

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

REPORTS NO. 50-373/96002; 50-374/96002

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

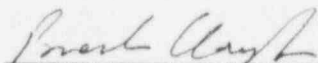
DATES

January 13 through February 28, 1996

INSPECTORS

P. Brochman, Senior Resident Inspector
K. Ihnen, Resident Inspector
H. Simons, Resident Inspector
N. Shah, Radiation Specialist
A. Walker, Lead Engineering Inspector
J. Schapker, Reactor Inspector
M. Holmberg, Reactor Inspector

APPROVED BY



Brent Clayton, Chief
Reactor Projects Branch 5

4/09/96

Date

AREAS INSPECTED

A routine, unannounced inspection of operations, engineering, maintenance, and plant support was performed. In addition, a special inspection was performed in accordance with Inspection Procedure 92709 to review ComEd's strike contingency plans.

RESULTS

OPERATIONS

Conservative decision making and safety focus continued to improve and were good. The action to manually scram Unit 2 due to the loss of transformer cooling demonstrated good safety focus. The decision not to perform reactivity manipulations simultaneously on both units was conservative. Rather, management chose to locate the fuel leak on Unit 2 and then shut down Unit 1 for the refueling outage.

Materiel condition problems continued to impact operations. Several materiel condition problems challenged LaSalle in their efforts to return Unit 2 to service. Electro-hydraulic control (EHC) system problems, control rod drive flow oscillations, and main power transformer (MPT) manual disconnects not fully engaged, were among these challenges. The first startup following the scram began on February 6; however, as a result of the materiel condition problems, the unit was not returned to service until February 12, 1996.

Two human performance issues, related to attention to detail, were noted in the operations area. An out of service was not properly restored and a non-technical specification surveillance was missed.

MAINTENANCE

Poor scheduling of work on the 0 diesel generator resulted in one planned design change being canceled and rescheduled. Several foreign material exclusion events occurred on the refuel floor which led to the decision by the refuel floor supervisor to stop all work.

ENGINEERING

The quality of two Technical Specification changes submitted to the NRC for review and approval was poor. A major reorganization of the engineering organization occurred during this inspection period. The inspectors reviewed the modifications to improve the turbine building ventilation and the modifications to the main steam leakage detection system to reduce the possibility of an automatic scram due to steam tunnel differential temperature or high temperature. Installation of the modifications was progressing adequately. The inspectors also noted the good progress in upgrading the materiel condition of the circulating water traveling screens and the overall materiel condition in the lake screen house.

PLANT SUPPORT

Overall, ALARA planning and controls for L1R07 were good, but some problems were noted with work planning and coordination. A radiation protection (RP) technician did not provide adequate job coverage which resulted in an inaccurate survey of a valve stem. The failure to conduct a proper survey is a violation. An unresolved item was identified regarding the possible issuance of respirators without performing required training.

In the area of fire protection, a Technical Specification surveillance on fire protection valve position was missed due to weak oversight and communications problems. Human performance weaknesses led to a missed firewatch.

Summary of Open Items

Violation: One was identified in Section 4.1.3.

Non-Cited Violations: two identified in Sections 4.2.1 and 4.2.2.

Inspection Followup Item: One was identified in Section 4.1.4.

INSPECTION DETAILS

1.0 OPERATIONS

NRC Inspection Procedure 71707 was used in the performance of an inspection of ongoing plant operations. Conservative decision making and safety focus continued to improve and were good. Materiel condition problems continued to impact operations. Several materiel condition problems challenged LaSalle in their efforts to return Unit 2 to service. Two human performance issues, related to attention to detail, were noted in the operations area.

1.1 Summary of Operations

Unit 1 continued in coastdown until a shutdown began on January 24, 1996, to commence the refueling outage (L1R07). The outage is estimated to end on April 4, 1996. Unit 2 operated at or near full power until the unit was manually scrammed on February 4 following a loss of cooling to the 2 East main power transformer. The Unit was started up and synchronized to the grid on February 12 after several problems during startup which are discussed in this report.

1.2 Manual Scram on Unit 2 Showed Good Safety Focus

Operator action to manually scram Unit 2 in response to loss of cooling to the main power transformer (MPT) on February 4 showed good safety focus and was a good example of improvements made in conservative decision making.

Upon receiving an alarm for transformer trouble, the operators began trending transformer temperature and consulted the system engineer. The operators set an upper limit of 100 °C for transformer temperature and if temperature reached that limit, the reactor would be manually scrammed. Operators continued to reduce power until the temperature limit was reached. At this time, the reactor was manually scrammed.

Troubleshooting isolated the problem to the 2 East MPT control logic cable. The cable, connecting the generator field breaker contacts and the transformer cooling logic, failed. This cable is routed to the MPT via a ground level concrete cable trough. Ice was found in the metal conduit which routes the cable from the bottom of the concrete trough to the transformer's junction box. The root cause appeared to be due to freezing of the water in the conduit. A temporary alteration was installed to operate the cooling fans for the 2 East MPT manually. A permanent repair is scheduled for the Unit 2 refueling outage in September 1996. During the refueling outage, the cable will be examined to obtain a definitive root cause.

1.3 Startup on Unit 2 Delayed Due to Poor Materiel Condition

Several materiel condition problems challenged LaSalle in their efforts to return Unit 2 to service. Electro-hydraulic control (EHC) system problems, control rod drive (CRD) flow oscillations, and MPT manual disconnects not fully engaged, were among these challenges. The first startup following the scram began on February 6; however, as a result of the materiel condition problems, the unit was not returned to service until February 12, 1996.

1.3.1 **Poor Materiel Condition of EHC System**

Materiel conditions problems with control valve (CV) #4; combined intercept valves (CIVs) #1, 3, and 5; and a large leak of EHC fluid delayed the startup of Unit 2. These problems are discussed below.

On February 7, 1996, ComEd started up Unit 2. During shell and chest warming of the main turbine, CV #4 would not open. In order to repair the valve, the reactor was shutdown on February 8, 1996. The servo-valve for the #4 CV was replaced and testing was completed. ComEd also decided to replace the shutoff valves of the #1, 3 and 5 CIVs as they have had problems in the past with the plunger in the valves' internals sticking.

On February 10, as startup was continuing, the operators received an EHC low level alarm. An equipment operator (EO) was sent to monitor level and determined that level was slowly decreasing. The field supervisor found a leak on the #1 CV. The operators tripped the main turbine (shell and chest warming were being performed) and EHC secured to stop the leak. The cause of the leak was a broken tack weld on the locking tab of a fitting to the servo valve for #1 CV. Later that day, the fitting was repaired and the EHC fluid was cleaned up.

1.3.2 **Control Rod Drive Flow Oscillations**

Startup on Unit 2 was also delayed by CRD flow oscillations. On February 9, 1996, startup began with rod pulls beginning around 6 a.m. Problems were experienced with flow oscillations in the control rod drive system. The operators swapped to the "B" CRD train; however, the oscillations were worse on that train. Work requests had previously been generated to correct the system problems on the "B" train. Rod pulls were suspended for several hours while troubleshooting and repairs were made. ComEd determined a leak on an air operated valve was causing the oscillations on the "A" train.

1.3.3 **Main Power Transformer Manual Disconnects Did Not Fully Engage**

During Unit 2 startup, the MPT manual disconnects did not fully engage. As a result, the turbine-generator was taken off line. On February 11, 1996, at 1 a.m. turbine roll began. An EO was sent to close the MPT manual disconnects. When he turned over to the dayshift EO, he asked him to make sure the disconnects were fully closed as it was dark when

he closed the disconnects and it was the first time he had performed the task. This demonstrated a good questioning attitude.

When the oncoming EO checked the disconnects during his rounds, he identified that the disconnects did not have good contact and there was about a one-inch gap on the A phase. The operators took the turbine offline to troubleshoot and repair the disconnects. On February 12, 1996, the disconnects were inspected and it appeared that they did not fully close even though the EO had cranked the disconnects to the stop knob which is past the fully closed position indicator. The disconnects were manually adjusted at the contacts and preparations were made for turbine roll. The disconnects will be repaired during a forced outage.

1.4 Large Steam Leak Causes Second Stage Reheat to be Taken Out of Service

On February 14, an Operating Supervisor viewing the heater bay via the installed cameras reported observing a large amount of steam. At this time, the second stage reheaters had just been placed on-line and this was suspected to be the cause of the leak. Radwaste received approximately 14,700 gallons of water from the leak, which was identified as coming from the second stage reheat drain tank check valves. Second stage reheat was secured and the Unit continued to operate.

1.5 Dirty Contacts Caused "A" Recirculation Pump to go to Zero Speed Rather Than Slow during Pump Downshift

On January 25, 1996, during Unit 1 shutdown for the refueling outage, the operators initiated a manual downshift of the reactor recirculation pumps to slow speed. During the downshift, the "A" recirculation pump failed to downshift properly and coasted to zero speed resulting in single loop operation. Operators performed the actions required for the loss of a single recirculation pump. Technical Specification 3.4.1.1 required that the average power range monitors (APRM) and the rod block monitor (RBM) trip setpoints be set for single loop operations within four hours, otherwise, the unit must be in hot shutdown within the next 12 hours.

ComEd made a decision not to restore the "A" pump and not to attempt to re-adjust the setpoints for the APRM and RBM trip, since the unit was scheduled to be shutdown within the next 12 hours in compliance with the Technical Specifications. A one hour notification was made to the NRC as the four-hour action statement was not met and the shutdown was then required by Technical Specifications.

Initial troubleshooting revealed that the control switch contacts were dirty and may have caused the pump to go to zero speed rather than slow. Further investigation was scheduled to be performed during the refueling outage.

1.6 Improper Return to Service of the 1D Condensate Booster Pump Results in Small Spill of Non-contaminated Water

On January 23, 1996, the operating department was in the process of clearing an out-of-service (OOS) on the 1D Condensate/Condensate Booster (C/CB) pump. The 1D C/CB pump had been drained for maintenance.

As the operator was opening the 1D CB pump suction valve, he observed water flowing out of the drain line. The operator immediately identified that the 1D CB middle casing drain was opened, and he took action to close the drain valve. Five to ten gallons of water spilled onto the floor before he could close the valve.

An investigation found that the special instructions on the OOS stated to close the drain valve prior to filling the pump. The drain valve was replaced during the pump maintenance so an OOS card could not be used to track the position of the valve.

The special instructions on the OOS were not followed by the operator returning the pump to service. Communications were deficient between the person who wrote the OOS instructions, the supervisor, and the operator clearing the OOS, in that the special instructions were not clearly understood and followed.

1.7 Conservative Reactivity Manipulations and Good Efforts to Identify Fuel Leak on Unit 2

The decisions made with respect to identifying the fuel leak on Unit 2 were conservative. ComEd decided to locate the fuel leak by performing flux tilt testing and then suppressing power around the leaking bundle. However, Unit 1 was scheduled to begin a refueling outage. Management made the conservative decision to first locate the fuel leak on Unit 2 and then shut down Unit 1 for the refueling outage. They consciously decided not to perform reactivity manipulations on both units concurrently.

The first indications of the fuel leak on Unit 2 appeared at 0800 hours on January 15, when the Unit 2 off-gas absorber vault radiation level began increasing from approximately 20-40 mr/hour to 250 mr/hr. At that time, no additional indication of an off-gas problem existed. Around 1800 hours, post-treatment radiation started an increase from 60 counts per second (cps) to 550 cps. Chemistry data of the off-gas pretreatment at that time confirmed an increase of noble gases characteristic of a fuel failure and entered the station into Action Level 1 of the failed fuel action plan (Administrative Procedure LAP-100-33). The leaker was identified and shielded on January 24.

1.8 Non-Technical Specification Surveillance Missed

On January 31, 1996, at 2230 hours, the onshift nuclear engineer entered the control room to perform LFS-100-4, "Core Alterations Shiftly Surveillance." During the surveillance checks, the engineer noticed

that control rod withdrawal was not electrically prevented by lifting leads in order to satisfy the procedural requirement for inhibiting rod withdrawal while moving fuel. LFS-100-4 was previously performed at 1215 hours that same day. At that time, the day shift nuclear engineer believed he saw a Withdraw Block on the control panel; however, the appropriate leads were not verified to be lifted. The requirement to verify the control rod withdrawal was electrically prevented was contained within the prerequisites of the procedure. As written in the prerequisites, it was not clear that this was a requirement.

1.9 No Problems Identified in LaSalle's Strike Plan

The inspectors reviewed LaSalle's strike plan in accordance with Inspection Procedure (IP) 92709 and no problems were identified. ComEd had made reasonable plans to deal with a strike and continue safe operation of the plant.

2.0 MAINTENANCE

NRC Inspection Procedures 62703 and 61726 were used to perform an inspection of maintenance and testing activities. No violations were identified. Poor scheduling of work on the 0 diesel generator resulted in a planned design change being canceled and rescheduled. Several foreign material exclusion events occurred on the refuel floor which led to the decision by the refuel floor supervisor to stop all work.

2.1 Poor Scheduling on Modifications to the "0" Diesel Generator

The 0 diesel generator (DG) was taken out of service for preventive maintenance and inspection during the refueling outage. Five design changes were also scheduled to be installed to improve electrical relays and instrumentation. One of the scheduled modifications had to be deleted and rescheduled due to insufficient installation time. The time to install the modifications had been underestimated by a factor of three.

Material condition problems emerged during the preventive maintenance. The DG turbocharger was rubbing on the housing and the exhaust bellows were cracked. Both of these items required corrective maintenance. As a result of the scheduling problems and emergent material condition problems, the DG work was just completed within the 7-day timeclock.

2.2 Foreign Material Exclusion Problems on Refuel Floor Resulted in Work Stoppage

Numerous foreign material exclusion (FME) problems occurred during this inspection period. Activities on the refueling floor were halted for seven shifts after it appeared that there was a performance problem associated with FME. There have also been FME problems on balance of plant equipment during the current refueling outage. Subsequent to the end of this inspection period, additional FME problems have occurred on the refuel floor.

Examples of FME problems experienced during the current outage:

- On January 24, an elastic band used to hold on a rubber glove was inadvertently snapped into the Unit 1 fuel pool while a worker was removing his protective clothing. The elastic band was removed from the pool.
- On January 30, an air fitting on the strongback used for the removal of the steam separator and dryer was damaged. Several ball bearings and the collar of the fitting fell into the Unit 1 reactor cavity. All of the material, except three ball bearings, was retrieved.
- On February 9, while a worker was replacing an underwater light, the lens cover and the O-ring fell into the reactor cavity. The lens cover was retrieved while the O-ring was not recovered.
- On February 20, during a review of tapes made during in-vessel visual inspections, debris was noted inside a spray nozzle on the high pressure core spray (HPCS) sparger. Communication of the identification of FME was initially weak. However, after management was informed, the debris was located and removed.
- On February 21, after performing a liquid penetrant examination on the internal seat ring of a combined intermediate valve, a worker inadvertently dropped an aerosol can of cleaner into the valve. The can was retrieved.
- On February 21, a plastic bottle containing mineral spirits fell into the low pressure end of the A turbine driven reactor feed pump (TDRFP). The bottle was retrieved.
- On February 24, during operator rounds on Unit 2, the handle crank of the plumb bob disconnected and fell into the standby liquid control (SBLC) tank. It was also retrieved.

3.0 ENGINEERING

NRC Inspection Procedure 37551 was used to perform an onsite inspection of the engineering function. Two Technical Specification changes submitted to the NRC for review and approval were of poor quality. A major reorganization of the engineering organization occurred during this inspection period. The inspectors reviewed the modifications to improve the turbine building ventilation and the modifications to the main steam leakage detection system to reduce the possibility for an automatic scram due to steam tunnel differential temperature or high temperature. Installation of the modifications was progressing adequately. The inspectors also noted the good progress in upgrading the materiel condition of the circulating water traveling screens and the overall materiel condition in the lake screen house.

3.1 Reorganization of Engineering

On February 21, 1996, LaSalle Engineering was reorganized. The major change was moving the System Engineering Department from the plant management organization to the Site Engineering Department. Site Engineering was divided into three sections; Design Engineering, Systems Engineering, and Support Engineering. Bob Fairbank was assigned as the System Engineering Supervisor replacing Rick Jacobs, an INPO loanee.

3.2 Engineering Submittals to the NRC Were of Poor Quality

ComEd submitted two Technical Specification changes to the NRC that were of poor quality. As a result, the NRC had to request additional information on both submittals. The first submittal pertained to the elimination of the main steam isolation valve (MSIV) leakage control system at LaSalle. Design calculations were not available for review and not properly documented. Assumptions in the submittal were not well justified.

The second submittal was a license amendment request for main steam tunnel leak detection isolations. This request proposed to change the setpoints for automatic primary containment isolation on main steam line tunnel differential temperature high and to delete the main steam line tunnel temperature high automatic isolation. The turn-around time on this change was short as modifications to the leak detection system were to be implemented during the current refueling outage. However, the quality of this submittal was such that additional information had to be requested of ComEd in order to fully review the proposed changes. At the end of the inspection period, ComEd was providing additional information to the NRC.

4.0 PLANT SUPPORT

NRC Inspection Procedures 71750, 83750, and 92904 were used to perform an inspection of plant support activities.

The inspectors evaluated radiological controls and performance during the ongoing Unit 1 refueling outage (L1R07). Overall, ALARA planning and controls for L1R07 were good, but some problems were noted with work planning and coordination. The inspectors reviewed two events involving a poor radiological survey by a station radiation protection technician (RPT) (violation), and the possible issuance of respirators without performing required training (unresolved item).

In the area of fire protection, a Technical Specification surveillance on fire protection valve position was missed due to weak oversight and communications problems. A fire watch was not properly performed due to human performance issues.

4.1 Radiation Protection

4.1.1 No Major Problems Noted in L1R07 Radiological Performance

Source term reduction efforts have had generally good results to date. Average general area drywell dose rates (20-100 mrem/hr) remained unchanged since the last Unit 1 outage, apparently due to the injection of depleted zinc. An ongoing hydrolazing project has effectively lowered general area radiation levels in the vicinity of some high dose rate piping. Chemical decontaminations were performed on the residual heat removal (RHR) system and on part of the reactor recirculation (RR) system, which resulted in decontamination factors of about 2.5 on both systems.

Overall, the accumulated outage dose (144 rem) was well controlled with about 50% of the work completed. The dose total was about 55% of the outage goal and ALARA planning and controls (cameras, shielding, etc) have been effectively implemented during the outage. For example, the B RR pump repair and reactor disassembly work (13.5 rem and 6.3 rem to date, respectively) should both be completed below their respective dose goals. The inspectors also noted good work controls despite some problems with work control and coordination (Section 4.1.2) with other departments.

Dose was tracking significantly higher than anticipated during the maintenance work on the 67A RR isolation valve as the original goal of 3.8 rem was exceeded with only about 40% of the job completed. The RR system chemical decontamination did not include this valve and attempts to lower the valve seat dose rates through hydrolazing were not as effective as was anticipated.

4.1.2 Weaknesses in L1R07 Work Planning and Coordination

The inspectors observed several examples of poor work planning and coordination which affected ComEd's ability to complete work on schedule. Specifically, these examples were:

- Untimely clearing of out of service (OOS) items by the operations department,
- Weak communication of non-critical path contractor work on the refuel floor to the RP and work coordinators, and
- Conflicting ownership of hydrolazing equipment between the maintenance and RP departments.

These examples did not have adverse radiological consequences, but did impact RP coverage of inservice inspection (ISI), refuel floor and source term reduction activities. They also reflect similar problems identified in inspection reports 95003 and 95011. ComEd was addressing

the work planning and coordination process in the 1996 Course of Action plan and had assigned a senior project manager for oversight. Performance in this area will continue to be reviewed by the inspectors.

The inspectors also identified several jobs where the estimated dose was incorrect and the appropriate ALARA reviews were not performed. The cause was inaccurate work time estimates used by the RP group for ALARA planning. These estimates, which were provided by maintenance work planners, did not distinguish time in and out of radiation areas. Although more accurate data was documented in RP job histories, they were not effectively used to verify the dose estimate. This problem was recognized by the ALARA planning staff, but had not been communicated to senior RP management. The inspectors verified that no adverse radiological consequences had occurred and that ComEd was developing corrective actions.

4.1.3 Inadequate Survey by a Station RP Technician (RPT)

On February 14, 1996, while overseeing a breach of a reactor core isolation cooling (RCIC) system valve, a senior RPT incorrectly surveyed the valve stem as reading 30 mrem/hr (contact) and having 80,000 dpm (smearable) contamination. The error was identified by another station RPT, after a mechanic, who was carrying the bagged valve stem, indicated that his electronic dosimeter (ED) was alarming. The ED alarm setpoint was 100 mrem/hr. The second RPT measured about 300 mrem/hr (contact) and, after three successive decontamination attempts, about 300,000 dpm of smearable contamination on the valve stem. The RPT informed RP management and verified that the mechanic had received about 3 mrem while carrying the stem.

ComEd identified several examples where the RPT overseeing the RCIC work had not followed RP procedures nor met management expectations. Specifically,

- The RPT was not in the immediate area of the valve breach, but covered the job from eight feet away.
- The RPT did not take an air sample during the breach, perform a general area survey after the breach, or survey the valve body after the internals were removed.
- The RPT documented the valve stem survey in the RP logbook, but did not fill out a survey map.
- The RPT did not label the bagged valve stem.

10 CFR 20.1501 requires licensee's to perform surveys which are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive material or the potential hazards that could be present. Failure to perform an adequate survey to determine the actual radiation and contamination levels on the valve stem is a violation of these requirements (Violation 50-373/374-

96002-01). The cause of this failure appears to be personnel error. Although this violation is of more than minor concern, ComEd took appropriate actions to address the situation, including disciplining the involved technician, and no response will be requested.

4.1.4 Possible Issuance of Respirators Without Required Training

ComEd identified a discrepancy in a computer database that possibly resulted in the issuance of respirators to workers who had not been appropriately trained in respirator use. The database erroneously indicated that all workers who had received annual nuclear general employee training (NGET) had also received respiratory training. ComEd corrected the problem immediately after discovery and verified that all workers using respirators at that time were appropriately trained. ComEd initiated an investigation to determine if untrained workers were provided respirators in the past. The results of this investigation will be reviewed by the inspectors upon its completion (Unresolved Item URI 50-373/374-96002-02).

4.2 Fire Protection

4.2.1 Missed Technical Specification Surveillance on Fire Protection Valves

Four fire protection valves were not verified to be in the proper position in accordance with LOS-FP-M3 due to several human performance weaknesses.

This Technical Specification surveillance (LOS-FP-M3) was started on February 4, 1996. The surveillance due date was February 11, 1996. The status of the surveillance was checked daily by the operations schedulers including on Friday, February 9, at which time the surveillance was open and in progress over the weekend.

The operators encountered problems performing the surveillance; however, management was not involved to correct the problems. High radiation levels were present in the rooms where these valves were located as a result of the residual heat removal system decontamination effort. Radiation protection personnel told the operators that if access was needed, special provisions would have to be made. However, the operators did not request special permission. On Monday, February 12, the work control center SRO issued the surveillance again to have it completed. On February 13, it came back with notations on the cover indicating that it could not be completed and that fire impairments were needed. At this time, it was discovered the surveillance was overdue and had not been completed. ComEd initiated a root cause investigation. Failure to perform the required surveillance constituted a violation of minor significance and is being treated as a Non-Cited Violation (50-373/374-96002-03) consistent with Section IV of NRC Enforcement Policy.

4.2.2 Missed Fire Watch Due To Personnel Performance Problems

A personnel error in operations department resulted in the failure to properly establish a fire watch. A change was made to a planned fire impairment and associated fire watch without fully understanding the impact of the change. The change was not communicated to the fire protection group.

On January 17, 1996, the fire detection systems for the Unit 2 Core Standby Cooling System (CSCS) division I, II, and III were requested to be taken out of service to support welding in the area. The welding was required to replace the watertight door between the Division II and III rooms. For this door replacement, an operator was in continuous attendance in the Division II and III rooms acting in the capacity of flood watch.

A fire impairment was written to have the contract fire watch personnel perform the hourly fire watch in the Unit 2 Division I, II, and III rooms. However, when the fire impairment was given to the Operations Supervisor, he reviewed the impairment and felt that operations could perform the fire watch, as an operator was already in the area performing a flood watch. Due to poor communications between the midnight and day shift control center SROs, and the Unit Supervisor, the operators were given the fire watch sheet but not clear locations of the areas that needed to be inspected. Therefore, the Unit 2 Division I room did not get inspected as required. The outage was hung and the operators performed the fire watch in Div II and III rooms only. Approximately six hours later, it was discovered by ComEd that an adequate fire watch was not in place. Failure to provide a fire watch for the Unit 2 Division I CSCS room constituted a violation of minor significance and is being treated as a Non-Cited Violation (50-373/374-96002-04) consistent with Section IV of the NRC Enforcement Policy.

5.0 SAFETY ASSESSMENT/QUALITY VERIFICATION

NRC Inspection Procedure 40500 was used to evaluate ComEd's safety assessment/quality verification capabilities. No violations were identified.

5.1 Site Quality Verification (SQV) Proactive Review of LaSalle Strike Plan

SQV performed a thorough review of the LaSalle Strike Contingency. This included performance based inspection of the proposed operations crews at the simulator. The SQV evaluation included a review of areas covered in the NRC inspection module, IP 92709. SQV review and independent insights into the strike plan were considered good.

6.0 REVIEW OF USFSAR COMMITMENTS

A recent discovery of a licensee operating their facility in a manner contrary to the Updated Final Safety Analysis Report (UFSAR) description highlighted the need for a special focused review that compares plant

practices, procedures and/or parameters to the UFSAR description. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the UFSAR that related to the areas inspected. The following inconsistencies were noted between the wording of the UFSAR and the plant practices, procedures and/or parameters observed by the inspectors.

6.1 Description of the Mechanical Vacuum Pump

The condenser mechanical vacuum pump design and the updated final safety analysis report (UFSAR) were reviewed and a discrepancy was noted. Additional followup showed that ComEd had identified this issue in 1993 as an unreviewed safety question. The documentation submitted to the NRC and the safety evaluation issued by the NRC were reviewed. The incorporation of the safety evaluation into the UFSAR has not been completed, and is scheduled for the next revision. No further review is needed.

6.2 Humidification Equipment in Control Room Ventilation System

System engineering identified a condition that was not in accordance with the UFSAR. The humidification equipment installed in the control room and auxiliary electric equipment room ventilation (VC/VE) systems was not seismically supported. ComEd performed a 10 CFR 50.59 safety evaluation for this condition and determined that an unreviewed safety question does not exist. Modifications will be made in the future to return the system to full compliance with the UFSAR.

6.3 Description of Spent Fuel Pooling Cooling and Refueling Practices

During the NRC review of the spent fuel cooling system and refueling practices, the inspectors identified that ComEd's refueling practices were not fully consistent with the wording in the FSAR. The FSAR was open to interpretation on whether or not a full core offload is an emergency heat load. ComEd's calculations show that during cooler months when the lake temperature is much less than design temperature, a full core offload is not an emergency heat load on the spent fuel pool. As a result of the review, ComEd revised the FSAR to be consistent with the current refueling practices and clarify the wording. These changes were properly reviewed by the Plant Operations Review Committee. The inspectors have no further questions regarding these changes.

7.0 PERSONS CONTACTED AND MANAGEMENT MEETINGS

The inspectors contacted various ComEd operations, maintenance, engineering, and plant support personnel throughout the inspection period.

7.1 Engineering Meeting

On February 23, 1996, a meeting was held at LaSalle to discuss ComEd corporate engineering initiatives and LaSalle specific engineering

issues. The meeting was hosted by Mr. J. Hosmer, Vice President - Engineering, and Mr. P. Antonopoulos, LaSalle - Site Engineering Manager. Mr. G. Grant, NRC, Region III, Director - Division of Reactor Safety; Mr. J. Grobe, NRC, Region III, Deputy Director - Division of Reactor Safety; and members of their staff attended this meeting.

7.2 Outage Meeting

On February 27, 1996, a meeting was held at LaSalle to discuss the materiel condition improvements being implemented during the current Unit 1 refueling outage. Plant tours and interviews with plant personnel were also conducted. The meeting was hosted by Mr. R. Querio, Site Vice President, and members of his staff. Mr. H. J. Miller, Regional Administrator Region III; and Mr. J. Caldwell, Deputy Director - Division of Reactor Projects; attended the meeting.

7.3 Routine LaSalle Team Exit

At the conclusion of the inspection on February 28, 1996, the inspectors met with ComEd representatives (denoted by *) and summarized the scope and findings of the inspection activities. ComEd 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. Fairbank, 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