

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos: 50-373/84-33(DRP); 50-374/84-40(DRP)

Docket Nos: 50-373; 50-374

Licenses No. NPF-11; NPF-18

Licensee: Commonwealth Edison Company  
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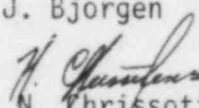
Facility Name: LaSalle County Station, Units 1 and 2

Inspection At: LaSalle Site, Marseilles, IL

Inspection Conducted: December 18, 1984 through February 13, 1985

Inspectors: M. J. Jordan

J. Bjorgen

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

2-25-85  
Date

Inspection Summary

Inspection on December 18, 1984 through February 13, 1985 (Report Nos. 50-373/84-33(DRP); 50-374/84-40(DRP))

Areas Inspected: Routine, unannounced inspection conducted by resident inspectors of licensee actions on previous inspection findings; operational safety; monthly surveillance; unit trips; monthly maintenance; Licensee Event Report Followups; headquarters requests; and regional/site observation. The inspection involved a total of 266 inspector-hours onsite by two NRC inspectors including 28 inspector-hours onsite during off-shifts.

Results: In the eight areas inspected, no items of noncompliance or deviations were identified in four areas; three items of noncompliance were identified in the remaining areas (failure to provide revised procedures and drawing after a modification - Section 2 and 5; failure to follow procedure - Section 3; failure to perform technical specification surveillance testing (two examples) - Section 4).

## DETAILS

### 1. Persons Contacted

- G. J. Diederich, Superintendent, LaSalle Station
- \*R. D. Bishop, Administrative and Support Services Assistant  
Superintendent
- \*R. M. Jeisy, Quality Assurance Supervisor
- \*W. E. Sheldon, Assistant Superintendent of Maintenance
- \*C. E. Sargent, Operating Assistant Superintendent
- \*P. F. Manning, Assistant Technical Staff Supervisor
- \*T. A. Hammerich, Assistant Technical Staff Supervisor

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

\*Denotes personnel attending exit interview held on February 13, 1985.

### 2. Licensee Action on Previous Inspection Findings

(Closed) Open Item (374/84-23-02(DRP)): Licensee to provide corrective action to prevent recurrence of the management breakdown that resulted in exceeding LCO action times during surveillance testing. The inspector reviewed Revision 9 to LAP 200-2 which now requires the unit operator to keep track of all short term LCO time clocks and Revision 0 to LAP 1600-11 which provides management controls for technical specification related work activities. The inspector has no further concern in this area at this time.

(Closed) Open Item (374/84-18-02(DRP)): The licensee was to investigate the causes and needed corrective actions for intermittent Unit 2 Reactor Water Cleanup (RT) System isolations. The licensee has conducted extensive evaluations of the system performance and design. The licensee has determined that during blowdown to the condenser, the flow seen by various instrumentation systems differs considerably due to the temperature gradients upstream and downstream of the heat exchangers. The isolation problem was aggravated by an "as-built" piping misalignment problem near the G33Z001 340 A & B relief valves which caused a piping stress concentration and spurious actuation of the relief valves and corresponding system flow surges. The piping misalignment has been corrected. The licensee also obtained a change to the plant technical specifications to eliminate the high pump room temperature and differential temperature isolations due to a system design evaluation (Amendment No. 20 to NPF-11 and Amendment 7 to NPF-18). The licensee also intends to modify the system instrumentation calibrations to better reflect the actual temperature corrected system flows and to increase the system isolation timer setting to absorb normal operational transients. The inspector considers the licensee action for system improvement to be adequate.

(Closed) Open Item (373/84-02-19(DRP)): The licensee was to submit a report on long-term corrective action for correcting excessive drywell temperatures. The licensee has committed to adding six new drywell fan coil cooling units and a new 400 ton drywell water chiller by the end of the first refueling outage. The inspector will track completion of these actions as open items (373/84-33-01(DRP); 374/84-40-01(DRP)).

(Closed) License Condition II.K.3.13 (373/81-00-97A): Licensee to modify the Reactor Core Isolation Cooling System such that it will autostart on low water level after shutdown. The inspector reviewed modification package M-1-1-81-009 including the revised licensee procedures LOP-RI-04, LOP-RI-05, LOP-RI-06, LOS-RI-02, LOS-RI-03, LES-RI-01. The modification is considered to have been satisfactorily completed with the following exception:

The modification was installed and declared operable in November 1984. Revised operating procedures for the system, LOP-RI-02 and LOA-RI-01, were not issued however until after the inspector inquired as to why the procedure had not been changed.

Failure to provide timely issuance of revised operating procedures is considered a violation of ANSI N18.7 as committed to in Regulatory Guide 1.33 and Section 6.2 of the technical specifications which requires the licensee to have procedures for control of documents and changes thereto to preclude the possibility or use of outdated or inappropriate documents. This is considered an item of noncompliance (373/84-33-02A(DRP); 374/84-40-02A(DRP)).

(Closed) Open Item (373/82-49-05(DRP)): The licensee was considering a modification to separate the power supplies to the low suction pressure trips for all three reactor feedwater pumps. The inspector reviewed modification package M-1-1-82-293 which separated the pump trip power supplies and added a three second time delay into the trip actuation to prevent tripping the pump on spurious pressure spikes.

(Closed) License Condition (373/81-00-97D(DRP)): Licensee had committed to provide for automatic restart of the High Pressure Core Spray System on a subsequent low water level signal following manual shutoff from the control room (item II.K.3.21 of the Safety Evaluation Report). The inspector reviewed the licensee's completed modification package M-1-1-81-007, including the revised operating procedures LOP-HP-03, LOP-HP-04 and LES-HP-02. The inspector considers that the modification has been satisfactorily completed and tested.

(Closed) Open Item (373/84-10-01(DRP)): Licensee to perform an environmental test on the Okonite taping sequence applied over nicks and cuts in conductor insulation. The inspector reviewed Wyle test report no. 17603-1 that performed laboratory tests of the taping sequence and noted that the test results were found to be satisfactory.

(Closed) Open Item (373/84-02-14(DRP)): The licensee was to conduct a nine month visual inspection of safety related components and cabling in the Unit 1 drywell to ensure that thermal degradation of qualified equipment had not become excessive. The inspector reviewed the results of this inspection performed by the licensee in October 1984 in accordance with procedure LST-84-172. The inspector noted that the inspection was satisfactorily completed with only a few minor maintenance items identified.

(Closed) Open Item (373/81-00-142(DRP)): The licensee was to conduct a feasibility study for performing Induction Heating Stress Improvement (IHSI) on primary system welds during the first refueling outage as committed to in Section 5.2 of Supplement 8 of the Safety Evaluation Report. The licensee has completed this study and intends to perform IHSI during the first refueling outage. The inspector has no further concern in this area at this time. The IHSI program will be evaluated by the Division of Reactor Safety during the first refueling outage (373/84-33-03(DRS)).

(Open) Open Item (373/83-01-03(DRP)): Licensee was to develop procedures for handling irradiated fuel for fuel loading and refueling. The inspector conducted a review of procedures and is still concerned about the adequacy and completeness of the licensee's refueling procedures. The inspector requested the licensee to evaluate procedure status and adequacy as part of the refueling planning effort now in progress for Unit 1.

(Closed) Unresolved Item (373/83-44-05; 374/83-48-08): Licensee to provide justification as to why bearded fire brigade members should be considered fully qualified to perform emergency response actions including the ability to wear respiratory equipment. The inspector has reviewed the actions taken by the licensee, including issuing Policy Guideline No. 54, which states that fire brigade members cannot have facial hair which would interfere with the proper seal of respiratory equipment. The inspector has no further concerns in this area at this time.

(Open) Open Item (373/84-14-05(DRP)): The licensee was to evaluate correction of the failure of the control room ventilation ammonia and chlorine detection system. The licensee had constructed a snow fence around the ventilation system intake. This change, however, has not eliminated the cold weather problems. Licensee corrective actions are continuing.

(Closed) Open Item (373/81-00-121(DRP)): The licensee was to provide criticality monitors in the new fuel storage area as committed to in Section 4.3.2.6 of Supplement 2 of the Safety Evaluation Report. The licensee has satisfactorily completed the modification M-1-0-84-06.

No other deviations or noncompliances 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 Units 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.

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls.

During the month of January 1985, the inspector walked down the accessible portions of the following systems to verify operability:

- Unit 1 & 2 Standby Gas Treatment Systems
- Unit 1 & 2 Standby Liquid Control Systems
- Unit 2 Reactor Core Isolation Cooling System
- Unit 2 High Pressure Core Spray System
- Unit 2 Low Pressure Core Spray System
- Unit 1 & 2 Diesel Generators

Facility Operating Licenses NPF-11 and NPF-18 require the licensee to maintain a fire protection program set forth in Appendix R to 10 CFR Part 50 as supplemented and amended by changes to the license and the Safety Evaluation Report. Licensee procedure LAP 900-22, which implements portions of the requirements of Appendix R to 10 CFR 50 and Regulatory Guide 1.120, requires that heat generating or heat source equipment must not be left unattended while it is warm enough to cause ignition of any surrounding combustible materials. The inspector noted, however, on January 24, 1985 that unattended portable electric space heaters were in use in the "0" and "1B" diesel generator rooms. Investigation determined that the heaters are not equipped with automatic shutoff controls such as a thermostat or "tilt" switches. In addition, the station Fire Marshall was unaware of their presence in the diesel generator rooms. The heaters were also not restrained to prevent tipping. The Shift Engineer stated that a one hour fire watch was in effect but the adequacy of the fire watch was not formally evaluated by the Fire Marshall.

Failure to have a person constantly attend the heaters while in use is considered to be an item of noncompliance (373/84-33-04(DRP); 374/84-40-03(DRP)).

In addition, review of licensee procedures LAP 900-10, LAP 900-14, LAP 900-15, and LAP 900-22 indicates that there may be inadequate controls placed on the use of ignition sources. This will be tracked as an unresolved item (373/84-33-05(DRS); 374/84-40-04(DRS)).

At 8:30 p.m. (CST) on January 14, 1985, the licensee declared an "Alert" on Unit 2 after it was determined that two of seven valves in the Automatic Depressurization System (ADS) were inoperable, and that one of three pumps in the Low Pressure Coolant Injection (LPCI) system also was inoperable. Technical specifications required the plant to shutdown within a 24-hour period because of the degradation of these two safety systems. The licensee's Emergency Classification System also required an "Alert" classification.

The "Alert" was declared because the ADS valves were declared inoperable due to an annunciator in the Control Room indicated low pressure in the valve accumulators. At the same time the A-Loop LPCI pump was inoperable because of maintenance.

The licensee began a shutdown of the unit, but it was halted and the "Alert" classification removed at 9:10 p.m. (CST), after it was determined that the accumulator alarm was due to a pressure switch problem and that the actual pressure on accumulators was acceptable.

Region III partially manned the Incident Response Center until the "Alert" was terminated.

On January 21, 1985 at 11:20 p.m. (CST), the licensee declared an Unusual Event Emergency Classification for Unit 2 because of a required shutdown in accordance with technical specifications. At 7:20 p.m. (CST), the outboard isolation valve on the return line from the primary containment to the Reactor Building Closed Cooling Water System (RBCCW) (2WR040) closed due to a failed relay. This cooling water is used to cool components in the containment such as the recirculation pumps. The licensee determined the isolation signal to this valve was invalid and manually reopened the valve after racking out the control breaker for the valve to return cooling water to the containment.

This put them in an Action Statement to correct the problem in four hours or be in hot shutdown in the next twelve hours. The licensee was unable to find a spare relay in shop stores. A spare was located in the Unit 1 electrical cabinet for a similar isolation valve. The relay was time tested and found satisfactory. The new relay was installed and the Unusual Event removed at 1:01 a.m. (CST) on January 22, 1985. Generator output had been reduced from 1100 MWe to approximately 800 MWe before removal of the Unusual Event.

No other deviations or noncompliances were identified in this area.

#### 4. Monthly Surveillance Observation

The inspector observed calibration of Unit 2 standby liquid control (SBLC) pump discharge pressure transmitter 2C41-N004 in accordance with procedure LIS-SC-202 and Unit 2 APRM Gain Adjustment in accordance with procedure LIS-NR-209 and verified the use of technically adequate procedures and properly calibrated instrument testing devices. The inspector noted that the control room indicator of (SBLC) pump discharge pressure was

significantly inaccurate due to a faulty single resistance unit. This unit was satisfactorily repaired by adding a resistor to the circuit. The inspector also observed the replacement of a power source on Local Power Range Monitor (LPRM) in accordance with authorized procedure (WR 455443). The failed power source was found while performing LIS-NR-209.

On January 16, 1985, the inspector observed control room portion of Unit 1 reactor low low level MSIV isolation calibration (LIS-NB-102) on pressure switch LITS-1B21-N026B. The inspector noted that the calibration was satisfactorily performed within the two hour time limit allowed by the technical specifications.

On January 22, 1985, the licensee reported to the inspector the channel functional test surveillance on the alarm setpoint of less than or equal to 190 psig for the RHR shutdown cooling header was not performed every 31 days as required by technical specification 4.4.3.2.2.b.1. A channel calibration surveillance was performed on Unit 1 on March 30, 1984 and on Unit 2 on October 9, 1982. The channel calibration surveillance on the alarm setpoint is required by technical specification 4.4.3.2.2.b.2 to be performed once every 18 months.

Technical specification 3.4.3.2.d states, in part, that with the pressure monitor inoperable, restore the inoperable monitor to operable status within seven days or verify the pressure less than the alarm setpoint once per twelve hours and restore the inoperable monitor to operable status within 30 days or be in at least hot shutdown within the next twelve hours and in cold shutdown within the following twelve hours.

After notification, the licensee promptly performed a calibration/functional test on the alarm switches for both units and found Unit 1 activated from 186.5 to 189 psig, and Unit 2 activated between 191.5 to 193 psig. The Unit 2 switches being found in excess of the technical specification limit of 190 psig was explained away due to the head of water above the switch. Taking this head of water into account, the licensee reported the pressure switch would have activated within the 190 psig limit, and thus never considered it inoperable.

The licensee thought the isolation switch to protect the RHR low pressure piping addressed in technical specification 4.3.2.1 was also the switch that causes the high pressure alarm on the RHR Leak Detection System addressed in technical specification 4.4.3.2.2. Thus, the functional test (Unit 1, LIS-NB-311; Unit 2, LIS-NB-411) and the calibration (Unit 1, LIS-NB-111; Unit 2, LIS-NB-211) the licensee felt covered both technical specifications in reality only addressed one.

Failure to provide an adequate procedure to perform the functional test and calibration test within the frequency specified in technical specification 4.4.3.2.2 is considered an item of noncompliance (373/84-33-06A; 374/84-40-05A(DRP)).

On January 23, 1985 because of the above noncompliance, the licensee reviewed the procedures for the remainder of the valve leakage pressure monitor alarm setpoints addressed in technical specification 4.4.3.2.2.b and determined that the tolerance specified in the procedure (LIS-HP-03) for the HPCS system was "100 +/- 1.5 psig." The technical specification states less than or equal to 100 psig. The tolerance of +/-1.5 came from the vendor list that was supplied during construction which gave a required accuracy for the instrument of +/-2 psig. A calibration check of the instruments determined that Unit 1 instrument had an alarm setting of 100.05 psig. Both units were recalibrated to less than 100 psig.

Failure to provide an adequate procedure to perform calibration tests on the HPCS valve leakage pressure monitor within the tolerances specified in the technical specification 4.4.3.2.2.b is considered an item of non-compliance (373/84-33-06B; 374/84-40-05B(DRP)).

No other deviations or items of noncompliance were identified.

#### 5. Unit Trips

On January 5, 1985 at approximately 1:14 p.m. (CST), Unit 1 was manually scrammed from approximately 100% power. The licensee transferred stator cooling water from heat exchanger "A" to heat exchanger "B". Heat exchanger "B" had been shutdown for several months. Upon initiation of the "B" heat exchanger, conductivity in the stator cooling system went to 9 micro mho/cm. The licensee received a generator stator ground indication because of the high conductivity. The licensee attempted to transfer some house loads to station power prior to initiating a manual turbine trip. An operator erroneously deenergized the bus that supplied power to the B and D condensate pumps and one recirculation pump. Loss of the condensate pumps caused a reduction in feedwater flow. The operator noticed the reactor water level reducing and manually scrammed the unit just prior to the scram on low reactor water. The level during the transient continued down to approximately -40 inches and picked up the initiation of the High Pressure Core Spray (HPCS) System which injected. All systems functioned as expected. The licensee is investigating modifications to the stator cooling heat exchanger to correct this problem in the future. The unit was returned to power the morning of January 7, 1985.

At approximately noon (CST) on February 2, 1985, Unit 1 scrammed from approximately 97% power due to a Group I isolation. The licensee had declared an Unusual Event at 11:15 a.m. (CST) due to failure of the reactor building ventilation exhaust damper air control solenoid valves. Loss of the ventilation allowed the temperature in the steam tunnel to rise to the setpoint and initiate a Group I isolation. During the event, the K, U, and S safety relief valves actuated to control pressure which actuated the low low set function of the Automatic Depressurization System (ADS). The Reactor Core Isolation Cooling System (RCIC) was utilized, along with ADS to control vessel level and pressure. The inspector noted; however, that subsequent to the initial reactor scram, six additional scram signals were received on low reactor vessel level (+12.5"). This



condition is caused by the vessel water inventory loss when the relief valves open and subsequent level shrink when the valve closes. The licensee intends to pursue improvements to the feedwater flow control valve associated with the motor driven reactor feed pump to allow automatic level control above the low level scram setpoint. The motor driven pump was not continually used during this event due to problems with the flow control valve. The Unusual Event was terminated at approximately 6:00 p.m. on February 2, 1985, and the unit restarted on February 4, 1985. At 10:18 a.m. on February 8, 1985, Unit 1 scrammed from 870 MWe on low reactor level when feedwater pumps were lost on a low suction pressure signal. The licensee had installed a jumper on the trip signal to the feedwater pumps in order to isolate the switch for repair of a leak in the packing for the root valve in the sensing line. The drawing used to install the jumper; however, did not reflect a wiring change recently performed (item 373/82-49-05(DRP) in paragraph 2 of this report; MOD M-1-1-82-293). Thus the jumper was installed improperly. The low suction trip of the feedwater pumps occurred when the sensing line was isolated. Vessel level reached the ECCS actuation level; HPCS injected, RCIC started but tripped, and Group 1 through 5 Primary Containment Isolation Systems (PCIS) initiated. All other ECCS support systems functioned normally. RCIC was restarted manually and used to control pressure and level. One ADS valve lifted twice. The Motor Driven Reactor Feedwater Pump (MDRFP) was out of service for seal repair. The licensee failed to declare an "Unusual Event", for initiation of the HPCS. The failure to declare an "Unusual Event" is considered an isolated event and no item of noncompliance will be issued at this time.

Failure to provide for control of documents (drawings) and changes thereto to preclude the possibility or use of outdated or inappropriate documents is considered an item of noncompliance (373/84-33-02B(DRP); 374/84-40-02B(DRP)).

No other deviations or noncompliances were identified.

#### 6. Monthly Maintenance Observation

The inspector witnessed the 2B RHR pump coupling inspection (W/R 41959) including disassembly, inspection, reassembly and bolt torquing. The inspector noted that the work was performed using technically adequate procedures. This inspection was initiated by the licensee as followup to a problem identified at another plant (WPPS No. 2 in Richland, Washington).

The inspector observed installation and partial testing of the Unit 2 Standby Gas Treatment System environmentally qualified heater (Modification M-1-2-83-009). In addition, the inspector reviewed the modification package for adherence to administrative controls, conforming to technical specification Limiting Conditions for Operation, and the post installation test results. During this review, the licensee noted on January 12, 1985, that the heater test results indicated a power rating outside of technical specification limits.

Accordingly, at 3:30 p.m. (CST) January 14, 1985, the licensee declared an "alert" according to its Emergency Classification System after both trains of the Standby Gas Treatment (SBGT) System were declared inoperable. The licensee had replaced heaters on both trains of the SBGT and upon testing found the heaters did not meet the 20 kilowatts (plus or minus 2 kilowatts) surveillance requirements specified in the technical specifications with the existing bus voltage. With both trains of the SBGT considered inoperable, the licensee commenced a shutdown of both units, as required by technical specifications.

At 5:30 p.m. (CST), the licensee removed the "alert" classification and stopped power reduction on the units. Following a conference call between NRR, the licensee and Region III, it was determined that the technical specifications on surveillance for the kilowatt readings on the heaters needed clarification to also specify the design voltage. At the "design" voltage of 460 volts, the new heaters met the technical specification requirements, but when "testing" the heaters at the bus voltage of 478 they did not. Variations of the bus voltage which supplies the heaters is due to load changes being added and/or removed during operations.

The licensee performed an onsite and offsite review of the event to determine that safety requirements were met. In addition, an administrative technical specification change was sent to NRR on January 16, 1985, to clarify the surveillance test.

At approximately 2:55 p.m. (CST) on February 5, 1985, an instrument mechanic initiated calibration of a Unit 2 reactor vessel level switch that closes the High Pressure Core Spray (HPCS) injection valve on a high vessel water level (LIS-HP-10). At 4:55 p.m. (CST), the HPCS system was declared inoperable because the calibration was taking longer than the two hours allowed by the technical specifications. The calibration of the switch was completed at 5:27 p.m. and the HPCS system was again declared operable. The on-shift operating personnel did not realize that declaring the HPCS system inoperable was a four hour reportable item per 10 CFR 50.72. The oncoming dayshift personnel noted this problem the following morning and made the required notifications at 9:35 a.m. on February 6, 1985. Calibration of a second switch was performed on the morning of February 6, 1985. The switch was found out of tolerance to an extent that the HPCS system was outside the operability requirements of the technical specifications. The on-shift personnel did not realize the significance of this fact until the morning of February 7, 1985, when another report was made to the resident inspector and NRC headquarters at approximately 10:00 a.m. (CST). The switch was calibrated properly before returning the system to operation on February 6, 1985.

Late reporting is an item of noncompliance; however, since the problem was identified by the licensee and prompt corrective action was initiated, a noncompliance will not be issued consistent with the NRC Enforcement Policy. To minimize the confusion of reporting requirements, the licensee intends to issue a special order to operating personnel to clarify the requirements.

No deviations or items of noncompliance were identified.

7. 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.

374/84-072-00 Reactor Building Ventilation Isolation Damper Closed on Wrong Unit. An operator closed the wrong damper on the reactor building ventilation system.

374/84-071-00 Scram Due to High Neutron Flux. This event is documented in Inspection Report 374/84-33, Section 8.

374/84-081-00 Vacuum Breaker Cycled Between Containment and Drywell while Venting the Containment

373/84-032-01 RWCU Isolation on Delta Flow. This LER was revised to reflect the cause code was also due to defective procedure. Original LER closed in Inspection Report 373/84-17.

373/84-074-00 RWCU Isolation. This isolation was due to personnel error and a noncompliance was issued in Inspection Report 373/84-29; 374/84-37.

373/84-085-00 Loss of Feedwater Heating Procedure Non-conservative with Analysis. This issue was addressed in Section 7 of Inspection Report 373/84-29 and 374/84-37.

374/84-080-00 Vacuum Breaker Venting from Primary Containment to Suppression Pool Due to Primary Containment Chiller Trip and Upon Restart Reduced Primary Containment Temperature and Pressure.

374/84-083-00 Primary Containment Vacuum Breaker Cycled While an Instrument Mechanic Started a Second Drywell Cooler in Order to Work on a Couple of Work Requests.

373/84-066-00 Ammonia Chlorine Detector Caused Isolation of Control Room and Auxiliary Equipment Room Ventilation Due to Ammonia. Detector had a jammed chemcassette tape.

373/84-064-00 Feedwater Isolation Valve Failed Local Leak Rate Test. This event was documented in Inspection Report 373/84-26, 374/84-33.

373/84-070-00 Uncontrolled High Radiation. A noncompliance was issued for this LER in Section 3 of Inspection Report 373/84-26; 374/84-33.

373/84-057-00 Group 1 Isolation on Low Condenser Vacuum. While performing surveillance testing with the unit shutdown, the Group 1 isolation occurred because of improper procedure.

373/84-064-01 Containment B and C Tests Exceeding Technical Specification Limits. This report records the valves exceeding local leak rate testing. All valves were repaired prior to returning the unit to power.

373/84-079-00 High Rad Door Not Posted. The security guard posted to control access was erroneously removed due to confusion by the Security Administrator. The door was reposted after about eight hours.

373/84-062-00 Loss of Shutdown Cooling Due to Valve (1E12-F009) Failure. This failure caused an "Alert" Emergency Classification and was documented in Section 7 of Inspection Report 373/84-26; 374/84-33.

374/84-079-00 Reactor Water Cleanup Isolation on Flow. During startup of the unit, the system isolated due to the flow indicators being calibrated for temperature readings at normal operation.

373/84-067-00 Failure of Mechanical Fire Penetrations. Three fire penetrations were found not sealed properly. They were not sealed properly during construction. All penetrations were sealed properly.

374/84-069-01 Group 1 Isolation on Low Condenser Vacuum. Bad lugs on a terminal board caused spurious opening of turbine stop valves when resetting main turbine. The unit was in hot shutdown at the time.

374/84-074-00 Reactor Water Cleanup Isolation on High Ambient Temperature. The isolation was spurious and a check of the wiring could not find any loose wiring. This isolation has subsequently been deleted from technical specifications.

374/84-077-00 Primary Containment Vacuum Breaker Cycled. This was due to the tripping of the drywell chillers and upon restarting the chillers, the containment temperature and pressure was reduced causing the vacuum breaker to operate. Calibration of several instruments and adding freon and oil to the chillers prevented their tripping again.

373/84-083-00 Unsecured High Radiation Area. The licensee found a pipe chase opening which would allow access into a high radiation area. Access could have been made by a tortuous path. A guard was posted until the access was prevented by a permanent barrier.

373/84-082-00 Reactor Water Cleanup Differential Flow Isolation. The unit was returning to power after an outage and the system isolated because the differential flow transmitters are calibrated at operating temperature and at low power the isolation function is low.

373/84-078-00 Control Room Ammonia/Chlorine ESF Actuation. The tape which takes the sample was found broken in the tape carriage machine. Surveillance procedure was revised to increase maintenance on the machine to reduce frequency by which this tape breaks.



373/84-076-00 Reactor Building Ventilation Isolation From RPS Bus Trip. Starting the A recirculation pump caused an undervoltage on the RPS bus. Tripping of this bus caused the reactor building ventilation isolation. A regulating transformer was installed on the RPS busses to reduce the undervoltage due to large loads.

373/84-069-00 Leak in Narrow Range Level Indication Variable Leg. The unit was in cold shutdown at the time. The line leaked because of tubing being installed crooked during construction. Tubing was replaced.

373/84-075-00 1B Recirculation Pump Suction Temperature Well Developed a Leak. A crack in the well for the Resistance Temperature Detector (RTD) on the B recirculation pump was identified and the well was removed and a new well was welded in place.

373/84-061-00 Local Leak Rate Test of Main Steam Isolation Valves

373/84-061-01 Exceeded 100 SCFH. The total leakage exceeded the technical specification limits. The seat and discs were machined to match fit. The unit was shutdown at the time of discovery.

374/84-073-00 Reactor Water Cleanup (RWCU) Isolations on High Differential Temperature and Differential Flow. The reactor building ventilation (VR) was shutdown for repair to a damper. Loss of VR caused the room temperature in RWCU to get to the high differential temperature isolation setpoint and isolated. Also upon starting the system, the RWCU isolated on flow. System was put back in service satisfactorily.

373/84-081-00 High Suppression Pool Level High Pressure Core Spray (HPCS) Suction Swap. The suction of the HPCS changed from the condensate tanks to the suppression pool due to high level in the suppression pool as the system was designed. The suppression pool level had increased due to minor valve leakage and valve cycling for surveillances. The suppression pool was pumped down and the valves were realigned to the condensate tank.

373/84-063-00 Mechanical Snubber Found Locked During Surveillance. The snubber was located on the reactor recirculation pump seal purge line. An analysis was conducted and determined the line was not overstressed with this failed snubber.

373/84-065-00 Failure of Low Pressure Coolant Injection "B" Testable Check Valve to Pass Local Leak Rate Test. Cause was tight packing and corrosion on the shaft. Repairs were made to the valve before returning the unit to service in late November.

374/84-082-00 Unsecured High Radiation Area Access. A rectangular hole providing access to Unit 2 condenser water box was found with styrofoam covering it which did not provide positive control. The licensee posted a guard to control the access until the area was positively controlled.

373/84-084-00 Control Room HVAC Chlorine Detector Spurious Actuation. The cause of the chlorine detector initiating the isolation could not be determined. After performing a calibration and functional test of the system with no discrepancies, the system was returned to service.

374/84-075-00 Loss of a RPS Bus. The instrument mechanic was checking the frequency of the RPS bus using the incorrect instrument. This issue was addressed in Inspection Report 373/84-29; 374/84-37.

373/84-071-00 Inadvertent Closure of Reactor Water Cleanup Outboard Isolation Valve. The Group 5 Isolation Logic Test procedure had erroneously identified a power breaker to the Reactor Water Cleanup (RWCU) precoat pump to be opened in lieu of the power breaker to the RWCU outboard isolation valve. The procedure was attempting to prevent the isolation. The similarity in the equipment numbers for the breakers resulted in the erroneous procedure. The procedure was corrected.

373/84-073-00 Unit 1 PCIS Group I Isolation Signal on Turbine Reset. The position switch on turbine stop valve 2 drifted such that turbine stop valves 1, 3, and 4 received an open signal. Also, stop valve 2 is the master valve which causes valves 1, 3, and 4 to open. The unit was shutdown at the time and no vacuum in the condenser. The Group I Isolation occurred with no vacuum in the condenser and stop valves opened. The position switch was adjusted and the problem was resolved.

373/84-093-00 Unsecured High Radiation Area. Personnel error.

374/84-069-00 Group I Isolation on Low Condenser Vacuum. The lug on the electro hydraulic control Unit #2 bypass valve limit switch terminal board was incorrectly crimped which led to the turbine stop valves opening and the isolation signal. The lug was repaired by recrimping and satisfactorily tested.

373/84-080-00 Potential Failure of Safety Related Battery Racks. This event is documented in Inspection Report 373/84-29.

374/84-076-00 Main Turbine Bypass Valve Inoperable. Solenoid on bypass valve was replaced after the unit was brought down to less than 25% power. This event was addressed in Inspection Report 374/84-37.

373/84-072-00 Standby Gas Treatment Door Leakage. This event was documented in special Inspection Report 373/84-28.

373/84-059-00 High Pressure Core Spray Discharge Valve Bellows Seal Failure. The relief valve connection to the drywell has been modified as described in Inspection Report 373/84-26, Paragraph 7.

373/84-051-01 Unit 1 Safety Relief Valve Lifting. A ground on the SRV "C" solenoid causing the valve to lift.

373/84-060-00 RCIC Isolation on Steam Line Differential Pressure High. Isolation occurred when realigning the system after an I.M. surveillance by steam flow through a line which had cooled causing a pressure spike.

374/84-078-00 HPCS Suction Swap on High Suppression Pool Level. Level increased due to minor valve inleakages and valve cycling for surveillances.

373/84-090-00 HPCS Suction Swap on High Suppression. Same as LER 374/84-078

373/84-077-00 Auto Start of "B" Control Room/Auxiliary Equipment Room Emergency Make-up Train. Personnel error and procedure error while performing a chemistry surveillance resulted in the auto start of the emergency make-up train. Personnel were briefed and the procedure was changed.

Upon reviewing the above LER's, the inspector brought to the attention of the licensee several errors in LER preparation that needs closer management review in the future to improve the LER issuances. Examples are as follows:

1. Improper classification of the reporting required and/or cause code.
2. The narrative description was not clear or specific enough to identify what occurred.
3. The corrective action was not specific enough to evaluate if it was sufficient to prevent recurrence of the event.
4. The section identified as "other facilities involved" was filled in with the same facility (unit) as the one in which the event occurred.
5. Incorrect LER number identified as previous occurrences. (IE 373/84... should have been 374/84...).
6. Use of undefined acronyms.
7. Identify previous occurrences sometimes were restricted to only a single unit in lieu of identifying all previous occurrences at the site. (Both units)
8. Improper reference to technical specification section.

All errors which were not of a minor nature, the licensee has agreed to revise the LER. However, a closer review prior to issuance of LER's needs to be done in the future.

No deviations or noncompliances were identified.

8. Headquarter Request

The inspectors evaluated and prepared a report on the licensee's performance in control room behavior and housekeeping. The results were forwarded to I.E. Headquarters as requested in the memorandum from Mr. W. J. Dircks dated December 18, 1984.

9. Regional Site Observation

During the inspection period, increased observation by Regional Management of LaSalle's performance was conducted. Members of Regional Management made frequent site visits to observe LaSalle's performance in control room operations, housekeeping, maintenance, health physics, security, etc. These regional visits were conducted by the Section Chief and Branch Chief responsible for the site and Deputy Director for the Division of Reactor Projects. Exit meetings were held at the end of each visit to discuss issues which were found during the visit.

10. 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 2.

11. Unresolved Item

Unresolved items are matters which more information is required in order to ascertain whether they are acceptable, items of noncompliance, or deviations. An unresolved item disclosed during the inspection is discussed in Paragraph 3.

12. 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. The inspector also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any such documents or processes as proprietary.