U.S. NUCLEAR REGULATORY COMMISSION

REGION III

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License Nos:	NPF-11, NPF-18
Report No:	50-373/97016(DRP); 50-374/97016(DRP)
Licensee:	Commonwealth Edison Company
Facility:	LaSalle County Station, Units 1 and 2
Location:	2601 N. 21st Road Marseilles, IL 61341
Dates:	September 20 - October 31, 1997
Inspectors:	M. Huber, Senior Resident Inspector J. Hansen, Resident Inspector R. Crane, Resident Inspector C. Mathews, Illinois Department of Nuclear Safety
Approved by:	Anton Vegel, Acting Chief, Projects Branch 2 Division of Reactor Projects

EXECUTIVE SUMMARY

LaSalle County Station, Units 1 and 2
NRC Inspection Report No. 50-373/97016(DRP); 50-374/97016(DRP)

This inspection report included aspects of licensee operations, maintenance, engineering and plant support. The report covers a 6-week period of inspection conducted by the resident staff.

Operations

- Based on routine inspector observations of control room activities, operators were attentive to the main control room panels, knowledgeable of various system configurations, and aware of activities in the plant. Shift pre-briefs were of high quality and effective in communicating plant conditions. (Section O1.1)

- The licensee initiated appropriate immediate corrective actions to address equipment failures involving an emergency diesel generator failure to start and two breaker failures. Plant personnel used the corrective action process at LaSalle to address the equipment failures. (Section O1.2)

- The licensee's completed and planned actions for protecting emergency sources of cooling water and critical plant systems from cold weather were adequate. The inspectors considered the licensee's use of previous plant experience in formulating its cold weather plans to be a good initiative. (Section O2.2)

Maintenance

- The inspectors observed several surveillance activities and the surveillance tests were performed by plant personnel in an acceptable manner. The inspectors did not identify concerns with personnel performance. (Section M1.1)

- The licensee incorporated lessons learned from previous maintenance activities into work planning. In addition, the licensee decontaminated the Division II residual heat removal (RHR) pump room. These improvements increased the licensee's ability to perform maintenance more efficiently. (Section M2.1)

Engineering

- An engineer performing a review of surveillance testing for the emergency diesel generators during the System Functional Performance Review (SFPR) incorrectly determined that a technical specification test procedure was acceptable. The engineer's error appeared to be an isolated instance where problems were not appropriately classified for resolution. The licensee's plan to review the SFPR documentation to ensure that identified problems were documented for resolution was appropriate. (Section E2.1)

Plant Support

- The inspectors identified that the licensee did not have a procedure to ensure prescription eyewear was available for use with emergency breathing apparatus by licensed operators with a license condition requiring the use of corrective eyewear when performing licensed duties. The licensee had identified the issue and was implementing corrective action to prevent recurrence. (Section P5.1)

Report Details

Summary of Plant Status

During this inspection period, the licensee maintained Unit 1 in cold shutdown (Operational Condition 4) for a forced outage and Unit 2 remained shut down for a refueling outage with all fuel removed from the reactor.

I. Operations

O1 Conduct of Operations

O1.1 General Comments

a. Inspection Scope (71707)

The inspectors conducted frequent reviews of ongoing plant operations by performing control room panel walkdowns and observing operator performance.

b. Observation and Findings

Overall, the licensee operated the plant safely and performed activities in accordance with procedures. The inspectors observed routine control room activities such as operator turnovers, operators' response to annunciators, and surveillance activities (discussed in Section M1.1). The operators were attentive to the main control room panels, knowledgeable of various system configurations, and aware of activities in the plant. The shift manager conducted pre-shift briefings for oncoming shift personnel which were thorough and effective in communicating plant operational and work activity status. In one instance, the briefing included presentations by engineering personnel and personnel from the outage management organization to the oncoming operating crew that had not been on shift for seven days. The presentations consisted of detailed updates of ongoing maintenance activities and were requested by the shift manager to ensure that the crew was well informed. Throughout the inspection period, the pre-shift briefings were conducted in a professional manner, both licensed and non-licensed operators discussed issues, and a good questioning attitude was displayed by operations personnel.

c. Conclusions

The inspectors observed that the operators were attentive to the main control room panels, knowledgeable of various system configurations, and aware of activities in the plant. The licensee generally conducted plant operations in accordance with procedures and in a safe manner. The pre-shift briefings have consistently been of high quality over the entire inspection period. The shift manager's request for detailed discussions of plant maintenance activities for his operating crew to help ensure that the operators were informed of the plant status was good.

O1.2 Corrective Actions for Equipment Failures

a. Inspection Scope (71707, 40500)

The inspectors reviewed the licensee's corrective actions for the following equipment failures:

- 0 emergency diesel generator (EDG) supply breaker to Unit 2 failed to energize on September 27, 1997, during surveillance testing.
- 0 EDG failed to start on September 29, 1997, during surveillance testing.
- Unit 1 Division III safety-related bus supply breaker from the station auxiliary transformer (SAT) failed to energize on October 7, 1997, during surveillance testing.

b. Observations and Findings

For each of the equipment failures listed above, the licensee generated a problem identification form (PIF), which is the beginning of the corrective action process. Appropriate management attention was placed on reviewing the failures and appropriate personnel from various departments performed the root cause investigations for the failures. The licensee assessed the impact of the failures on the operability of other components, and determined the corrective actions in a timely manner.

For the failure of the Unit 2 supply breaker from the 0 EDG, on September 27, 1997, the licensee determined that the root cause for the failure was binding of the cubicle mounted breaker position switch linkage. The switch monitored the breaker position as part of the breaker control logic. The switch contacts must be open or the breaker would not energize. In this particular event, the switch never opened when the operator returned the breaker to service (racked-in the breaker) following maintenance. When the licensee was performing post-maintenance testing (PMT) of the breaker, it failed to actuate. The engineering department recommended corrective actions which included additional switch inspections and revision to maintenance procedures to include the linkage configuration inspection. The licensee's root cause and corrective actions appeared appropriate.

On September 29, 1997, during a surveillance test of the 0 EDG output breaker the 0 EDG failed to start. The operators were using a procedure which required that the operat[illegible] take manual control of the fuel system and slowly increase the EDG speed after it started. From the investigation, the licensee concluded that the procedure was adequate and the operators followed the procedure. In addition, the licensee did not ident[illegible]y any equipment deficiencies. However, the licensee enhanced the EDG starting procedure by adding an operator to improve communications when the operators were performing the procedure and other steps to ensure that the EDG was running before operators could take manual control of the fuel system. The inspector reviewed the procedure, LaSalle Operating Procedure (LOP)-DG-02, "Diesel Generator Startup and Operation," Revision 25, and did not identify any problems with the procedure that was used by the operators. The inspectors reviewed the training that had previously been given to the operators. The inspectors determined that the operators had received

training on the manual starting procedure and recently performed the LOP-DG-O2 procedure without incident. The licensee's corrective actions appeared appropriate.

Concerning the failure of the Unit 1 Division III supply breaker from the SAT on October 7, 1997, the licensee replaced the breaker and transported the failed breaker to the vendor for further inspection. The breaker that failed was manufactured by General Electric (GE). While reviewing failure histories for GE breakers, the licensee identified two additional instances where GE breakers had failed to energize during testing within the past year. The licensee evaluated the three GE breaker failures that occurred over the last year and concluded that no single common mode problem existed. However, the root cause for the Unit 1 Division III supply breaker from the SAT was still being evaluated by engineering personnel.

The licensee's immediate corrective actions for the Division III breaker failure appeared adequate. However, the licensee's investigation of the Unit 1 Division III supply from the SAT was ongoing to determine the root cause of the October 7, 1997, failure and the potential for related failures of other GE breakers in service in the plant. This was considered an inspection followup item pending NRC review of the results of the breaker failure investigation (50-373/97016-01).

c. Conclusions

Licensee personnel implemented corrective actions for the equipment failures listed above. The corrective action process was used by personnel involved with reviewing the failures and the inspectors observed that appropriate management attention was given to the equipment failures and the corrective action process was properly utilized.

O2 Operational Status of Facilities and Equipment

O2.1 Out-of-Service (OOS) Error Performance Indicator Evaluation

a. Inspection Scope (71707)

The licensee's response, dated March 28, 1997, to the 10 CFR Part 50.54(f) letter delineated performance indicators that would be used to trend and monitor plant performance. During this inspection period, the inspectors reviewed the performance indicator data reported by the licensee through September 1997 and assessed the performance indicator for OOS errors. The inspectors interviewed plant personnel and reviewed the following documents:

- Nuclear Operating Division (NOD)-OA.39, "Performance Indicators for Nuclear Operations Branch," Revision 1
- Commonwealth Edison (ComEd) Critical Performance Indicator 50.54(f) Variance Reports for August 1997 and September 1997
- PIFs completed during June through September 1997 for OOS issues

b. Observations and Findings

The OOS error performance indicator accurately reflected the OOS errors documented by plant personnel between June 1997 and September 1997 on PIFs. In addition, the data used to evaluate LaSalle's performance in the area of OOS errors was consistent with the definition of the data used to support the performance measure. ComEd defined the OOS error performance indicator in NOD-OA.39 as the total number of OOS PIFs over the period of a month designated as a significant condition adverse to quality.

For more than three months prior to October 1997, LaSalle station OOS errors had exceeded the site established threshold of greater than five OOS errors and the NOD threshold of greater than one OOS error per month. In response to the performance indicator threshold being exceeded, the licensee increased corporate and site management oversight of the OOS program and initiated corrective actions to address the OOS errors occurring in the plant.

Licensee personnel responsible for the oversight of the OOS error performance indicator were knowledgeable of the performance indicator criteria and corrective actions initiated to address the number of OOS errors. The licensee correctly determined that, while the number of OOS errors has remained relatively constant when compared to early 1997, the causes of the OOS errors changed from human performance problems in the plant to poor performance in the areas of scheduling and planning of OOS activities. The additional corrective actions initiated by the licensee to resolve the scheduling and planning issues appeared appropriate.

c. Conclusions

The OOS error performance indicator accurately reflected the status of significant OOS errors and personnel responsible for the indicator were knowledgeable of the OOS program problems. Also, corporate and site management responded as directed by procedure to address the OOS errors at LaSalle.

02.2 Cold Weather Preparations

a. Inspection Scope (71714)

The inspectors reviewed the licensee's program for protecting safety-related systems against the effects of cold weather. The inspectors reviewed applicable licensee documentation, interviewed operations staff, and conducted plant system walkdowns.

b. Observations and Findings

Operations personnel were performing LaSalle Operating Surveillance (LOS)-ZZ-A2, "Preparation for Winter Operation," Revision 14, and making progress toward completing station preparations for the onset of cold weather.

Due to the fact that both units were not operating, the licensee was installing equipment to supplement the existing plant heating systems. For example, the licensee planned to install a submerged air sparger which was designed to prevent the buildup of ice on submerged portions of the intake structure, primarily the trash racks. In addition, the

licensee planned to stage other portable heating equipment in critical areas to prevent freezing of sensitive equipment during extreme cold weather.

The inspectors evaluated the stored emergency sources of cooling water, external to plant buildings, and found that they were heated and supplied with heat tracing on piping exposed directly to the environment. In addition, operators were required by LOS-ZZ-A2 to verify the proper operation of heaters and heat tracing.

The licensee incorporated lessons learned from last year into the planning for the forthcoming cold weather season. To address problems previously experienced, the licensee was installing additional heating equipment throughout the plant. No deficiencies were noted by the inspectors in the licensee's preparations for cold weather.

c. Conclusions

The licensee's completed and planned actions for cold weather protection appeared adequate to protect emergency sources of cooling water and critical plant systems from cold weather. The inspectors considered the licensee's use of previous plant experience in formulating cold weather plans to be a good initiative.

O8 Miscellaneous Operations Issues

O8.1 10 CFR 50.54(f) Letter Commitment Review

a. Inspection Scope (71707)

The inspectors reviewed licensee commitments, Numbers 1, 54, 75, 100, 271, 316, and 322, pertaining to Commonwealth Edison Company's March 28, 1997, response to NRC's request for information pursuant to 10 CFR 50.54(f) and observed two Management Review Meetings (MRM).

b. Observations and Findings

On September 22, 1997, the inspectors observed a portion of a MRM where OOS errors were discussed by the operations manager. Corporate management attended the meeting and the discussion addressed the licensee's corrective actions planned and completed for OOS errors. In the March 28, 1997, response, the licensee had committed to review performance indicators that exceeded their corresponding thresholds. The OOS performance indicator exceeded the established threshold (as discussed in Section 02.1) and was reviewed during the meeting.

During the MRM held on October 23, 1997, the licensee discussed the status of the implementation of the maintenance rule and the status of human performance improvements at LaSalle Station. During the human performance presentation, station management discussed the current status and trends, the status of the strategies identified in the restart plan for improving human performance, and potential changes to the human performance improvement initiatives necessary to address adverse performance trends.

c. Conclusions

The licensee made progress toward addressing 10 CFR 50.54(f) commitments discussed in the March 28, 1997, letter to the NRC. The discussions in the MRM met commitments made by the licensee in the March 28, 1997, letter to the NRC and management attention remained focused on the improvement initiatives established at the station.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (61726)

The inspectors observed portions of the following surveillance tests:

- LOS-HP-Q1, "HPCS [High Pressure Core Spray] System Inservice Test," Revision 35
- LaSalle Technical Surveillance (LTS)-800-103, "Unit 1 1B Diesel Generator 1E22-S001 Start and Load Acceptance Surveillance," Revision 2
- LOS-500-111, "Unit 1 Integrated Division III ECCS [Emergency Core Cooling System] Response Time Surveillance," Revision 4

b. Observations and Findings

Operations, maintenance, and engineering personnel followed procedures, were knowledgeable of the purpose of the overall test and the individual steps in the test, and practiced good three-way communications during the performance of surveillance tests. Engineering personnel conducted a thorough heightened level of awareness briefing prior to performing LTS-800-103. Equipment failures which occurred during the tests were discussed in Section O1.2 and a surveillance procedure problem was discussed in Section E2.1.

c. Conclusion

The surveillance tests were performed in an acceptable manner and no concerns with personnel performance were identified by the inspectors.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 General Comments

a. Inspection Scope (62707)

The inspectors observed portions of maintenance activities associated with the repair of the residual heat removal (RHR) heat exchanger discharge valves, repair of the EDG 1A

cooling water pump, and installation of a temporary modification to support safety-related electrical bus maintenance. The inspectors also interviewed engineering and maintenance personnel and reviewed associated work packages which included:

- Work Request (WR) 970070996-01, Perform Ultrasonic Test of RHR Piping
- WR 970039772-01, Replace Valve Discs and Guides of 1E12F068B
- WR 960085704-01, Pump [EDG 1A Cooling Water Pump] Outboard Seal Leak

b. Observations and Findings

The inspectors determined that, overall, the maintenance work was performed satisfactorily and in accordance with the appropriate work procedures. Also, the inspectors observed good coordination among departments involved with the maintenance activities. Outage department personnel incorporated lessons learned from past maintenance activities into the work schedule which resulted in work progressing in a more efficient manner. Personnel involved in work activities were knowledgeable of the equipment operation, design, and work documents.

The inspectors noted that the Division II RHR pump room had recently been decontaminated. In addition, mechanics could access the room and perform maintenance without constraints of anti contamination clothing. The supervisor with oversight of the 1B RHR service water heat exchanger discharge valve work commented that decontamination of the Division II RHR corner room resulted in maintenance activities in the area being performed more efficiently and effectively than previously when the area was contaminated.

The inspectors identified one minor foreign material concern in the Division II core standby cooling system pump room. The inspectors informed the licensee and the items were properly dispositioned. A sump cover plate was not installed, which created a situation where foreign material could be introduced into the sump. However, the sumps did not perform a safety-related function.

c. Conclusions

The licensee incorporated lessons learned from previous maintenance activities into work planning and decontaminated the Division II RHR pump room. These improvements increased the licensee's ability to perform maintenance more efficiently.

M8 Miscellaneous Maintenance Issues

M8.1 (Closed) Inspector Follow-up Item 50-373/94005-02: Inoperable EDG penthouse heaters resulted in a differential temperature causing reverse rotation of the ventilation fans. The inspectors verified that the licensee had completed an analysis which ensured reverse rotation would not preclude the fans from performing as required on an automatic start. This item was closed.

M8.2 (Closed) Violation 50-373/94002-10: Ten safety-related excess flow check valves were found to be improperly stored and no inspection or test program was found to be in place to assure quality of the poppet assemblies. The inspectors performed a walkdown of the warehouse and determined that equipment was stored as required by the licensee's material control program. Also, the inspectors reviewed documentation and determined that adequate receipt instructions were provided for warehouse personnel to verify proper quality of poppet assemblies. This item was closed.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Failure to Perform Adequate Emergency Diesel Generator Surveillance Test

a. Inspection Scope (37551)

The inspectors reviewed the licensee's actions to address technical specification testing that was not performed on all five EDGs at LaSalle Station. The inspectors evaluated the licensee's corrective actions, which included the performance of a special procedure, and reviewed documentation of the System Functional Performance Review (SFPR) previously completed by the licensee for the EDGs.

b. Observations and Findings

On October 8, 1997, the licensee identified that a surveillance test procedure, LTS-500-111, "Unit 1 Integrated Division III ECCS Response Time Surveillance," Revision 5, performed to meet technical specification surveillance requirement 4.8.1.1.2.d.9, was inadequate.

The surveillance test was performed with the EDG running and all of the automatically connected loads being powered by the EDG under normal conditions instead of accident conditions. In the LTS-500-111 procedure, many of the loads were operated at a lower load than the postulated load conditions which would exist when the equipment was operating during an accident. Therefore, the test did not evaluate the worst-case accident load conditions of the EDGs to ensure that 2860 kW would not be exceeded.

Technical Specification Surveillance Requirement 4.8.1.1.2.d.9 required that the licensee verify that all loads that would be automatically connected to the EDG during an accident would not exceed the 2000-hour EDG rating of 2860 kW. However, the licensee had never documented that the required surveillance testing, using worst case loading conditions, was adequately completed for both LaSalle Unit 1 and Unit 2.

When the issue was identified by the licensee staff, the Shift Manager was notified and he declared all five EDGs at LaSalle inoperable. Subsequently, engineering personnel developed and completed a new surveillance procedure to document the verification required by technical specifications. The inspectors reviewed the completed procedure and did not identify any problems. The licensee documented the issue on a PIF and initiated a root cause investigation.

The licensee's failure to perform surveillance testing to verify that all automatically connected loads did not exceed the 2000-hour EDG rating of 2860 kW is a violation of Technical Specification Surveillance Requirement 4.8.1.1.2.d.9 (50-373/97016-02; 50-374/97016-02). However, the NRC is not citing this violation because it satisfies the criteria delineated in Section VII.B.2 of the NRC's enforcement policy (NUREG-1600). Specifically, the licensee has entered an extended shutdown; enforcement action was not considered necessary to achieve remedial action; the violation was based upon activities of the licensee prior to the events leading to the shutdown; the violation would not be categorized at Severity Level II; the violation was not willful; the licensee's decision to restart the plant requires implicit NRC concurrence; and the violation was identified by the licensee.

The inspectors reviewed documentation of the SFPR completed by the licensee for the EDGs. The SFPR was performed by the licensee to review the material condition of the EDGs and assess the adequacy of EDG surveillance tests. In this case, the engineer reviewing the EDG surveillance tests identified that the surveillance procedure used to satisfy the requirements of Technical Specification Surveillance Requirement 4.8.1.1.2 d.9 was inadequate. However, the engineer further reviewed the issue and subsequently determined that the surveillance procedure was adequate, but did not document his rationale for concluding that the procedure was acceptable.

The licensee initiated a PIF to document the engineer's error. In addition, the licensee reviewed the SFPR documentation for the standby gas treatment system, the primary containment vent and purge system, the RHR system, the EDGs, and the EDG diesel fuel oil systems, to determine if additional errors similar to the one made by the engineer during the SFPR of the EDGs existed. The licensee's review of the SFPR documentation for the five systems did not identify errors similar to the error made by the engineer performing the review of the EDG testing.

c. Conclusions

The licensee's corrective action for the inadequate surveillance testing was appropriate and the licensee's review of the EDG loading was adequate. However, the licensee's failure to perform the required technical specification testing was a non-cited violation. The licensee's review of the SFPR documentation to ensure that identified problems were documented for resolution was appropriate. The inspectors concluded that the engineer performing the review of the EDG surveillance testing during the SFPR identified the inadequate test but incorrectly determined that the test procedure, LTS-500-111, was acceptable.

IV. Plant Support

P5 Staff Training and Qualification in EP (82701)

P5.1 Emergency Responder Qualifications

a. Inspection Scope (82205)

The inspectors used Inspection Procedure 82205 to review the qualifications of the licensee's shift personnel required to respond to plant emergencies.

b. Observations and Findings

The inspectors determined that, overall, the licensee had implemented a program for providing breathing apparatus and appropriate training for operators to meet the requirements of 10 CFR 50, Appendix R, Section H. However, of the 34 control room operators with a corrective lens restriction in their individual license, only 8 had eyewear suitable for use with a breathing apparatus. The inspectors identified that there were no instructions or procedures to ensure that all licensed operators, who were required to wear corrective lenses as a condition of their individual NRC licenses, had corrective lenses of the appropriate type available should these individuals be required to wear self-contained breathing apparatus while performing licensed duties.

The inspectors identified that LaSalle Operating Abnormal (LOA)-FX-101, "Unit 1 Safe Shutdown with a Loss of Offsite Power and a Fire in the Control Room or AEER [Auxiliary Electric Equipment Room]," Revision 1, and LOA-RX-101, "Unit 1 Control Room Evacuation Abnormal," Revision 1, required operators to use control room emergency breathing apparatus when the control room was uninhabitable concurrent with a loss of coolant accident (LOCA) or loss of offsite power (LOOP). Operators were required by the procedures to evaluate the control room environment during a loss of coolant concurrent with a fire in the control room and use the apparatus if necessary. However, as previously stated, the licensee's failure to have procedural or programmatic controls to ensure that corrective eyewear was available to operators which require it, is a violation of 10 CFR 50, Appendix B, Criterion V. However, this non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy (50-373/97016-03; 50-374/97016-03). The licensee had initiated corrective action to procure appropriate eyewear inserts for the breathing apparatus and to ensure that licensed operators have the necessary corrective lenses as specified as a condition in their respective licenses. This action was scheduled to be completed on December 15, 1997. Furthermore, the licensee was evaluating NRC Information Notice 97-66, "Failure to Provide Special Lenses for Operators Using Respirator or Self-Contained Breathing Apparatus During Emergency Operations," which was scheduled to be completed by January 18, 1998. Operations personnel indicated that a quarterly surveillance revision was in progress to add a review to verify that all licensed control room operators have appropriate eyewear for use with breathing apparatus.

An additional licensee initiative had been undertaken to qualify all mechanical maintenance mechanics in the use of respirators. This action exceeds the requirements

for emergency responders as specified in the station emergency plan.
The inspectors considered the mechanical maintenance department initiative to be good.

c. Conclusions

The licensee's failure to have procedures to ensure respirator eyewear was available for control room personnel was a non-cited violation. However, the licensee had initiated action to procure appropriate eyewear for current control room personnel. The licensee's permanent corrective action, which involved a surveillance revision to ensure operator eyewear was available, was in progress. The licensee's initiative to qualify all mechanical maintenance department personnel was good and no other deficiencies were noted in the qualifications of emergency responders.

VI. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the results of these inspections to licensee management listed below at an exit meeting on October 31, 1997. The licensee acknowledged the findings presented.

The inspectors asked the licensee if any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

ComEd

*W. Subalusky, Site Vice President
F. Dacimo, Plant General Manager
*S. Smith, Plant Manager
J. McDonald, Safety Quality Verification/Safety Assessment Manager
*R. Helsterman, Maintenance Manager
*R. Palmieri, System Engineering Supervisor
*N. Hightower, Health Physics Supervisor
*P. Barnes, Regulatory Assurance Supervisor

* Present at exit meeting on October 31, 1997.

INSPECTION PROCEDURES USED

IP 37551	Onsite Engineering
IP 40500	Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
IP 61726	Surveillance Observation
IP 62703	Maintenance Observation
IP 71707	Plant Operations
IP 71750	Plant Support Activities

ITEMS OPENED, CLOSED, OR DISCUSSED

Open

50-373-97016-01	IFI	Review of GE breaker failure investigation
50-373/374-97016-02	NCV	Failure to perform adequate technical specification test
50-373/374-97016-03	NCV	No procedural or programmatic guidance for ensuring prescription eyewear was available

Closed

50-373/374-97016-02	NCV	Failure to perform adequate technical specification test
50-373/374-97016-03	NCV	No procedural or programmatic guidance for ensuring prescription eyewear was available
50-373/94005-02	IFI	Inoperable EDG penthouse heaters resulted in a differential temperature causing reverse rotation of the ventilation fans
50-373/94002-10	VIO	Ten safety-related excess flow check valves were found to be improperly stored and no inspection or test program was found to be in place to assure quality of the poppet assemblies

LIST OF ACRONYMS USED

AEER	Auxiliary Electric Equipment Room
DRP	Division of Reactor Projects
COMED	Commonwealth Edison
ECCS	Emergency Core Cooling System
EDG	Emergency Diesel Generator
GE	General Electric
HPCS	High Pressure Core Spray
LOA	LaSalle Operating Abnormal
LOCA	Loss of Coolant Accident
LOOP	Loss of Offsite Power
LOP	LaSalle Operation Procedure
LOS	LaSalle Operating Surveillance
LTS	LaSalle Technical Surveillance
MRM	Management Review Meeting
NOD	Nuclear Operating Division
NRC	Nuclear Regulatory Commission
NCV	Non-Cited Violation
OOS	Out-Of-Service
PDR	NRC Public Document Room
PIF	Problem Identification Form
RHR	Residual Heat Removal
SAT	Station Auxiliary Transformer
SFPR	System Functional Performance Review
WR	Work Request