO and the vendor of this problem in March 1984. Air pressure in all cylinders had been immediately reduced to 4000 psi and on April 9, 1984 the SCBA Monthly Inspection Procedure, LRP-1310-5, had been revised to reflect the new pressure limits. In order to ensure an adequate supply of air per 10 CFR 50 Appendix R, the licensee increased the required number of SCBA air cylinders from 120 to 145. The licensee is waiting for new cylinder "O" rings and upon receipt of these rings an inspection of all cylinders will be performed in order to determine if any cylinder wall cracking has occurred. Completion of this inspection will be tracked as an open item (373/84-03-04(DPRP)).

(Closed) IE Information Notice 83-35: This IEN provided notification of events that resulted in drywell pressure increases following a reactor scram and the subsequent unavailability of systems that could be used to reduce drywell pressure. Because of the potential seriousness of this type of event, the IEN suggested that licensees consider design changes to prevent tripping drywell coolers and/or provide convenient override arrangements to permit rapid restarting of drywell coolers when a high drywell pressure condition still exists. LaSalle Procedure LOA-VP-02, "Primary Containment Pressure Reduction - Drywell Coolers," specifies actions to be taken in response to the type of event described in the IEN including a detailed description of jumper installation.

(Closed) IE Information Notice 82-17: This IEN provided notification of two cold overpressurization events at pressurized water reactors. The inspector reviewed the IEN for applicability to LaSalle and, after discussion with I&E Headquarters, determined that while cold overpressurization is possible at LaSalle through either the motor driven High Pressure Core Spray System (HPCS) or the Control Rod Drive System (CRD) it is an extremely unlikely event. The bases for this determination was that the reactor vessel is normally not filled and maintained in a solid water condition, HPCS is automatically secured on high reactor vessel water level, and any water addition from CRD would occur at a sufficiently low rate that the operator could terminate the transient in a timely manner.

(CLosed) IE Information Notice 84-32: This IEN provided notification of water hammer problems unique to pressurized water reactors. As such, it is not applicable to LaSalle.

11. <u>Regional Requests</u>

The resident inspector received a request for assistance concerning unmonitored circuit breakers. The licensee provided the following information:

Circuit Breaker Manufacture Information

A. The 4160 volt buses, Division I and II are ITE manufactured by Gould Division, and Division III is manufactured by General Electric.

B. The 480 volt switchgear are manufactured by General Electric.

C. The 480 volt Motor Control Centers (MCC), Division I and II are manufactured by Knocker Moeller; and Division III is manufactured by International Switch Board Corporation.

What Type of Indication Does the Licensee Have of Power Available to the Closing Circuit

A. Power to the 4160 V bus if interrupted would produce several alarms in the control room.

B. For the 480 volt components most of the components have a yellow component trip light in the control room; however, not all components are indicated.

C. For the 480 volt MCC if the breaker is tripped for any reason other than thermal overload, there will not be any indication of this problem in the control room. The exception being if the breaker trips while the valve is mid position then dual indication of valve position will occur in the control room. Dual indication is an abnormal indication for most valves in the control room and should be identified during panel walkdowns. If the breaker trips on thermal overload the valve position lights in the control room will be extinguished indicating a problem with power to the breaker.

12. Assistance to Headquarters Concerns

The inspectors attended the meeting between the Committee for the Review of Generic Requirements (CRGR) and the licensee's corporate and site management. The inspectors responded to questions concerning resident inspectors involvement with site operations. Topics discussed covered a broad area of plant programs, such as training, Organization and Staffing, Salem Generic Issues, Quality Assurance, and NUREG-0737, Supplement No. 1 issues.

13. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. An unresolved item disclosed during the inspection is discussed in Paragraph 4.

14. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspector, and which involve some action on the part of the NRC or licensee or both. Open items disclosed during the inspection are discussed in Paragraphs 7, 8, 9, and 10.

15. Exit Interview

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