U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-373/84-26(DRP); 50-374/84-33(DRP)

Docket Nos. 50-373; 50-374 Licenses 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: September 19 through October 29, 1984

Inspectors: M. J. Jordan

C. D. Evans

M. C. Choules
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Approved By: N. Chrissotimos, Chief
Reactor Projects Section 2

11-26-84
Date

Inspection Summary

Inspection on September 19 through October 29, 1984 (Report Nos. 50-373/84-26(DRP); 50-374/84-33(DRP))
Areas Inspected: Routine, unannounced inspection conducted by resident and regional based inspectors of licensee actions on previous findings, operational safety, Licensee Event Reports, maintenance, surveillance, followup on licensee events, plant trips, Part 21 followup, and annual emergency exercise. The inspection involved a total of 200 inspector-hours onsite by three NRC inspectors including 35 inspector-hours onsite during off-shifts.
Results: Of the nine areas inspected, no items of noncompliance or deviations were identified in seven areas; two items of noncompliance were identified in the area of operation safety (failure to follow radiation control procedures and failure to control access to high radiation area - Paragraph 3) and one item of noncompliance with two examples was identified in the area of maintenance (failure to provide adequate maintenance instructions - Paragraph 5).

DETAILS

1. Persons Contacted

*G. J. Diederich, Superintendent, LaSalle Station
*R. D. Bishop, Administrative and Support Services Assistant Superintendent
*C. E. Sargent, Operating Assistant Superintendent
*W. Huntington, Technical Staff Supervisor
R. Kyrouac, Quality Assurance Supervisor
R. Clark, Quality Control Supervisor
*W. E. Sheldon, Maintenance Assistant Superintendent
*F. R. Lawless, Rad/Chem Supervisor
D. S. Berkman, Unit 2 Operating Engineer
J. Schmeltz, Unit 1 Operating Engineer

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

*Denotes personnel attending exit interview on October 29, 1984.

2. Licensee Action on Previous Inspection Findings

(Closed) Noncompliance (374/84-01-01): Failure to control locked valves. The licensee ordered new locks to provide more adequate control. Procedure LAP-240-5 was changed so that keys are controlled by the Shift Engineer.

(Closed) Noncompliance (373/84-05-04): Failure to land leads on IRM B. Procedure LIP-GM-35 has been revised to add verification of proper IRM cable connections prior to startup following a shutdown of 72 hours.

(Closed) Noncompliance (373/83-51-01): Failure to follow procedure in that flow rate was higher than allowed. The control room operator was instructed to check flow more frequently during the Secondary Containment Integrity Test (SCIT). The result of the SCIT retest was satisfactory.

(Closed) Open Item (374/84-02-01): Procedure LRP 1410-2 will be revised to include guidance for instrument mechanics to wear rubber gloves while performing surveillances on equipment where potentially contaminated water is expected.

(Closed) Open Item (373/83-54-02): This item tracked the development of a permanent calibration program for measuring and testing equipment. Procedures LAP 1500-3 and 2500-5 have been revised to include a requirement that when an instrument is found out of tolerance, a check will be made to determine if any Technical Specification surveillances could have been affected. A Technical Specification instrument matrix was developed to provide easy cross-reference between the last surveillance and the associated Technical Specification.

(Closed) Noncompliance (373/84-05-03): A mode change was made with Division II Low Pressure Coolant Injection Systems inoperable. The isolation valves to instruments 1B21-N413 B and D were left closed contrary to the requirements of the surveillance procedure. A discussion was held between management and workers to emphasize the importance of attention to detail. Also a review of all instrument surveillances were conducted to verify that they contain double verification when returning to service.

(Closed) License Condition (374/81-00-05): This item addressed a license condition requiring installation of an automatic scram during startup and refueling modes on low control rod drive pump discharge pressure (License Condition 2.C.(7)). The licensee has installed, and tested the scram function. Also the required surveillance testing procedures have been identified to insure the system remains operational.

(Closed) Open Item (373/83-15-04; 374/83-13-03): There was no guidance which specified the types of documents which should be included in modification history packages. The licensee had revised the plant modification procedure LAP-1300-2 to include guidance on the type of documents that should be included in modification history packages.

No items of noncompliance or deviations were identified.

3. Operational Safety Verification

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

During the inspection period, the inspectors walked down the accessible portions of (1) Unit 1 - all three diesel generators, A-Residual Heat Removal System (RHR), Standby Liquid Control and High Pressure Core Spray, and (2) Unit 2 - both diesel generators, A-Residual Heat Removal System (RHR), High Pressure Core Spray, Standby Liquid Control System, Control Rod Drive System and RHR Service Water.

These reviews and observations were conducted to verify that facility operations were in conformance with the requirements established under technical specifications, 10 CFR, and administrative procedures.

On October 1, 1984, at 12:56 a.m. CDT, the Unit 2 Control Room Emergency Ventilation System (CREV) actuated unexpectedly during the performance of Procedure LIS-AR-05, "Main Control Room Radiation Monitor Calibration and Functional Test." The cause of the CREV System actuation was

attributed to the lack of communication between the center desk nuclear station operator (NSO) and the instrument mechanic (IM) conducting the surveillance. The control room had returned the CREV System fan from out of service to automatic start during the time the IM had left the control room for lunch. Upon returning to the control room, the IM continued the surveillance by introducing a trip signal to the control room radiation monitor which caused the CREV System to actuate. The CREV System was then secured allowing for completion of the surveillance, whereupon the system was returned to automatic start. The inspectors discussed this event with the NSO and station management and determined it to be an isolated occurrence. Thus no further action was taken by the resident inspectors.

On October 24, 1984, the inspector was touring areas that were radiologically accessible on Unit 1. The inspector was monitoring area dose rates with a direct reading radiation meter and noted that dose rates at 18" from the "B" residual heat removal suction header and drain line were 150 mR/hr. The inspector requested the licensee's health physics organization to conduct a survey of the area. The results of the survey confirmed the inspectors dose rate measurements. The licensee immediately secured and posted the lower elevation of the Unit 1 reactor building as a High Radiation Area.

Technical Specification 6.1.1.1 requires, in part, that in lieu of a "control device" or "alarm signal" required by paragraph 20.203(c)(2) of 10 CFR 20, each high radiation area in which the intensity of radiation is greater than 100 mrem/hr but less than 5000 mrem/hr shall be barricaded and conspicuously posted as a High Radiation Area and entrance thereto shall be controlled by the security computer system. The failure to secure and post the lower elevation of the Unit 1 reactor building confining the residual heat removal suction header and drain line as a High Radiation Area is considered a violation of Technical Specification 6.1.1.1. (373/84-26-01(DRP)).

A followup inspection by the inspector confirmed that the licensee had correctly posted the area, and radiological control personnel were appraised of the improper posting. The licensee action is considered adequate, and no reply to this violation is required. We have no further questions regarding this matter.

On October 24, 1984, during a routine inspection of the radiologically accessible areas of Unit 1 reactor building, the inspector noted the ladder from the 710' elevation to the 740' elevation was not posted as a contaminated area. The ladder provided access to the Unit 1 CRD changeout area on the 740' elevation which had been determined earlier by the licensee to be contaminated to levels in excess of 1000 dpm/100 cm^2. The inspector informed licensee representatives of his findings and the licensee immediately posted the access ladder.

LaSalle Radiological Procedure LRP 1130-1, Paragraph F.1.e defines the requirement for posting of areas with contamination levels in excess of 1000 dpm/100 cm^2. Technical Specification 6.2.B requires that "radiation control procedures shall be maintained, made available to all station

personnel, and adhered to". The failure to post the ladder from the 710' elevation to the 740' elevation providing access to the CRD changeout area as a contaminated controlled area is considered an item of noncompliance (373/84-26-02(DRP)).

A followup inspection identified that the licensee had correctly posted access to a contaminated area and the health physics personnel had been briefed on proper posting of access to contaminated areas. The licensee's action is considered adequate, and no reply to this item of noncompliance is required and we have no further questions regarding this matter.

Two items of noncompliance were identified in this area.

4. Licensee Event Reports Followup

Through direct observations, discussions with licensee personnel, and review of records, the following Licensee Event Reports (LERs) 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.

374/84-40-00	Drywell Crane Circuits Not on Technical Specification Surveillances
373/84-43-00	Reactor Water Cleanup (RWCU) Differential Flow Isolation
374/84-041-00	RWCU High Differential Flow Isolation
374/84-38-00	Unsecured High Radiation Area
374/84-39-00	RCIC Low Pressure Isolation Set Point Instrument Drift
373/84-045-00	RWCU Isolation on High Differential Flow
374/84-049-00	High Radiation Door Unsecured. The station security computer was changed on July 27 and 29, and during this change the rad door to the RWCU valve alley was accidentally left off the high rad control status. The access control to this door was put back into the computer as a high rad door.
374/84-062-00	Division II Isolation on RHR Shutdown Cooling
374/84-043-00	Violation of Technical Specification 3.6.1.8 Action Statement (See Inspection Report 374/84-30 for Noncompliance Associated With This LER)
374/84-060-00	CRD Charging Water Header Pressure Time Delay Greater Than 10 Seconds
374/84-052-00	Reactor Scram Due to Phase A Stator Winding Failure. This scram was addressed in paragraph 4 of inspection report 373/84-20 and 374/84-26.
373/84-050-00	RWCU Isolation Because of Personnel Error
374/84-061-00	RWCU Isolations During Startup
374/84-063-00	Time Clock Exceeded on RCIC Isolation Surveillance by Eight Minutes. The licensee exceeding the LCO by only 8 minutes was not considered to be a significant safety concern since RCIC is not take credit for during accident conditions. The LCO violation was due to a delay in a surveillance test which was being accomplished at the time. Operations personnel have been briefed on this event and cautioned to coordinate the surveillance test with the LCO requirements more closely.

374/84-064-00 Reactor Water Cleanup Differential Flow Isolation
374/84-066-00 RWCU Isolation Because of Broken Hose
373/84-051-00 Unit 1 Safety Relief Valve (SRV) Lifted Three Times Because of Ground in Solenoid Winding. This SRV actuation was addressed in the special inspection report 373/84-23 and 374/84-30.
374/84-068-00 High Pressure Core Spray Discharge Relief Valve Failure
373/84-023-00 Reactor Water Cleanup Differential Flow Isolation Rev. 1
373/84-047-00 Reactor Water Cleanup High Differential Flow Isolation
373/84-048-00 Missed Noble Gas Sample From U-1 SBGT and Particulate and Iodine Samples Counted Late
373/84-050-00 Reactor Water Cleanup Isolation Differential Flow
374/84-021-00 Reactor Water Cleanup High Differential Flow Isolation Rev. 1
374/84-048-00 Unit 2 Reactor Scram Initiation - Reactor Instrument Line Valved In. This scram was addressed in inspection report 373/84-20 and 374/84-26, paragraph 4.
374/84-050-00 Reactor Scram From Reactor Pressure Vessel High Pressure. This scram was addressed in inspection report 373/84-20 and 374/84-26, paragraph 4.
374/84-053-00 Missed Hydrogen Sample of Off-Gas. This was considered an isolated occurrence and was the result of poor communication between operations and Rad Chem department. Both departments were briefed on this LER to prevent repeatability.
374/84-059-00 Missed Surveillance LIS-RD-403. This missed surveillance was due to one procedure having two parts. One part was to perform a surveillance on Control Rod Drive Scram Discharge Level Functional Test required by technical specifications, and the second part was to perform a surveillance requested by SNED on the sensing lines. The licensee had considered the surveillance of tech specs being completed erroneously because the second part was accomplished on the computer printout which indicated that the procedure had been performed. Because of this misinterpretation the licensee has separated the two parts into two separate procedures.
374/84-060-00 CRD Charging Water Header Pressure Time Delay Greater Than Ten Seconds
374/84-062-00 Division II Isolation on RHR Shutdown Cooling - This event resulted in an alert emergency classification and is addressed in paragraph 7 of this report.
374/84-051-00 Reactor Water Cleanup High Ambient Temperature Isolation
374/84-056-00 Reactor Water Cleanup Isolation
374/84-051-00 Reactor Water Cleanup Isolation
374/84-058-00 Reactor Water Cleanup Isolation on High Differential Temperature Isolation

LER 374/84-055 documented a failure of the "B" RHR full flow test valve. The LER was submitted in a timely fashion, contained the required information, and is considered closed; however, the corrective modification specified in the LER has yet to be completed. These actions will be tracked as an open item (374/84-33-01(DRP)).

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

5. Monthly Maintenance Observation

Station maintenance activities of 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 or reviewed:

Changeout of Air Start Motors on 2A Diesel Generator, repair on Main Steam Isolation valves, and replacement of Overspeed Switch on 1A Diesel Generator.

On October 23, 1984, a leak was identified on the variable leg side supply line to a number of reactor vessel instruments on instrument rack 1H22-P027. Prior to the line being isolated, a temporary supply line to the instruments on rack 1H22-P027 was installed so that reactor vessel wide range level indication could be maintained. The inspector reviewed special procedure LLP 84-31 which provided instruction on installation of the temporary supply line and also observed the installation of the temporary supply line.

The inspector reviewed the failure of feedwater check valve 1B21-F010A to pass a Local Leak Rate Test. On October 3, 1984, the licensee determined that the above valve was leaking in excess of 2100 SCFH. On October 5, 1984, the licensee partially disassembled the valve. A measurement between the valve seat and the valve disk soft seat seal showed there was a gap of approximately .0032 inches completely around the seating surface. This indicated the valve was not completely closed. When an attempt was made to lift open the check valve disk, the disk would not move. The valve disk was subsequently removed by removing the hinge pins which hold it in place. Inspection of the valve showed that one of the hinge pin bushings, which was interference fitted into the disk assembly, had come loose and moved out against the shoulder on the hinge pin. The bushing moved such that a lip on the bushing wedged between the hinge pin shoulder and a spot weld on the disk which had been installed to keep the bushing from rotating. A small high spot was also found on the hinge pin associated with the bushing that moved. With the bushing wedged between

the hinge pin shoulder and the weld, the disk would not move. This caused the valve disk to not go completely shut resulting in failure of its leak rate test. The other bushing on the disk had not moved. Inspection of the soft seat seal showed it to be in good condition.

The licensee repaired the valve by removing the bushing, obtaining and verifying the bushing bore diameter and hinge pin diameter, fabricated a new bushing with dimensions to assure an adequate interference, removed the high spot from the hinge pin, and installed the new bushing. The valve was reassembled and leak tested. The leak rate was acceptable at 4.5 SCFH. All dimensions were verified and recorded in the Work Request (WR) package (L42159).

This was an improvement over the previous recording of dimension in other work request packages involved in bushing fabrication and installation as described in the following paragraphs.

A review was conducted of past maintenance on the valve disk to determine what may have caused the bushing to move. Review of WRs L29832 and L29357 revealed that new stellite bushings with eccentric pin bearing bores for the hinge pins were installed in December 1983 to provide better vertical alignment of the valve disk with the valve seat. In February 1984, the 1B21-F010A valve failed its leak rate test. At that time the hinge pin to bushing clearance was reduced to improve the horizontal alignment of the valve disk with the valve seat.

A review was conducted of WR L32527, which was the WR under which the February maintenance on the 1B21-F010A valve was performed. Although not specifically required by the WR and the attached Maintenance/Modification procedure, a write-up attached to the WR indicated that the bushing on the valve disk had been removed so that the horizontal alignment check could be performed as specified in the procedure. There was no indication if the same bushings or new bushings were reinstalled after this check. Interviews revealed that the old bushings were reinstalled. There were no bushing bore or bushing diameters recorded nor any requirements to measure and record them to indicate if the interference fit of the bushings in the valve disk was adequate. Since the bushing was removed and reinstalled, it appears that the removal of the bushing may have increased the diameter of the bore and when the bushing was reinstalled, the interference fit was not adequate to prevent the bushing from moving. A reduced interference fit coupled with a high spot on the hinge pin may have caused the bushing to move. Measurements taken after the bushing was removed showed the bushing outside diameter to be less than the bore diameter (2.751"/2.752" bushing OD vs. 2.753 disc bore diameter) which would be expected since the bushing had moved. The failure to specify instruction including acceptance criteria for the interference fit for the removal and installation of the bushings for the 1B21-F010A valve was contrary to 10 CFR 50, Appendix B, Criterion V and is considered an item of noncompliance (373/84-26-03A(DRP)).

WRs L29357, L29832, L32526, L32910 and L31455 were the work requests associated with the fabrication and installation of the new hinge pin bushings for the Unit 1 and 2 feedwater check valves 1B21-F010A, 1B21-F010B, 2B21-F010A and 2B21-F010B. The bushings were installed between November 1983 and March 1984 to improve the vertical alignment of valve disks with their valve seats. Review of the Maintenance/ Modification procedures associated with the WRs showed that with the exception of WR 31455 for 2B21-F010B, no acceptance criteria was specified regarding the interference fit of the hinge pin bushings nor were sufficient dimensions recorded to determine the interference fit. The outside diameters of the bushing for all valves except the 1B21-F010A valve were recorded. The bore diameter on the valve disks in which the bushings fit into were not recorded.

The failure to specify acceptance criteria in the Maintenance/Modification procedures for the interference fit of the bushing and requirements to document dimensions to determine this fit is contrary to 10 CFR, Appendix B, Criterion V and is considered an item of noncompliance (373/84-26-03B(DRP); 374/84-33-02(DRP)).

The licensee recognized that the dimensions of the bushing and bores should have been recorded in the past as they were in the WR package for the recent repair of the 1B21-F01CA valve. The licensee indicated that the interference fits of the bushing were accomplished with verbal instructions.

Since none of the bushings other than those for the 1B21-F010A have been removed and the leak rate test of 1B21-F010B was satisfactory, the licensee believes installations of bushings on this valve and the Unit 2 valves should be adequate. The inspector concurs with this position. The licensee committed to leak testing the Unit 2 feedwater check valve 2B21-F010A and 2B21-F010B during the scheduled March 1985 outage or before if an outage of sufficient duration occurs. This is considered an open item (374/84-33-03(DRP)).

One item of noncompliance with two examples was identified in this area.

6. Monthly Surveillance Observation

The inspector observed Technical Specifications required surveillance testing on the Control Rod Scram Accumulator Instrumentation and the Drywell Vacuum Breaker Instrumentation and verified: that testing was performed in accordance with procedures LIS-RD-102 and LES-VQ-01 respectively, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test 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 inspector noted that terminal wire numbers and terminal block numbers associated with the limit switches on the C vacuum breaker did not correspond. The electrician performing the surveillance assumed that the wire numbers indicated the correct wire to terminal block connections based on instruction from earlier on the job training. Correct position of the wires could also be verified by the circuitry continuity and non-continuity.

The fact that the terminal block numbers and wire numbers did not correspond, however, could be a source of confusion to an inexperienced electrician. Licensee representatives agreed to review the terminal block and wire number indications. This concern will be tracked as an open item (373/84-26-04(DRP)).

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

7. Followup on Licensee Events

On September 28, 1984, at 8:00 p.m. CDT, Unit 1 commenced a shutdown for a 30 day outage. The outage was to accomplish the 18 month surveillance testing of safety systems required by Technical Specifications and perform some maintenance activities such as recirculation pump seal replacement.

On September 30, 1984, at 1:30 a.m. CDT, the licensee was unable to open the inboard isolation valve of the shutdown cooling mode of the Residual Heat Removal (RHR) System. The unit was in a hot shutdown condition at approximately 80 to 90 lbs at this time. Maintenance personnel were called in and commenced work on the valve. With the valve closed the licensee was unable to use the normal shutdown cooling method to cool the unit below 212°F. The licensee did have available an alternate method of cooling the unit down if needed using the Safety Relief valves and the suppression pool which is addressed in the Final Safety Analysis Report (FSAR). The Senior Resident Inspector was dispatched from his residence to the site at 4:00 a.m. CDT and the Incident Response Center (IRC) in Region III was partially manned at approximately 4:30 a.m. CDT. The NRC monitored the licensee's actions until the valve was opened on September 30, 1984, at approximately 10:15 a.m. CDT. On September 30, 1984, at 07:30 a.m. CDT, the licensee declared an Alert emergency classification status because both RHR shutdown cooling modes were inoperable. Alternate methods of cooling down the reactor coolant were available for use if needed to commence cool down. The Alert was suspended at approximately 1:36 p.m. CDT on September 30, 1984.

On October 3, 1984, the licensee reported that the bellows on the High Pressure Core Spray System (HPCS) relief valve on Unit 1 were blown while performing the monthly surveillance test of verifying adequate flow using the condensate storage tank. Failure of the bellows causes communication between primary and secondary containment because the relief line goes to the suppression pool. The unit was shut down and cooled down such that primary containment was no longer needed. The licensee has prepared a modification package for both units that changed the routing of the

relief line from the suppression pool to the HPCS equipment room. The inspectors verified the modification was accomplished on Unit 2. Unit 1 HPCS modification will be accomplished prior to returning the unit to power.

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

8. Plant Trips

Following the plant trips on September 21, and October 27, the inspector ascertained the status of the reactor and safety systems by observation of control room indicators and discussions with licensee personnel concerning plant parameters, emergency system status and reactor coolant chemistry. The inspector verified the establishment of proper communications and reviewed the corrective actions taken by the licensee.

All systems responded as expected, and the plant was returned to operation on September 22 and October 28 respectively.

On September 21, 1984, at 2:30 p.m. CDT, Unit 1 scrammed from approximately 23% power as a result of closure of the Main Steam Isolation Valves (MSIV), a Group I isolation. An instrument mechanic was performing a functional test on one pressure switch for Main Steam Line Low Pressure (MSLLP) isolation when he placed a two-way radio on the support stanchion for another MSLLP and caused that switch to trip. All systems functioned as expected and no ECCS initiation occurred. The unit was returned to the grid on September 22, 1984.

On October 27, 1984, Unit 2 scrammed from 100% power on High Neutron Flux. The control signal to the B recirculation pump flow control valve failed low which caused the flow control valve to close to the minimum valve position. After the valve got to the minimum flow position, it started ramping back open. This sudden increase in flow caused an increase in the neutron flux in the core and caused the unit to scram. All systems functioned as expected. A new Linear Voltage Differential Transformer and cable were installed to repair the failed signal. While shut down the licensee worked on repairing some steam leaks in the turbine heater system. The unit was returned to power the evening of October 28, 1984.

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

9. Part 21 Followup

The licensee received a Part 21 notification from General Electric concerning ground fault failures of actuator solenoids on Automatic Depressurization System valves manufactured by Crosby Valve and Gauge Company. The licensee has completed the action on both units recommended by the vendor and meggered the solenoid coils. No failures were found on Unit 2 and two failures were found on Unit 1. One failure was on a "c" coil which was not associated with the ADS function of the valve but caused the valve to cycle open and close without the operator being aware of the condition (see Inspection Report 373/84-23(DRP); 374/84-30(DRP)).

The second failed solenoid was found on Unit 1 during the present outage when it was meggered. This solenoid was replaced. This completes the action associated with this Part 21 notification (373/84-26-05(DRP); 374/84-33-04(DRP)).

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

10. Annual Emergency Exercise

The resident inspectors participated in the annual emergency exercise for the site. The drill started at approximately 6:00 p.m. (CDT) on October 10, 1984, and ran until approximately 1:00 a.m. (CDT) on October 11, 1984. The residents played their normal roll as inspectors observing the licensee's actions and keeping Region III and NRC headquarters appraised on the actions being taken via the Emergency Notification System telephone. The results of this drill will be addressed in a separate inspection report (373/84-18; 374/84-24).

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

11. Regional Request

The inspectors followed up on a regional request dated October 3, 1984. The request concerned the applicability to the site of a Notice of Violation that was issued to Sequoyah Unit 2. The Notice of Violation concerned the operability of the direct position indication of Safety/ Relief valves (SRV) addressed in standard Technical Specifications and in NUREG 0737 task action item II.D.1., and the fact that a backup valve indication system addressed in the Safety Evaluation Report (SER) could not be used to meet Technical Specification requirements.

The primary valve position indication addressed in the LaSalle's SER was the stem mounted limit switches with the tail pipe temperature readings as a backup. The inspectors informed the licensee that the only acceptable valve position indication for the SRV's addressed in Technical Specifications would be the stem mounted limit switches and not the tail pipe temperatures and the precedent had been set by the Sequoyah non-compliance. This open item is considered closed (373/84-26-06(DRP); and 374/84-33-05(DRP)).

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

12. 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 Paragraph 4, 5, 6, and 11.

13. 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 these findings.