U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-373/83-52(DRS); 50-374/83-55(DRS)

Docket Nos. 50-373; 50-374 License Nos. NPF-11; NPF-13

Licensee: Commonwealth Edison Company
P. O. Box 767
Chicago, IL 60690

Facility Name: LaSalle County Station, Units 1 and 2

Inspection At: LaSalle Site; Marseilles, IL

Inspection Conducted: November 8, 1983 - October 22, 1984

Enforcement Conference Conducted: February 28, 1984

Inspector: R. D. Lanksbury 10/25/84
Date

Approved By: M. A. Ring, Acting Chief 10/25/84
Test Programs Section Date

Inspection Summary

Inspection on November 8, 1983 - October 22, 1984 (Report Nos. 50-373/83-52(DRS); 50-374/83-55(DRS))
Areas Inspected: Reactive, unannounced special safety inspection to determine if a previously identified unresolved item was a violation. The inspection involved a total of 73 inspector-hours onsite by one inspector including 16 inspector-hours during off-shifts.
Results: In the one area inspected, one violation was identified - (failure to implement all design requirements in a safety-related system - Paragraph 2).

DETAILS

1. Persons Contacted

Commonwealth Edison Company

*G. R. Crane, LaSalle Project Engineer
*C. W. Schroeder, Nuclear Licensing Administrator
*D. Farrar, Director of Nuclear Licensing
*R. E. Jortberg, Director of Nuclear Safety
*C. Reed, Vice President of Nuclear Operations
*L. O. DelGeorge, Assistant Vice President
+*R. D. Bishop, Administrative and Support Services Assistant Superintendent
+G. J. Diederich, LaSalle Station Superintendent
+W. R. Huntington, Technical Staff Supervisor
+T. Hamerich, Test Engineer

Sargent and Lundy

*S. O'Hare, C&I Division
*D. L. Rahn, Senior Project Engineer

Isham, Lincoln & Beale

*B. R. Giloman, Attorney

The inspector also interviewed other licensee employees including members of the quality assurance, technical, and operating staff.

*Denotes persons attending the Enforcement Conference of February 28, 1984.
+Denotes persons participating in exit interview of October 22, 1984.

2. Resolution of Unresolved Item on Engineered Safety Feature (ESF) Reset Controls

IE Inspection Reports 50-373/83-46(DE) and 50-374/83-39(DE), in Section 2 under Unresolved Item 374/83-29-02(DE) and in Section 8, identified discrepancies in licensee responses to NRC directives on the functioning of ESF valves following reset of ESF actuation signals. Specifically, NUREG-0737, "Clarification of TMI Action Plan Requirements," Item II.E.4.2, position 4, required that the resetting of a containment isolation signal would not result in the automatic reopening of containment isolation valves. This design requirement was included in Appendix L, Section L.29, of the Final Safety Analysis Report (FSAR). FSAR Question 031.285, which implemented IE Bulletin 80-06 for LaSalle, extended this requirement to all ESF systems and actuation signals (containment isolation is a subset of ESF). Both directives required the licensee to explicitly identify and justify to the NRC any deviations from these directives. While responding to NRC inquiries on the status of testing to demonstrate conformance to these directives, the licensee re-identified eight Unit 1 and two Unit 2 isolation (ESF)

valves that did not meet the above criteria. Subsequently, the inspector identified that these isolation valves had not been reported to the NRC in their previous submittals made in response to the above directives. The inspection reports also noted that the failure of the licensee to modify the additional isolation valves or report them to the NRC was being reviewed for possible escalated enforcement action along with the materiality and significance and would be tracked as an Unresolved Item (373/83-46-03(DE)).

On November 21, 1983, a management meeting was held in the Region III offices between members of the Region III staff and representatives of the licensee to discuss several concerns at LaSalle County Station. Details regarding this management meeting are documented in IE Inspection Reports 50-373/83-50(DPRP) and 50-374/83-53(DPRP). One of the concerns discussed was a question, raised as the result of the above finding, regarding the licensee's responses to NRC initiatives in general. During their presentation, the licensee stated that the isolation valves in question had been identified by Sargent and Lundy (S&L), LaSalle's Architect Engineer, prior to the submittal of their responses and that a detailed evaluation performed by S&L, and accepted by them, of the valves led to the conclusion that they were not subject to the NRC directives. Region III indicated that they would take this information, along with the remainder presented by the licensee, into consideration in assessing the implications on the noted findings.

The NRC staff has completed a review of the licensee's failure to modify or report the additional isolation valves in their submittals in response to NUREG-0737 (FSAR Appendix L) and FSAR Question 031.285. Unresolved Item 373/83-46-03(DE) that was being used to track this review is therefore considered closed. In response to specific NRC staff questions, the licensee provided, in letters dated November 15, 1983, and November 28, 1983, their justification for not modifying or having initially reported the eight Unit 1 and two Unit 2 isolation valves. The NRC staff has reviewed these submittals and has concluded that the licensee should have either modified the eight Unit 1 and the two Unit 2 isolation valves or reported them in their original submittals in response to NUREG-0737. In addition, the staff has concluded that the justifications provided by the licensee for not modifying six of the eight Unit 1 and the two Unit 2 isolation valves were not adequate to warrant relief from the requirements of the criteria imposed in NUREG-0737 and FSAR Question 031.285. As a result, the licensee was required to modify these valves. The modification of the two Unit 2 isolation valves has been completed. Until the required Unit 1 logic modifications are completed, the licensee has committed to keep in place caution cards which require the hand switch for these valves to be placed in the closed position prior to resetting of the isolation logic. The staff considers that this schedule and interim action are acceptable. For the remaining Unit 1 isolation valves (1E51-F008 and 1E51-F063) the NRC staff has concluded that their design is acceptable and is not inconsistent with the requirements of either of the above directives. Each of these valves has a separate reset button, which must be depressed to allow the valves to open after an isolation signal. The above review and

requirement, as well as the licensee's schedule for modification of the six Unit 1 valves, is documented in SER Supplement No. 8.

The apparent cause of the failure to either report or modify the subject valves was reliance by the licensee upon an engineering analysis by S&L and conclusions as to what valves were included in the scope of NUREG-0737 and FSAR Question 031.285 (IE Bulletin 80-06). It was concluded that since these valves do not receive an ESF actuation signal they were not within the scope of these directives and therefore did not require any modification nor were they required to be reported to the NRC. Both of these conclusions were incorrect in that the transmittal letter for NUREG-0737 and FSAR Question 031.285 required the licensee to report any deviations from the criterion, and the valves in question do receive an ESF actuation signal (primary containment isolation signal).

Although the licensee failed to identify and report these ten valves, the staff has concluded that the safety significance of the violation was not great. The actual safety significance of the valves was small because of the small size of the affected lines and the multiple failures, including line break, that would have to occur prior to any release of radioactivity. The staff believes that in situations such as this where: (1) the safety significance of the violation is limited, (2) the statement did not indicate a serious management deficiency, (3) the submittal of false information is not knowing or intentional, nor made in careless disregard of NRC requirements, and (4) the statement did not represent a serious communication problem, that the licensee should be cited for the underlying cause of the violation; namely, the inadequate review of NUREG-0737 and IE Bulletin 80-06, as implemented by FSAR Question 031.285. Therefore, the NRC staff has concluded that this is a violation of 10 CFR 50. Appendix B, Criterion III which appropriately places the emphasis on the inadequate review and evaluation of the design of safety-related systems. This conclusion is basically in agreement with the licensee's evaluation as noted in Section 3 of this report. Based on the above, this finding is considered to be an item of noncompliance (373/83-52-01(DRS); 374/83-55-01(DE)) with 10 CFR 50, Appendix B, Criterion III.

The staff has also considered whether the failure of the licensee to identify these valves in its submittals indicated a broader problem with the accuracy of the licensee's submittals. The staff has concluded that this violation represents an isolated event and that the licensee has in place appropriate management systems to provide confidence in the accuracy of its submittals.

3. Enforcement Conference

The regional staff met with the licensee and their representatives on February 28, 1984, to discuss deficiencies in the licensee's submittals regarding the Engineered Safety Feature (ESF) reset functions. Licensee personnel and their representatives who attended the enforcement conference are delineated in Paragraph 1. The NRC was represented by A. B. Davis, Deputy Regional Administrator, and other members of the NRC Region III staff. The licensee made a presentation covering the action

they had taken since the November 22, 1983, management meeting, a brief review of the events leading up to the enforcement conference, the significance of the findings, and their conclusions regarding how they felt the enforcement policy related to the findings. They concluded that their January 29, 1981, response to FSAR Question 031.285 was not adequate but that the material omitted was of minimal safety significance, that it was neither deliberate nor intentional, and was not the result of a careless disregard of regulatory requirements. They also concluded that their review of the enforcement policy would lead them to believe that the finding should be categorized at Severity Level IV.

The staff acknowledged the remarks made by the licensee and stated that the enforcement package along with all the pertinent information would be transmitted to the Office of Inspection and Enforcement for evaluation. This evaluation has been completed and, as documented in Section 2 of this report, the staff has concluded that they are basically in agreement with the licensee on this matter.

4. Exit Interview

A conference call between Region III (represented by Messrs. R. D. Lanksbury, L. A. Reyes, and R. B. Landsman) and the licensee (representative denoted in Paragraph 1) on October 22, 1984 was made to provide the final results of the inspection. The inspector provided the final staff conclusions on the inspection findings. The licensee acknowledged the statements by the inspector with respect to the item of noncompliance (Paragraph 2).