U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-373/87035(DRP); 50-374/87034(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: December 1 through January 6, 1988

Inspectors: M. J. Jordan
R. Kopriva

Approved By: M. A. Ring, Chief
Reactor Projects Section 1C

1/26/88
Date

Inspection Summary

Inspection on December 1, 1987 through January 6, 1988 (Reports No. 50-373/87035(DRP); 50-374/87034(DRP))
Areas Inspected: Routine, unannounced inspection conducted by resident inspectors of licensee actions on previous inspection findings; operational safety; surveillance; maintenance; training; Licensee Event Reports; regional requests; unit trips; Part 21 notifications; bulletins/temporary instructions; and allegations.
Results: Of the eleven areas inspected, no violations or deviations were identified in ten areas; one violation was identified in the remaining area (failure to follow procedures - Paragraph 3).

The licensee had two examples of operating personnel failing to follow procedures resulting in the issuance of one Notice of Violation with two examples. The licensee continues to need to stress adherence to procedures. A CAL was issued to establish an agreement on the actions needed to be taken concerning a problem with the main steam isolation valve fast acting solenoid (See Paragraph 3). This event and the event with the wall thinning of a main feed line minimum flow line (See Paragraph 3) demonstrated the licensee's cooperativeness in communicating the detail of the events and establishing the corrective action to resolve them.

The overall performance of the licensee continues to improve with some minor problems with procedure adherence.

DETAILS

1. Persons Contacted

*G. J. Diederich, Manager, LaSalle Station
*R. D. Bishop, Services Superintendent
*J. C. Renwick, Production Superintendent
D. Berkman, Assistant Superintendent, Work Planning
*W. Huntington, Assistant Superintendent, Operations
P. Manning, Assistant Superintendent, Technical Services
*T. Hammerich, Assistant Technical Staff Supervisor
W. Sheldon, Assistant Superintendent, Maintenance
J. Atchley, Operating Engineer
*D. A. Brown, Quality Assurance Supervisor
D. Winchester, Quality Assurance Engineer
*M. Richter, Assistant Technical Staff Supervisor

*Denotes personnel attending the exit interview on January 6, 1988.

Additional licensee technical and administrative personnel were contacted by the inspectors during the course of the inspection.

2. Licensee Action on Previous Inspection Findings (92701)

(Closed) Violation (374/87012-01): Operator manipulation of wrong valve and overfilling the shipping cask well, subsequently spilling approximately 100 gallons of water into Unit 2 reactor building and ventilation. The inspector finds the licensee's response adequate.

(Closed) Open Item (374/83049-02): Need to change procedural requirements for crosstieing busses to the 125 VDC system Division 2 for locating and isolating grounds. Procedure LOP-DC-05, "125 VDC System Division 2 Ground Location and Isolation," was revised April 1987.

(Closed) Violation (373/87011-04): The high primary containment pressure switch (1C71-N002A) was inoperable for 7.5 hours (which made the number of operable channels less than required) without placing the channel A1 in the tripped condition within two hours. This was a Technical Specification violation. The licensee has implemented a Technical Specification time clock stamp program and has re-emphasized the need to comply with all Technical Specification time clocks to all personnel who could be involved with time clock requirements. The inspector finds the licensee's actions adequate.

No violations or deviations were identified in this area.

3. Operational Safety Verification (71707, 71881, 71709)

a. 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 including the following: the appropriate number of security personnel were on site; access control barriers were operational; protected areas were well maintained, and vital area barriers were well maintained. The inspector verified the licensee's radiological protection program was implemented in accordance with the facility policies and programs and in compliance with regulatory requirements.

During the month of December 1987, the inspector walked down the accessible portions of the following systems to verify operability:

Unit 1 and 2 Diesel Generators
Unit 2 Reactor Core Isolation Cooling System

b. On December 1, 1987, on Unit 2 at approximately 9:30 a.m. (CST), the licensee was performing LOS-RI-Q3, "Reactor Core Isolation Cooling (RCIC) System Pump Operability and Valve Inservice Tests In Conditions 1, 2, and 3." The surveillance was being performed subsequent to the replacement of several static-o-ring switches in the RCIC system. The licensee was to perform a slow start and then a cold-quick start of the RCIC turbine in trying to determine if there were any abnormal perturbations on the system that may have caused the static-o-ring switches to fail. The slow start was performed with no anomalies noted. The licensee then proceeded to perform the cold-quick start of the RCIC turbine which started and promptly proceeded to trip on turbine overspeed. When reviewing the records, the turbine did, in fact, trip on overspeed. The turbine had reached 5660 RPM and the trip is set at 5625 plus or minus 50 RPM. The operator, with concurrence from the shift engineer and station control room engineer, had not closed the 2E51-F022 valve (RCIC full flow test to Condensate Storage Tank (CST) stop valve) and the 2E51-F046 valve (turbine lube oil cooler supply stop valve) after completion of the slow start test. When the RCIC cold-quick start was started, the 2E51 F022 valve was throttled down and was not opened per the procedure. With the RCIC turbine increasing speed and the flow in the system being minimized by the partially opened 2E51-F022 valve, the turbine proceeded to ramp up in speed due to lack of resistance from less than normal system flow and tripped on overspeed.

Technical Specification 6.2.A.7 states, in part, "Detailed written procedures, including applicable checkoff lists, covering items below shall be prepared, approved and adhered to:

Surveillance and Testing Requirements"

Procedure LOS-RI-Q3, step F.11.b states, "Open both RCIC full flow test return to CST valves 2E51-F022 and 2E51-F059".

Contrary to the above on December 1, 1987, during the testing of the RCIC turbine and system, the operator failed to open the RCIC full flow test return to CST valve 2E51-F022 in accordance with the procedure. This caused the RCIC turbine to obtain an overspeed condition and trip. This is considered a violation (374/87034-01(DRP)).

c. On December 9, 1987, at approximately 8:30 a.m. (CST), with Unit 1 operating at 90% power, the licensee identified a leak on the Unit 1B Turbine Driven Reactor Feed Pump (TDRFP) minimum flow line to the condenser. The licensee reduced power and took the 1B TDRFP out of service for further inspection. After the removal of the piping insulation, three through wall pin hole leaks were discovered, one of which appears to be 0.031 inches in diameter. The leaks were located on the outside arc of the piping elbow between the minimum flow air operated valve (1FW011B) and a manual isolation valve (1FW012B) to the condenser.

Ultrasonic Testing (UT) was performed on the elbow to determine the pipe wall thickness in that area. Ultrasonic testing results indicate a six (6) inch by five (5) inch area with pipe wall thicknesses ranging from 0.300-0.700 inch. The elbow is eight (8) inches schedule 160 chrome moly pipe with a nominal pipe wall thickness of 0.906 inches.

Subsequent inspection on the remaining Unit 1 and 2 TDRFP minimum flow lines and the Unit 1 and 2 Motor Driven Reactor Feedwater Pump (MDRFP) minimum flow lines indicated pipe wall thinning on all TDRFP minimum flow lines and virtually no pipe wall thinning on either unit MDRFP minimum flow lines. The Unit 2A TDRFP minimum flow line had a through wall hole such that it was leaking. The licensee discussed their repair plans for weld overlaying the deteriorated elbows with NRC Region III management.

Since both units were running, the licensee took precautions to inform workers of potential problems while in the area (i.e. other pipes in the area contained steam or possibly two phase flow (steam and water)) and what to do if problems occurred. Each reactor feedwater pump was individually shut down and isolated prior to repair work being performed.

All repairs have been completed. The cause of the wall thinning was attributed to the design of the disk on the minimum flow valve. The disk was cone shaped which directed any valve seat leakage onto the pipe wall and caused the thinning. The valve manufacturer has redesigned the valve disk of the future replacement.

d. On December 13, 1987, at approximately 12:45 a.m. (CST), Unit 1 experienced an ESF actuation when the Reactor Water Clean Up (RWCU) system isolated. The RWCU system isolation was due to a spurious hi filter demineralizer inlet temperature. Actual inlet temperature indications were normal. The licensee jumpered out the temperature switch and restarted the RWCU pumps. A special log to monitor RWCU temperatures was initiated until the Instrument Mechanics (IM) repaired the temperature switch.

e. On December 16, 1987, while the plant was in the hot shutdown mode, tne licensee tested the closing function of the eight Unit 1 Main Steam Isolation Valves (MSIV's). All eight were closed using the slow closure solenoids. The fast closure solenoids were then actuated. When the slow closure switch was released, one of the valves, (the outboard MSIV on the C steam line) opened, indicating that the fast closure solenoid had malfunctioned. The licensee attempted to close the valve two additional times and it drifted back open.

The unit remained shut down for investigation of the MSIV problem. The fast acting solenoids were replaced on the affected MSIV. The fast acting solenoid was disassembled and a gummy substance was observed on some of the internal components. The licensee inspected three other solenoids and also found the gummy substance, but to a lesser extent.

The licensee replaced the remaining seven solenoids on Unit 1. Five solenoids, including the one which malfunctioned were returned for analysis to the vendor, Automatic Switch Company (ASCO).

The licensee has tested the MSIVs on Unit 2, which is in operation, and no problems were observed.

The senior resident inspector and an inspection specialist from the regional office monitored the licensee's evaluation. (The specialist had led two Augmented Inspection Teams at Perry to investigate MSIV closure problems there). Region III issued a Confirmatory Action Letter (CAL) on December 18, 1987, to document the licensee's agreement to a program to evaluate the MSIVs and increase surveillance testing of the valves.

The CAL states that the licensee agreed to the following seven items within the CAL:

1. Replace the remaining solenoid valve assemblies on Unit 1 (the failed MSIV solenoid has been replaced) (373/87035-01)). This item was completed by December 19, 1987 and is considered closed.

2. Perform an initial evaluation of the quality (i.e., moisture, oil, particulates) of the air system supplying the failed valve and the valves whose solenoid assemblies are being replaced by sampling the immediate supply to the solenoid assemblies (373/87035-02). This item was completed by December 19, 1987 and is considered closed.

3. Perform increased frequency testing of the MSIVs on Unit 1 as described in a LaSalle Station letter to M. Jordan dated December 18, 1987 (373/87035-03).

4. Perform further analysis of the quality of the air system for the purpose of detecting contaminants which may degrade the solenoid assemblies (373/87035-04).

5. Disassemble the removed valves and examine them for potential causes which could lead to failures similar to the one experienced. Four of these valves may be disassembled by the vendor (ASCO) at the vendor's location. The purpose of the examination is to determine a root cause for the failure (373/87035-05).

6. Perform a test of the dual solenoid valves on the Unit 2 MSIVs to determine if a similar problem exists on Unit 2 (373/87035-06). This item was completed by December 19, 1987, and is considered closed.

7. Submit to Region III a formal report of your findings and conclusions within 30 days of receipt of this letter (373/87035-07).

With the successful completion of items 1 and 2, Region III approved the restart of Unit 1.

On December 22, 1987, the three remaining solenoids were sent to the licensee's System Materials Analysis Department (SMAD) to see if there was enough gummy substance to be analyzed. Also, preliminary review of the solenoids sent to ASCO appears to indicate that the substance was not the lubricant used in assembly of the solenoid nor is it in the licensee's air supply system due to the fact that the substance is only being found in one particular port of the solenoid. Further investigation is still pending.

f. On December 16, 1987, at approximately 9:55 a.m. (CST), Unit 1 reactor scrammed from 74% power due to a feedwater transient and subsequent low reactor vessel water level. The licensee at that time elected to take the reactor to cold shutdown so as to accomplish some necessary maintenance on Unit 1. At 5:20 p.m. (CST), the Unit 1 Reactor Core Injection Cooling (RCIC) System keep fill pump seized up. At this time, RCIC was declared inoperable. At approximately 7:38 p.m. (CST), while still working toward cold shutdown the reactor vessel pressure was reduced to less than 150 psi at which time the RCIC system is no longer required to be operable. Unit 1 achieved cold shutdown at 2:15 a.m. (CST) on December 17, 1987. When the dayshift management personnel arrived on site on December 17, 1987, and reviewed the operations log books from the previous evening, they recognized that RCIC being inoperable is a 4 hour reportable event per 10 CFR 50.72 and proceeded to make the necessary notifications at 12:22 p.m. (CST) on December 17, 1987. The RCIC system had been inoperable for approximately 19 hours prior to being reported.

Technical Specification 6.2.A. states, in part, "Detailed written procedures including applicable checkoff lists covering items below shall be prepared, approved, and adhered to:

1. The applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978", which includes administrative procedures.

Procedure LZP-1310-1, "Notifications," step F.2.b.3)c) which states, in part, "Non Emergency Events Four Hour Reports": any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to:

(4) mitigate the consequences of an accident.

Contrary to the above on December 16, 1987, the RCIC keep fill pump seized up causing the RCIC system to become inoperable. This is a non-emergency reportable event with a four hour notification to the NRC. The licensee did not report the event for approximately 19 hours after its occurrence. This is considered a violation (373/87035-08).

Four open items and two violations were identified in this area.

4. Monthly Surveillance Observation (61726)

The inspector observed Technical Specification required surveillance testing and verified for actual activities observed that testing was performed in accordance with adequate procedures, 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 Specification 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 witnessed portions of the following test activities:

LOS-DG-M3	1B Diesel Generator Operability Test
LIS-HP-102	Unit 1 HPCS Pump Discharge Pressure Indication Calibration
LIS-RH-410	Unit 2 LPCS/RHR Injection Line Integrity Monitor Functional Test
LIS-RI-313	Unit 1 RCIC Pump Water Leg Line Low Pressure Functional Test
LIS-NR-403	Unit 2 Average Power Range Monitor Rod Block and Scram Functional Test
LIS-PC-304	Unit 1 High Drywell Pressure HPCS Initiation Functional Test
LIS-RT-301	Unit 1 Reactor Water Cleanup High Differential Flow Isolation Functional Test

No violations or deviations were identified in this area.

5. Monthly Maintenance Observation (62703)

During the inspection period, the inspector observed portions of the following maintenance activities:

Unit 2B Reactor Building Closed Cooling Water Pump/Motor Replacement

No violations or deviations were identified in this area.

6. Training (41400)

The inspector, through discussions with personnel and a review of training records, evaluated the licensee's training program for operations and maintenance personnel to determine whether the general knowledge of the individuals was sufficient for their assigned tasks. In the areas examined by the inspector, no items of concern were identified.

No violations or deviations were identified in this area.

7. Licensee Event Reports (92700)

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.

(Closed) 373/87032-00 - Reactor Scram Due to Low Reactor Vessel Water Level During Low Flow, Low Power Condition. The root cause of this event is the difficulty of controlling reactor water level with the Feedwater Regulating Valve (FRV) at low flow, low power conditions due to system design. During the next refueling outage for each unit, a low load regulating valve will be added to the feedwater system, which should provide improved feedwater and reactor water level control at low flow, low power conditions. The resident inspector is following the licensee's actions.

(Closed) 374/87018-00 - Reactor Water Cleanup (RWCU) Isolation Due to Personnel Error. A RWCU isolation was received during the removal of the Residual Heat Removal (RHR) area and differential temperature relay from the leak detection circuitry for repair. The root cause of this event was inattention to detail (inadequate review) by the Electrical Maintenance (EM) personnel involved. The review for the work was performed using electrical schematics more extensively than wiring diagrams. The review failed to identify a common ground between several relays in the leak detection circuitry. The EM personnel were trained on this event, and instructed on the use of wiring diagrams. A Notice of Violation was issued on this in Inspection Report 373/87030; 374/87029. The resident inspector has reviewed the licensee's actions and finds them adequate.

(Closed) 373/87034-00 - Automatic Start of Control Room Ventilation Emergency Makeup Train Due to Spurious Radiation Spike. Investigation of

the radiation monitor revealed no problem which would have caused the spurious trip. It is believed that random noise in the electronics may have induced the spurious trip. Corrective actions included the successful performance of the calibration and functional test on the radiation monitor. Since being returned to service, the radiation monitor has experienced no further problems. The station is investigating a logic revision for the VC radiation monitors. The resident inspector finds the licensee's actions adequate.

(Closed) 373/87031-00 - Loss of 1B Reactor Protection System Motor Generator Due to Relay Failures. The "B" Reactor Protection System (RPS) Motor Generator (MG) set tripped due to a control relay fault, which in turn, deenergized the "B" RPS bus. Power was restored to the "B" RPS bus through the alternate feed and all isolations were reset. The cause of the control relay failure is unknown. An investigation of the control circuitry revealed no conditions (grounds, shorts) which could have contributed to the relay's failure. All isolations and actuations occurred as designed for this event. The resident inspector reviewed the licensee's actions and found them adequate.

(Closed) 373/87035-00 - Spurious Ammonia Detector Trip Due to Failure of the Detector's Front Optics Indicator Lamp. Per design, an Engineered Safety Feature (ESF) damper actuation occurred which isolated the "B" VC train from the outside air and recirculated the air flow through the charcoal absorber. The Instrument Maintenance Department investigated the event and found that the front optics indicator lamp had failed. The lamp was replaced and the detector was returned to service. This was the first occurrence of a failed optics lamp causing an ammonia detector trip. The resident inspector finds the licensee's actions adequate.

(Closed) 374/87019-00 - Failure of Static-O-Ring Differential Pressure Switch Due to Leakage Across the Diaphragm. Reactor Core Isolation Cooling (RCIC) Steam Line High Flow Isolation Switch PDS-2E31-N013AA was found to have leakage across the diaphragm. This was discovered during the performance of a LaSalle Instrument Surveillance.

A new differential pressure switch, identical to the failed one, was certified for service, installed, and calibrated. The root cause of this failure has not been determined. The defective switch has been sent to its manufacturer, Static-O-Ring Inc., for disassembly and inspection.

The condition of flow switch PDS-2E31-N013AA compromised the outboard isolation function of the RCIC steam line in the event of a high flow condition. However, redundant instrumentation was available to provide the inboard isolation of the RCIC steam line had an actual high flow condition existed. The resident inspector finds the licensee's actions adequate.

(Closed) 373/87033-00 - Failure of Diesel Generator "1A" to Close Onto Bus 142Y During Surveillance Testing. The operator had started the "1A" Diesel Generator (DG) and attempted to close the output breaker and synchronize to Bus 142Y. However, the output breaker would not close. Several attempts were made and all were unsuccessful. The "1A" DG was then shutdown and declared inoperable.

Troubleshooting efforts on the output breaker closing circuitry revealed no discrepancies. All breaker components, including associated closure permissive contacts, were verified to operate as designed following the event. The surveillance was then performed successfully and the "1A" DG was declared operable. The safety consequences of this event were minimal since the "1B" and "0" Diesel Generators, and all Unit 1 Emergency Core Cooling Systems, were operable at the time of this event.

The resident inspector has reviewed the licensee's actions and finds them acceptable.

(Closed) 374/85011-01 - Failure of Type C Leak Rate Test. On February 26, 1985, the 2FC086 and 2FC115 Reactor Well Drain Valves failed their Local Leak Rate Test. The Actions of Technical Specification 3.6.3 were taken as appropriate. Initial inspection showed that foreign matter on seat and seat irregularities caused the valves to fail the Local Leak Rate Test. The valves were disassembled and the seat surfaces lapped. The resident inspector has reviewed the licensee's data and discussed this matter with the regional office. The licensee's actions taken are adequate. Revision 0 was closed in Inspection Report 374/85010. The revision reflects the supplemental report after completion of the outage which details all failures and the corrective action taken for each valve.

(Closed) 374/85010-01 - Control Rod Drive Hydraulic Control Unit Accumulator Pressure Switch Failures Due to Setpoint Drift. Between February 15, 1985 and March 1, 1985, the accumulator pressure switches for the Unit 1 and Unit 2 Control Rod Drive hydraulic control units were found out of calibration in the non-conservative direction. Both units were in Operational Condition 1 (Run) at the time of the event, therefore, scram capability was not significantly affected. The cause of the event is attributed to setpoint drift. The setpoints drifted to a lower pressure. No cause for the drift could be determined by the licensee or the pressure switch manufacturer (Barksdale). Immediate corrective actions included: recharging of any accumulators found to have low pressure; recalibration of all accumulator pressure switches; and increased monitoring of all accumulator pressures. The Technical Specifications for Unit 1 and Unit 2 were subsequently amended to allow for a more conservative pressure switch setpoint. The resident inspector finds these actions adequate. Revision 0 was closed in Inspection Report 374/85009. The revision reflects the amendment of the Unit 1 and Unit 2 Technical Specifications to allow for a more conservative pressure switch setpoint.

(Closed) 373/87036-00 - Spurious Ammonia Detector Trip Due to Broken Chemcassette Tape. On November 14, 1987, the "A" Control Room HVAC System "A" ammonia detector tripped. Per design an Engineering Safety Feature (ESF) damper actuation occurred which isolated the "A" control room ventilation from outside air. The Instrument Maintenance Department investigated the event and found that the chemcassette tape was broken at the takeup spool. The chemcassette was replaced and the detector was declared operable on November 16, 1987. The inspector finds the licensee's actions adequate.

(Closed) 374/87020-00 - Failure of Several SOR Differential Pressure Switches Due to Diaphragm Failures. During the period of November 19, 1987 to November 24, 1987, four Unit 2 Reactor Core Isolation Cooling (RCIC) Residual Heat Removal (RHR) Steam Line Isolation Switches were found to have internal leakage from one side of their diaphragm to the other. These discoveries were made during the performance of a LaSalle Instrument Surveillance.

Redundant equipment in the form of area temperature sensors remained fully operable during this time period, and would have provided the necessary isolations had a leak developed. Repairs were made by replacing two of the leaking switches on RCIC. The RCIC system was restored to operability on November 25, 1987. The Steam Condensing Mode of RHR remains out of service pending replacement of the two RHR switches. This mode of RHR is not taken credit for in any accident scenario, therefore, not required. The inspector finds the licensee's actions adequate.

No violations or deviations were identified in this area.

8. Regional Requests (92701)

On November 17, 1987, the resident inspector received a copy of NRC Information Notice No. 87-56, "Improper Hydraulic Control Unit (HCU) Installation at Boiling Water Reactor (BWR) Plants." The notice described loose or missing hold down bolts on the HCUs and the incorrect attachments of Branch Junction Modules (BJMs). The resident inspector contacted the licensee's site technical staff supervisor and reviewed the different items within the notice. The inspector then proceeded to physically inspect both the Unit 1 and Unit 2 HCUs' bolting and BJM attachments. No anomalies as discussed in the notice were found. The inspector on a periodic basis will reinspect the HCUs for missing or loose hold down bolts.

No violations or deviations were identified in this area.

9. Unit Trips (93702)

On December 16, 1987, at approximately 10:00 a.m. (CST), Unit 1, while operating at about 77% power, tripped due to low reactor vessel water level. The low pressure feedwater heater string isolated causing low condensate/condensate booster pump suction pressure which in turn caused the feedwater pumps to trip on low suction pressure, and resulted in the low vessel level and the trip. All systems functioned as expected. The licensee stayed shut down while other minor repairs were completed (i.e. replacement of some intermediate range monitor detectors). While shutdown, the licensee experienced problems with the fast acting solenoids on the MSIV's which were replaced prior to startup (see paragraph 3). The cause of the scram was due to the licensee performing a test to see if it was feasible to isolate their feedwater heater string and maintain operation and correct leaks in feedwater minimum flow piping (see paragraph 3). During the test, all the low pressure feedwater heaters isolated causing the transient. The unit was returned to service on December 19, 1987.

No violations or deviations were identified.

10. Part 21 Notifications (36100)

The inspector received a notification of a 10 CFR Part 21 Notification in correspondence dated December 15, 1987 from C. E. Norelius, Director, Division of Reactor Projects to Senior Resident Inspectors. The Part 21 Notification concerned the General Electric HFA relays with latching mechanisms. The inspector verified that the licensee had received the Part 21 and has assigned an internal tracking number to it (AIR#373/454-88-190.1). This item is considered closed as the licensee is taking action (373/87035-09; 374/87034-02).

No violations or deviations were identified.

11. Bulletins/Temporary Instructions (25026)

(Open) IE Bulletin 87-02 - In accordance with Temporary Instruction (TI) 2500-26, the inspector participated with the licensee in selecting a sample of fasteners, both safety and non-safety. These samples were then labeled and sent off for analysis. Besides the samples which were sent off for analysis, the inspector randomly looked at other fasteners for proper marking and tried to identify any fasteners which may had been marked by a manufacturer which were of particular interest to the NRC. None of the safety fasteners had these manufacturer's identification on them. A couple of the non-safety fasteners exhibited the manufacturer's markings in question and they were made part of the non-safety sample. The results of this analysis will be made part of the licensee's response to the bulletin. The remainder of the TI and bulletin review will remain open until the licensee response is issued and the inspector can assess it. (373/87035-10;374/87034-03).

One open item was identified in this area.

12. Allegations Followup

a. Allegation (No. RIII-87-A-0102)

The resident received a request from Region III, dated August 5, 1987 to inform the licensee of a potential problem with the weld on the fuel storage racks at Kewaunee. The same vendor was preparing the high density storage rack for LaSalle. The licensee was given a copy of the inspection report describing the problem identified by Kewaunee to evaluate the racks which they are purchasing. LaSalle agreed to evaluate their new fuel racks. They do not feel a similar problem exists as a 100% weld inspection was required and QA audits of this vendor have been done to assure completion. This item will remain open pending further review by the resident inspector. (373/87035-11; 374/87034-04).

No violations or deviations were identified in this area, however, one item requiring further review was identified and is documented as an open item.

b. Allegation (No. RIII-87-A-0159)

On June 26, 1987, a contractor contacted the resident inspector with a concern he had pertaining to a burned piece of electrical wiring connected to a motor operated valve inside the Unit 2 drywell. The contractor was supposed to connect the wire to the limitorque operator. The contractor, after inspecting the cable and finding it damaged (i.e., burned or exposed to high temperature), had refused to connect the cable to the limitorque operator without first replacing the cable. The contractor said bare wire was showing through the insulation and he had no indication from the person supervising the job that it was going to be replaced. The contractor did not finish the job at that time, nor did he return to finish that job. The unit was starting up and the contractor assumed that the wire was never replaced.

The wire was the control cable from the junction box to the limitorque operator on the 1V21-F005 valve (reactor pressure vessel head vent valve to "A" steam line). The valve is not safety related, nor code work. The work request written for reterminating and testing the valve notes that the control cable was damaged and a new control cable was placed at junction box 2JB207 and pulled to the valve, relugged and reterminated.

The inspector reviewed the work request package, procedures, the documentation for the different parts installed, and has reviewed the results of the motor operator testing. After confirming that the control cable was replaced and the valve tested satisfactorily, the inspector contacted the contractor and informed him of the results of the investigation. Also, the inspector informed the contractor on the use of the valve. The contractor was satisfied that the cable was replaced and did not express any further concerns.

No violations or deviations were identified in this area.

13. 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. Seven open items disclosed during the inspection are discussed in Paragraphs 3, 10, 11, and 12.

14. Exit Interview (30703)

The inspectors 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 inspectors also discussed the likely informational contents 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.