U.S. NUCLEAR REGULATORY COMMISSION
REGION III

Report Nos. 50-373/91025(DRP); 50-374/91025(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 3, 1991, through January 14, 1992

Inspector: C. Phillips

Approved By: B. L. Burgess, Chief 2/6/92
Reactor Projects Section 1B Date

Inspection Summary

Inspection from December 3, 1991 through January 14, 1992 (Report Nos. 50-373/91025(DRP); 50-374/91025(DRP)).

Areas Inspected: Routine, unannounced safety inspection by the resident inspectors of licensee action on previously identified items; licensee event reports; operational safety; shut down risk assessment; monthly maintenance; monthly surveillance; report review; evaluation of licensee quality assurance program implementation; installation and testing of modifications; and review of concerns.

Results: Of the ten areas inspected, no violations were identified. Four unresolved items were identified pending further review. These included workers given an incorrect survey and ALARA briefing (section 4.b), an inoperable low pressure coolant injection valve due to a pinched power lead (section 6.a), a trip of a reactor feedpump caused by opening of an incorrect fuse panel (section 6.b), a contaminated water spill caused by inadequate controls on a sump pump (section 6.c), and setting of all six average power range monitor gains simultaneously in the nonconservative direction due to a miscommunication (section 7).

Plant Operations

Management supervision of the Unit 2 shutdown was a strength. Supervisors discussed evolutions with the unit operators before they occurred, what the possible outcomes were, and what the operator actions should be in each case.

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radiation protection technicians to have all job documentation with them prior to signing the radiation work permit. This is considered an unresolved item (374/91025-01 (DRP)) pending review of licensee administrative requirements.

c. Security

Each week during routine activities or tours, the inspector monitored the licensee's 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. Housekeeping in radiological areas declined during the beginning of the period but improved with prompting from the inspectors.

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

e. Unit 2 Reactor Shutdown

The inspector observed the Unit 2 shutdown. The licensee modified the normal shutdown procedure to perform a "soft shutdown" to minimize the source term for the refueling outage. The "soft shutdown" involved taking the reactor subcri ical through control rod insertion alone, and increasing the cooldown period to avoid steaming, with its possibility of disturbing crud on the control rod blades. Management supervision and control of the shutdown was a strength. Supervisors discussed evolutions with the unit operators before they occurred, possible outcomes, and appropriate operator actions for each case. However, the inspector reviewed a copy of the approved "soft shutdown" procedure, prior to its use, and found it to be inaccurate and confusing in some places. Licensee management was notified of the concerns and the procedure was corrected prior to commencement of the shutdown. The incomplete licensee review of the procedure was a considered a weakness. The inspectors will continue to monitor the licensee's procedures to assess whether a generic problem exists in this area.