U.S. NUCLEAR REGULATORY COMMISSION

REGION III

REPORTS NO. 50-373/95007; 50-374/95007

FACILITY
LaSalle County Station, Units 1 and 2

Licenses No. NPF-11; NPF-18

LICENSEE
ComEd
Executive Towers West III
1400 Opus Place Suite 300
Downers Grove, IL 60515

DATES
July 22 through August 31, 1995

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Reactor Projects Branch 1

AREAS INSPECTED

A routine, unannounced inspection of operations, engineering, maintenance, and plant support was performed. Safety assessment and quality verification activities were routinely evaluated. Follow-up inspection was performed for non-routine events and for certain previously identified items.

RESULTS

Assessment of Performance

Performance within the area of OPERATIONS was good.

The operators' response to the main steam isolation valve (MSIV) closure and reactor scram was good. ComEd's review of the event was complete and conservative. The inspectors were concerned with the design of the reactor building ventilation (VR). The loss of a reactor protection system (RPS) bus can ultimately result in a MSIV closure and reactor scram on both units if extraordinary operator actions are not taken. The design adequacy of VR is considered an inspection followup item.

Performance within the area of MAINTENANCE was adequate.

Work planning with respect to corrective maintenance on the Unit 2 reactor core isolation cooling system (RCIC) was poor. Materiel condition of the RCIC system was still in need of improvement as the trip and throttle valve had not been permanently repaired.

Performance within the area of ENGINEERING was mixed and considered weak.

The engineering response to the Unit 1 scram and restart activities was good. However, engineering response to an operations concern on control room ventilation operability was poor. In addition, the root cause evaluation performed for a snubber failure lacked thoroughness.

Performance within the area of PLANT SUPPORT was good.

Overall performance during the annual emergency preparedness (EP) exercise was good. The control room simulator and Technical Support Center performance were good with no significant concerns identified. Performance in the Operational Support Center was poor. Dispatch of repair teams was slow as a result of an ineffective method of forming, briefing, and dispatching the teams.

Performance within the area of SAFETY ASSESSMENT/QUALITY VERIFICATION was mixed.

Operations management's ability to objectively assess personnel performance in that department continued to improve. Management was taking more extensive actions directed at basic root causes of personnel errors. Management's ability to address materiel condition of the facility continued to be inconsistent. While good actions to address some materiel condition problems were noted, others were deficient. This included a design vulnerability, making the plant more susceptible to MSIV isolations, that had not been adequately addressed. Despite improved problem identification capabilities, the inspectors were concerned that other design vulnerabilities may not have been identified or received sufficient plant management focus to ensure resolution.

Summary of Open Items
Violations: none identified in this report
Unresolved Items: none identified in this report
Inspection Follow-up Items: identified in section 1.2.2
Non-cited Violations: none identified in this report

INSPECTION DETAILS

1.0 OPERATIONS

NRC Inspection Procedure 71707 was used in the performance of an inspection of ongoing plant operations. No violations were identified and performance in this area was good. The operators' response to the main steam isolation valve (MSIV) closure and reactor scram was good. ComEd's review of the event was complete and conservative. The inspectors were concerned that the design of the reactor building ventilation (VR) was such that the loss of a reactor protection system (RPS) bus can ultimately result in a MSIV closure and reactor scram on both units if extraordinary operator actions are not taken. The design adequacy of VR is considered an inspection followup item.

1.1 Summary of Operations

Unit 1 operated at or near full power until August 16, 1995, when a MSIV isolation and reactor scram occurred as a result of the loss of an RPS bus. Unit 1 was restarted and subsequently synched to the grid on August 21, 1995. Unit 2 operated at or near full power with slight deratings due to lake temperature and problems with the recirculation system flow control valve.

1.2 Unit 1 Reactor Scram Revealed VR Design Vulnerability

The August 16, 1995, scram occurred upon loss of an RPS bus when an electrical protection monitoring assembly (EPMA) breaker tripped open. This caused VR to isolate, resulting in actuation of MSIV isolation logic with the associated temperature increase. The MSIVs isolated, causing the reactor scram, despite operator actions to bypass the isolation logic. The following paragraphs provide the inspectors' assessment of ComEd's evaluation of root causes, corrective actions, and adequacy of system designs.

1.2.1 Electrical Protection Monitoring Assembly (EPMA) Trip

ComEd's preliminary root cause determination for the loss of the RPS bus was reasonable and corrective actions were acceptable. The B train RPS EPMA tripping due to a failed logic card was confirmed during bench testing. ComEd concluded that all equipment actuations were as expected for the loss of a single RPS bus. Numerous primary containment isolations resulted, including isolation of the VR dampers on both units.

The EPMA breaker and logic card were removed and bench tested. The breaker tripped properly; however, the logic card was out of calibration low for underfrequency and undervoltage. Physical inspection of the card identified several cold solder joints. In addition, it was identified that a wire that connected to the breaker undervoltage release mechanism had fallen off during card removal. This logic card was an older design. Subsequent testing was able to lock-up the EPMA logic in a continuous tripped state. Preliminarily, ComEd believed the logic card had failed and that the disconnected wire may have only been a contributor to the breaker trip. The inspectors concluded the preliminary root cause determinations were reasonable.

General Electric (GE) service information letter (SIL) No. 496, "Electrical Protection Assembly Performance," recommended logic card replacement to an improved design if logic reset problems were occurring. There were 12 EPMAs used at LaSalle. Six original design logic cards were in service at the time of the event. Four revised cards were installed with only one card requiring replacement. This card was replaced when the underfrequency trip would not calibrate. Two later revision cards were installed in Unit 2 and have performed satisfactorily. The revised cards at LaSalle have had a decreased card failure rate of one out of six compared to six out of 12 from the original design. The inspectors concluded that the failure history was not excessive and that ComEd was addressing failed logic cards according to SIL recommendations.

ComEd re-inspected a newly installed card, identified several cold solder joints, and replaced the card. All together, ComEd obtained four new cards and installed them on Unit 1. The EPMAs' calibration and circuit checkouts were acceptable. To date, the other two cards installed on Unit 2 had performed satisfactorily at LaSalle. Two Unit 2 EPMAs contained their original logic cards. ComEd planned to examine these cards during an upcoming outage. The inspectors concluded that ComEd's corrective actions were acceptable.

1.2.2 Group 1 Isolation and Subsequent Reactor Scram

Actions taken by operators to mitigate the EPMA trip by resetting the primary containment isolation system (PCIS) half isolations were in accordance with procedures and appeared correct. The operators had an excellent knowledge and understanding of the installation of jumpers and method for resetting PCIS logic. However, those actions were unsuccessful in preventing a MSIV isolation and reactor scram. The need to take extraordinary actions to prevent a MSIV isolation on a VR isolation was an operator work around that had not been adequately addressed.

The trip of the 1B RPS EPMA (20:06:50 hours) caused a half scram, other valve group isolations, and a half (Div 2) Group 1 MSIV isolation signal. It also caused a Group 4 isolation signal which tripped the VR systems that were common to both Units. The operators concurrently entered off-normal procedure LOA-RP-01, "Loss of Reactor Protection Power," and LOA-VR-01, "Recovery from a Group 4 Isolation of Spurious Trip of Reactor Building Vent." The B train RPS was transferred (20:07:15 hours) to the alternate supply and the half scram was reset. Per LOA-VR-01, the operators installed jumpers bypassing the Division 2 (B train) leak detection system (high ambient or high delta main steam line tunnel temperature) and reset the PCIS logic at 20:08:05 hours.

These actions should have prevented a full MSIV isolation. However, at 20:13:29 hours, the MSIVs closed due to the DIV 1 MSL PIPE TUNNEL TEMP HI (A2) combined with the un-reset DIV 2 (B2) logic. Once initiated, the logic performed as designed.

The reason for the MSIV isolation despite the operator actions could not be determined. ComEd developed special test procedures to test the MSIV reset logic. The inspectors reviewed the tests and concluded the licensee had tested all aspects of the logic. No anomalies were identified.

ComEd indicated that the LOA-RP-01 procedure could be improved. A possible solution was to include the LOA-VR-01 jumper steps in this procedure. In addition, the main steam tunnel temperature setpoints are set lower than at other boiling water reactors. ComEd indicated that they may evaluate the current temperature settings to see if margin existed to raise the setpoints. The proposed corrective actions were reasonable to the inspectors.

The inspectors were concerned that the VR system design forced the operators to work around a loss of an RPS bus to prevent a reactor scram on high main steam line tunnel temperature. Anytime VR was lost operators were required to take extraordinary measures to prevent a MSIV closure and reactor scram. A loss of power to one RPS bus on either unit would trip the VR systems for both units. This design vulnerability could result in a common trip of both units.

ComEd indicated that they were going to evaluate the VR system response to a loss of RPS power. This is considered an inspection followup item (373/374/95007-01(DRS)) for the NRC to review ComEd's evaluation.

1.2.3 Nuclear Instrumentation (NI) Reliability Challenged Operators

Although ComEd was operating within Technical Specifications with respect to NI, the lack of reliability challenged the operators following the reactor scram. (NI reliability concerns were discussed in inspection report 373;374/95005.) Before the reactor scram, four out of eight intermediate range monitors (IRMs) and one source range monitor (SRM) were inoperable. Two of these inoperable IRMs and the SRM had been repaired and were awaiting paper work closeout. However, the onshift operators were unaware of their status. Preliminary troubleshooting indicated that the other two IRMs would require detector replacement during a unit outage.

Following the scram, a SRM did not come on scale. ComEd determined the detector did not drive fully into the core. Troubleshooting identified that the sprocket gear had separated from the drive tube. This was corrected by restoring the drive tube to sprocket alignment and adjusting the limit switches on the motor module.

NI work activities were prioritized in an acceptable manner. If minimum operability requirements were met, NI work requests were normally classified as B2 (within the next two weeks). If minimum channel operability requ rements were being approached, the priority increased to B1 (next shift or as soon as possible). When troubleshooting identified the problem was located in the drywell, the work was scheduled for the next outage. Routine maintenance tasks were classified as priority C and were placed on the normal 8-week work schedule.

1.2.4 <u>Good Operations Response to the Unit 1 Scram</u>

Despite the aforementioned challenges to the plant, the crew response to the group I isolation and subsequent reactor scram was good. Proper actions in accordance with the abnormal procedures were implemented, and upon reactor scram, proper emergency operating procedures (EOPs) were used. The crew exhibited good command and control, communications, and the shift briefings were good.

1.3 <u>Management Continued Efforts to Improve Operations</u>

Operations management continued to implement new standards and expectations in the conduct of operations activities through a series of training sessions and simulator exercises. Operations management used the normal training cycle to observe and evaluate crew performance. They also used this opportunity to provide guidance to the crews with regard to conservative decision making, improved standards, and new expectations. Areas for improvement identified by operations management included more consistent shift technical advisor (STA) utilization, command and control improvements, and better plant status briefs as a crew.

1.4 <u>Follow-up on Non-Routine Events</u> NRC Inspection Procedures 90712 and 92700 were used to perform a review of written reports of non-routine events. For items which are "Closed" on the basis of this inspection, the Inspection Procedures were satisfied with regard to review of appropriateness of corrective and preventive actions.
(Closed) LER 373/94010, Revision 0: "Scram Due to Reactor Water Level Control Signal Loss to the 1B Turbine Driven Reactor Feed Pump"

(Closed) LER 373/94010, Revision 1: "Scram Due to Reactor Water Level Control Signal Loss to the 1B Turbine Driven Reactor Feed Pump"

(Closed) LER 373/94011, Revision 1: "Reactor Scram During TDRFP Tuning in Automatic Mode"

1.5 <u>Follow-up on Previously Opened Items</u> A review of previously opened items was performed per NRC Inspection Procedure 92901.

(Closed) Unresolved Item (373/93013-01 DRP): Evaluate adequacy of Operations Manager qualifications with respect to a senior reactor operator's (SRO) license. NRC review of this item was to be evaluated through submittal of a TS amendment request by ComEd. ANSI N18.1, "Selection and Training of Nuclear Power Plant Personnel," dated

March 8, 1971, required the Operations Manager to hold an SRO license. This ANSI provision was previously fulfilled through a TS requirement for the Assistant Superintendent Operations (ASO) (the title for the manager of the LaSalle operating organization at the time) to hold the SRO license. However, an early 1993 reorganization established the title of Operations Manager for which ComEd did not require an SRO license. The ASO title was initially retained (given to one of the Operating Engineers) to fulfill the TS requirement but the entire operating organization did not report through this individual. The remaining operating organization di' report through the other Operating Engineers who had SRO licenses.

ComEd submitted a TS amendment request to the NRC on April 24, 1995, which included title changes to reflect the current organization. The requested amendment would change the requirement for the ASO (a now non-existent title) to hold an SRO license to the Operations Manager or Shift Operations Supervisor. As this issue is now being tracked through the NRC licensing action, this item is closed.

2.0 MAINTENANCE

NRC Inspection Procedures 62703 and 61726 were used to perform an inspection of maintenance and testing activities. No violations were identified and performance in this area was considered adequate. Work planning with respect to corrective maintenance on the Unit 2 reactor core isolation cooling system (RCIC) was poor. Materiel condition of the RCIC system was still in need of improvement as the trip and throttle valve had not been permanently repaired.

2.1 Materiel Condition of Unit 2 RCIC Still In Need of Improvement

Work planning for the repair of the RCIC trip and throttle valve was weak. As a result, maintenance personnel working on the repairs had not performed the pre-job walkdown and were not fully familiar with the job. Also the work package was incomplete which caused delays to beginning the work. Although extensive attention had been given to this problem, the root cause of the problem had not been corrected.

The work package for the RCIC trip and throttle valve repair was incomplete in that it did not contain a chemical control release for the vendor recommended grease. The grease was marked as class three and not compatible for use on stainless steel components. This was identified by the mechanics and brought to the system engineer's attention just before they left the shop to begin work on the valve. As a result, the system engineer had to contact the chemical coordinator to obtain the release. This delayed the job at least a hour and 15 minutes.

Although the considerable time and attention had been given to resolving the root cause of the RCIC trip and throttle valve failure, the valve had not been permanently repaired. The root cause was previously thought to be due to the presence of a non-hardened set screw. During the work on the trip mechanism, the system engineer determined that the root cause of the problem was wear on the brass sliding nut on the linkage. The sliding nut compressed the spring and provided a latching point for the latch on the trip mechanism. The brass sliding nut was worn at the interface with the trip lever. Through trial and error, the mechanics and system engineer set the tolerances on the coupling and were able to get the valve to relatch. However, these tolerances were not per the vendor recommendations. Due to the internal wearing of the trip mechanism, the system engineer could not determine how long the trip mechanism would continue to relatch before this piece wears down and the valve fails to relatch. The system engineer determined the valve would require major work during an outage.

2.2 Follow-up on Non-Routine Events NRC Inspection Procedures 90712 and 92700 were used to perform a review of written reports of non-routine events. Items which were "Closed" as a result of the inspection satisfied the criteria established in the Inspection Procedures.

(Closed) LER 373/94012, Revision 0: "Untested Contacts in the NR and RP Systems Due to Procedure Deficiencies," described an event where a contractor performing a programmatic review, of relay and contact testing for ComEd, identified that 12 relays (K18) involved in the nuclear instrumentation system had never been properly tested since original plant startup. This condition affected both units. These contacts affected an interlock between the reactor mode switch and the average power range monitors (APRM) involving the 15 percent power scram setpoint being operable in Operational Condition (OC) 2, 3, and 5. The APRMs were always operable in OC 1. The 15 percent power setpoint was required to be tested every six months per Technical Specification 4.3.1.1. The failure to test the contacts would be a violation; however, identification of this problem was part of the ongoing corrective actions for violation (373;374/91019-07(DRS)). Consequently, no violation will be issued and this LER is considered closed.

(Closed) LER 374/95007, Revision 0: "Division 2 ESF Actuation Due to Instrument Reference Line Pressure Spike"

(Closed) LER 373/95010, Revision 0: "Auto Start of Standby Gas Treatment, Unit 1 and 2 Division 2 Reactor Building Ventilation Isolation, and Other Isolation Signals Received Due to the Wrong Fuse Being Pulled Due to Personnel Error"

2.3 Follow-up on Previously Opened Items A review of previously opened items was performed per NRC Inspection Procedure 92902.

(Closed) Inspection Followup Item (373/93004-03 (DRP)): Technical specifications (TS) did not require periodic channel checks for reactor vessel level instrumentation that provided reactor protection system, automatic depressurization system, primary and secondary containment isolation systems, emergency core cooling systems and reactor core isolation cooling system actuations. Although TS originally required these channel checks, the TS were amended in 1985 because the instrumentation was changed to a type that did not provide for channel checks (i.e., no readout capability). The instrumentation was subsequently changed again to a type providing the channel check capability. Although ComEd implemented channel checks, the TS were not also revised to reflect the change. After the NRC raised this issue in January 1993, the licensee indicated that this would be addressed in a larger TS amendment request involving instrumentation surveillance intervals. This request was finally submitted on December 14, 1994, and approved by the NRC on August 2, 1995. This item is closed.

3.0 ENGINEERING

NRC Inspection Procedure 37551 was used to perform an onsite inspection of the engineering function. No violations were identified. Engineering performance was mixed and considered weak during this inspection period. The engineering response to the Unit 1 scram and restart activities was good. However, engineering response to an operations concern on control room ventilation operability was poor. In addition, the root cause evaluation performed for a snubber failure lacked thoroughness.

3.1 Good Engineering Support Observed During the Post Scram Response

Response to the Unit 1 August 16, 1995, MSIV isolation and scram after a RPS MG set breaker tripped was observed. This included the post-trip review committee activities, replacement of the circuit cards, training of the Electrical Maintenance (EM) personnel on soldering techniques, discussions with system engineers and site engineers, and interviews with Operations staff on duty at the time of the event. Good support was provided from both site and system engineering as well as Operations and Maintenance Departments. Communication and interface between these organizations was effective. Plant management was thoroughly involved and asked very probing questions. See paragraph 1.2 for a complete description of the event and equipment operation.

Engineering was also challenged to resolve several operational questions following the scram including an unidentified control room buzzing noise and a recirculation pump trip. The troubleshooting and conclusions drawn on both of these issues were reasonable. The root cause of the buzzing sound could not be identified; however, the engineers performed thorough testing and the sound could not be duplicated. After thorough review of the event, ComEd determined that the recirculation pump tripped properly due to an anticipated transient without scram (ATWS)/recirculation pump trip signal as a result of water level reaching the level 2 setpoint of -50 inches.

3.2 Poor Engineering Response to Operations Concern Regarding Operability Determination

Operations initially expressed an operability concern via a problem identification form (PIF) on November 25, 1994, regarding the operability of the control room emergency makeup filtration unit with the refrigeration unit out-of-service (OOS). However, system engineering did not provide a Technical Specification clarification until August 22, 1995, even though the issue was raised several times.

The PIF initiated on November 25, 1994, requested an operability determination per LAP 220-5 to determine the operability of the control room ventilation (VC) emergency makeup system with the refrigeration unit OOS. Another PIF was generated on December 20, 1994, documenting a problem with the "B" VC refrigeration unit. This PIF also stated that operations was still awaiting the operability evaluation; however, per the initial operability determination VC was considered operable. Since that time, several PIFs have been generated documenting problems with the VC system.

On March 28, 1995, the inspectors asked to review a copy of the operability evaluation and instead were given a memo by the system engineer stating that a Tech Spec clarification and administrative technical requirement were needed instead of an operability evaluation. This document also stated that the administrative technical requirement would be based on the Improved Tech Specs and require operating to enter a 30-day timeclock if either compressor was inoperable. This was a more conservative approach than was currently being taken by operations in their initial operability screening. At the end of this inspection period, the issue had not been resolved.

This event demonstrated poor communications between operations and engineering. Operations was not aggressive in resolving this issue and engineering was not responsive to operations concerns. This event demonstrated a failure to take timely corrective actions when problems were raised via the PIF system.

3.3 Snubber Failure Root Cause Lacked Thoroughness

ComEd's report documenting the investigation into a snubber failure did not recognize several inconsistencies in the data and appeared to lack thoroughness. The report, "Reactor Recirculation Snubber Root Cause Investigation," No. 373-200-94-00435PIF, Revision 0, concluded that the observed structural damage was caused by a locked-up snubber which transferred significant thermal loads into the support steel during system cooldown. While the report contained detailed information regarding the failure, it did not evaluate all of the findings from the investigation.

For example, if the support damage was caused by thermal loads during piping cooldown, then the maximum displacement rate was relatively slow. This premise contradicted the metallurgical report's conclusion that the fractographic evidence suggested a high deformation rate or possibly an impact failure. The metallurgist's conclusions were not considered as refuting evidence for the thermal contraction scenario nor as supporting evidence for the postulated hydraulic transient scenario.

Another example was the estimated load caused by the locked-up snubber. The initial calculation assumed an ultimate tensile strength of the specified material as 58 ksi. Data from the metallurgical report stated that the actual tensile strength was 74.5 ksi, or 25 percent higher. There was no documentation indicating that this information was fed back into the evaluation process.

A third example pertained to the damage discovered late in the investigation on the snubber's pipe clamp. The initial evaluations were performed assuming the load occurred during system cooldown since the original damage only indicated a load being applied in that direction. Later, additional damage was found on the pipe clamp that could have only occurred during heatup. However, the report did not address the magnitude of this heatup load, based on the observed damage, nor determine if this load direction was more critical than the initial evaluation.

Although ComEd provided plausible justifications for the above issues during followup discussions, the lack of documentation and disregard of certain data indicated a lack of thoroughness in the root cause investigation.

3.4 Weaknesses in Processing Licensing Submittals

Two technical specification (TS) amendment request submittals were untimely. One was needed to reflect changes in the ComEd's organization and ensure NRC review of a position qualification requirement. The other was needed to reflect the addition of required surveillances due to changes in equipment design. The specifics are discussed in more detail in sections 1.5 and 2.3 of this report. These examples indicated licensee difficulties in resource utilization with regard to processing licensing submittals.

3.5 Follow-up on Previously Opened Items NRC Inspection Procedure 92903 was used to perform a review of previously opened items. The following items were closed:

(Closed) Inspection Followup Item (373/94005-06(DRS)): Review the root cause report for the snubber failure on the reactor recirculation piping. The Region III inspector reviewed ComEd's report documenting the investigation into a snubber failure on the recirculation piping. The report concluded that the failure was due to vibration induced wear on the snubber subcomponents which caused it to transfer significant thermal contraction loads into the auxiliary steel members. The inspector concurred with this conclusion. However, several pertinent issues were not documented in the report indicating that the root cause evaluation was not thorough. These issues were eventually clarified during discussions with engineering personnel. See paragraph 3.2 of this report for additional details. This item is closed.

(Closed) Violation (373;374/93040-01(DRS)): There was no formal program to test main steam system safety relief valves (SRVs). This resulted in two of the SRVs failing to meet a Technical Specification surveillance test requirement. ComEd subsequently developed an acceptable program and tested all the safety related SRVs. This item is considered closed.

4.0 PLANT SUPPORT

NRC Inspection Procedures 71750 and 83750 were used to perform an inspection of plant support activities. No notable observations were made in the radiological protection and physical security programs. Performance in these areas continued to be good. Performance during the annual emergency preparedness (EP) exercise was good.

4.1 <u>Good Performance During Annual EP Exercise</u>

The inspectors observed the utility only annual exercise and concluded that overall performance was good. The scenario adequately tested the emergency response capabilities of the emergency response organization. However, the inspectors concluded the scenario could have been more realistic and solvable.

The performance in the control room simulator was good with no significant problems observed. Performance in the Technical Support Center (TSC) was also good. Staffing of the TSC was prompt and effective. ComEd chose to double staff most positions which was considered positive management oversight and support of the EP program. The use of three way communications in the TSC and briefings were considered strengths. The use of status boards was very good. However, the status board used to track the Operational Support Center (OSC) teams was not indicative of the team status, rather it was used to prioritize the tasks deemed to be important in the TSC.

Performance in the OSC was poor. Team dispatch was slow due to poor communications and a weak process for forming, briefing and dispatching teams. For example, the number one priority was to perform a damage assessment of the reactor building due to the simulated plane crash. However, it took over an hour and a half to dispatch this person. At another time, it took 40 minutes to dispatch the team to the 0 DG after the team participants had been designated. The player critique following the exercise was considered effective with valuable inputs made by the players.

4.2 <u>Follow-up on Non-Routine Events</u> NRC Inspection Procedures 90712 and 92700 were used to perform a review of written reports of non-routine events. The following items were closed:

(Closed) LER 374/95002, Revision 0: "Missed Technical Specification Hourly Firewatch Due to Personnel Error"

(Closed) LER 374/95004, Revision 0: "Missed Technical Specification Hourly Firewatches Due to Management Deficiency"

These LERs described events in which compensatory fire watches were not performed within the required time periods due to both personnel errors as well as management deficiencies. The issues discussed in these LERs have been subsumed under the NRC's concerns with the LaSalle fire protection program described in Inspection Report 373;374/95006(DRP). The corrective actions associated with these LERs will be reviewed with the overall corrective actions for the fire protection program taken in response to violation 373;374/95005-04(DRS); consequently, these LERs are considered closed.

5.0 SAFETY ASSESSMENT/QUALITY VERIFICATION

NRC Inspection Procedure 40500 was used to evaluate inspection findings in this report and related findings in other reports toward assessing licensee safety assessment/quality verification capability. This was broadly defined as effectiveness in identifying, resolving, and preventing problems. This area continued to be mixed at LaSalle.

5.1 Increased Efforts to Address Personnel Performance

Operations man ent's ability to objectively assess personnel performance in that department continued to improve. New management was taking more extensive actions to more effectively address previously identified root causes (Section 1.3).

5.2 Inconsistent Efforts for Materiel Condition

Management's ability to address materiel condition of the facility continued to be inconsistent. Plant staff continued to perform well with respect to reactive, high profile issues. However, the approach to more routine, lower profile (but just as safety significant) issues was still a concern. Good actions were noted with respect to RPS EPMAs and NI. (However, NI reliability remained a concern.) (Sections 1.2.1 and 1.2.3) Other problems including the root cause evaluation for a failed snubber and evaluation of control room ventilation operability concerns were either not thorough or untimely (sections 3.2 and 3.3). Although RCIC problems had been extensively evaluated and addressed over the last few years, resolving several equipment concerns, Unit 2 RCIC trip and throttle valve problems continued (section 2.1). In addition, a design vulnerability, making the plant more susceptible to MSIV isolations, had not been adequately addressed (section 1.2.2). Despite improved problem identification capabilities, the inspectors were concerned that other design vulnerabilities may not have been identified or received sufficient plant management focus to ensure resolution.

6.0 PERSONS CONTACTED AND MANAGEMENT MEETINGS

The inspectors contacted various licensee operations, maintenance, engineering, and plant support personnel throughout the inspection period. Senior personnel are listed below.

At the conclusion of the inspection on August 31, 1995, the inspectors met with ComEd representatives (denoted by *) and summarized the scope and findings of the inspection activities. The licensee did not identify any of the documents or processes reviewed by the inspectors as proprietary.

*R. Querio, Site Vice President
*D. Ray, Station Manager
*L. Guthrie, Operations Manager
*P. Smith, Maintenance Superintendent
*R. Jacobs, System Engineering Supervisor
*P. Antonopoulos, Site Engineering and Construction Manager
*D. Boone, Health Physics Supervisor
*R. Crawford, Work Control Superintendent
J. Burns, Regulatory Assurance Supervisor