



Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

April 27, 1993

U.S. Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

Subject: LaSalle County Nuclear Power Station Units 1 and 2
Reply to Notice of Violations
Inspection Report Nos. 50-373/93007; 50-374/93007
NRC Docket Nos. 50-373 and 50-374

Reference: H. B. Clayton letter to L. DelGeorge dated March 29, 1993
transmitting NRC Inspection Report 50-373/93007; 50-374/93007

Enclosed is the Commonwealth Edison Company (CECo) response to the Notice of Violations (NOVs) which were transmitted with the referenced inspection report.

The violations address failure to follow procedures due to inattention to detail.

If your staff has any questions or comments concerning this letter, please refer them to Sara Reece-Koenig, Regulatory Performance Administrator at (708) 515-7250.

Sincerely,

D. L. Farrar
Regulatory Services Manager

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Attachment

cc: A.B. Davis, Regional Administrator - Region III
B. Stransky, Project Manager, NRR
D. Hills, Senior Resident Inspector

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ATTACHMENT A

Response to Notice of Violation
NRC Inspection Report
50-373/93007; 50-373/93007

VIOLATION: 373/93007-01

1. Technical specification 6.2.B requires radiation control procedures to be maintained and adhered to.

LaSalle Radiation Procedure (LRP) 1350-20, "The Startup and Operation of the Single Channel Continuous Air Monitor (CAM)," Revision 6, step F.4, requires performance of a daily routine on the single channel CAMs including a source check and other operational checks and step E.1 requires notification of health physics supervision if equipment does not function properly.

LRP 1350-24, "Startup and Operation of the Manifold Sample System Continuous Air Monitors," Revision 7, step E.2, requires notification of health physics supervision if the equipment does not function properly.

Contrary to the above, the daily routine was not performed on one or both single channel CAMs OPLA1J and OPLB1J for the refueling floor on January 1, 4, 5, 8, 16-18 and February 1-5, 1993. Health physics supervision was not informed that equipment did not function properly upon daily source check failures of manifold sample system CAMs 1PL83JA (on January 31 and February 1, 3-5, 1993) and 1PL15J (on February 1-6, 1993) for the Unit 1 reactor building and primary containment and upon daily identification on January 19-22, 1993 that single channel CAM OPLB1J for the refueling floor was shutdown.

This is a Severity Level IV violation (Supplement 1).

REASON FOR THE VIOLATION

During the months of January and February 1993, there were numerous dates in which the daily surveillance for the two refuel floor continuous air monitors (CAMs) was not performed. Normally, a single RPT is assigned to perform all CAM surveillances in the plant as part of a routine assignment. During times of increased work on the Refuel floor, as is the case during or near the end of an outage, an RPT is assigned to work on the refuel floor and will perform the daily surveillance for the CAMs on the refuel floor. This practice of having a shared responsibility for performing this surveillance led to the surveillance not being performed. The CAM surveillance for the refuel floor was not performed on the occasions cited due in part to inattention to detail by management in assignment of the duties and also inattention to detail by RPTs in job performance.

There were several instances where daily source check failures were not reported directly to Health Physics supervision as required by procedure. The source check failures were noted on the documentation during the surveillance, and the surveillance was subsequently reviewed by Health Physics supervision, but management expectations of a direct and timely report were not met.

ATTACHMENT A

Response to Notice of Violation
NRC Inspection Report
50-373/93007; 50-373/93007

CAM OPLBLJ on the refuel floor was not in operation. The power cord was coiled up and placed on the CAM. Due to the time lapse since this event, neither the reason for this CAM being shutdown nor the person(s) involved could be determined. Discussions with RPTs revealed there was a perception that the CAM was not required to be in operation since there were no work activities being performed on the refuel floor.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The Health Physics department has reorganized responsibilities within the department. As part of the reorganization, management oversight of the CAMs has been assigned to the newly created positions of Unit Health Physicists. One of their primary responsibilities will be to maintain cognizance of CAMs within their specific assignment. Additionally, the Unit Health Physicists will serve as the System Engineer for the non-Tech Spec related CAMs. Tech Spec related CAMs will continue to be covered by the Systems Engineer department.

All Health Physics personnel were tailgated on this event to convey expectations when performing surveillances and on the specifics of this violation. It was additionally emphasized that the person assigned to perform the surveillance on the CAMs will be accountable for all CAMs regardless of plant conditions or other RPT work assignments.

Those CAMs which experienced source check problems were corrected and operational by March 12, 1993.

CAM OPLBLJ which was shutdown on the refuel floor was started and observed to work properly. The department tailgate included clarification by management that all CAMs are required to be in operation, with exceptions addressed by management.

CORRECTIVE ACTIONS THAT WILL BE TAKEN

One RPT will be specifically counselled for poor performance, which resulted in the problems during February, as to the responsibilities when performing this surveillance and management's expectations while performing the routines.

THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

LaSalle County Station is currently in full compliance.

ATTACHMENT A

Response to Notice of Violation
NRC Inspection Report
50-373/93007; 50-373/93007

VIOLATION: 373/93007-02a,b

2. Technical specification 6.2.A.a requires written procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, be established, implemented, and maintained. Regulatory Guide 1.33 includes administrative procedures and procedures for performing maintenance and surveillances.

LaSalle Maintenance Procedure (LMP)-MS-06, "Removal/Installation of Main Steam Safety Relief Valves," step F.7.26.8, requires tape to be removed from the actuator air valve exhaust port at the bottom of the cylinder head.

LaSalle Administrative Procedure (LAP)-300-7, "Preparation and Control of Nuclear Work Request," Appendix C, step C.31, requires maintenance to be performed as required by the work instructions and step C.60 requires performance of identified post maintenance testing.

LaSalle Technical Surveillance (LTS)-1100-6, "Local Power Range Monitor (LPRM) Cable Connection Verification", step F.1.C, requires verification that LPRMs are properly connected.

Contrary to the above, administrative procedures and procedures for performing maintenance and surveillances were not correctly implemented in the following examples:

- a. In December 1992, tape was not removed from the actuator air valve exhaust port at the bottom of the cylinder head for Unit 1 safety relief valve 'A' in accordance with LMP-MS-06.
- b. Work was not performed as specified in the work instructions for work request (WR) L17076 in late 1992 and WR L21004 on February 16, 1993, in accordance with LAP-300-7 as Unit 1 LPRM 32-41 was connected incorrectly.
- c. On December 2, 1992, Unit 1 LPRM 32-41 was not verified as being properly connected in accordance with LTS-1100-6.
- d. On February 16, 1993, post maintenance testing to verify proper connection of LPRM 32-41 identified in WR L21004 was not performed in accordance with LAP-300-7.

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ATTACHMENT A

Response to Notice of Violation
NRC Inspection Report
50-373/93007; 50-373/93007

REASON FOR VIOLATION: (example a)

Duct tape was not removed from "A" Safety Relief Valve (SRV) Actuator Air Valve Manifold Exhaust Port due to inattention to detail during the use of Procedure LMP-MS-06, "Removal/Installation of Main Steam Safety Relief Valves."

CORRECTIVE ACTIONS TAKEN

A team composed of engineering, maintenance and operations personnel performed a visual inspection of "A" SRV on January 27, 1993 and removed the duct tape found on the exhaust port. All other Unit 1 SRVs were inspected. "D" and "V" SRVs were found to contain pieces of duct tape on the exhaust ports, the duct tape was removed. As indicated by testing, no other Unit 1 SRVs were adversely affected.

Although considered adequate, Mechanical Maintenance Procedure LMP-MS-06 Step F.7.26.8 has been enhanced to require the worker signature for removal of duct tape along with a second verification by a Supervisor, verses the current single signature indicating that a list of items have been addressed. Also graphics have been included to indicate possible tape locations.

All Unit 2 SRVs were cycled satisfactory after the last maintenance conducted and no further action is required.

CORRECTIVE ACTION TO AVOID FUTURE VIOLATION

No further action required.

DATE OF COMPLIANCE

Full compliance has been achieved.

ATTACHMENT A

Response to Notice of Violation
NRC Inspection Report
50-373/93007; 50-373/93007

THE REASON FOR THE VIOLATION: (examples b, c, d)

The reason for the violation was personnel not following acceptable work practices and procedures. The problem initially occurred when a workman connected extender "pigtails" to the LPRM connectors and then incorrectly connected the LPRMs. The technician wasn't sure how to connect the cables and did not consult an electrical schematic drawing to ensure correct connections.

Normally, connectors are sequenced by height, "A" through "D" (low to high). During the LTS, when the engineer found the serial number for the "A" level (actually connected to the "D" LPRM) and continued in sequence down, each serial number was observed at the next connector height. Thus the connectors were in the correct order, but reversed. The engineer should have gone up in "height" sequence after finding the "A" serial number. The engineer was looking more for a single error than a complete string reversal and was not attentive to detail.

A second problem occurred during the troubleshooting of the cable connections on February 16, 1993. The crew based their assessment of the problem on the connector location of the "pigtail" ends verses the actual LPRM connections. This led to incorrectly connecting two of the four LPRMs. Additionally, the post maintenance test (PMT) was not correctly performed by independent personnel. Due to the adverse conditions at the work location under the reactor vessel, a poor work practice was exhibited by the independent verifier by only observing the actions of the worker, verses actively checking the connections. This was only part of the PMT, since the final test was comprised of a test at power which subsequently revealed the incorrect connections.

In both occurrences improper and unacceptable work practices were used.

ATTACHMENT A

Response to Notice of Violation
NRC Inspection Report
50-373/93007; 50-373/93007

THE CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

March 2, 1993 a composite team consisting of engineering and maintenance personnel conducted troubleshooting of the connection problems on this LPRM. This team identified and corrected the problem. The connections were independently verified by all team members. The proper connections were confirmed during startup testing when the Unit returned to service later in March 1993.

The Instrument Maintenance Department personnel received training on this event. Training included specifics on confirming LPRM cable identification via detector connector position and inscribed marking rather than by utilizing "pigtail" location and the need to transfer the inscribed marking to the other end of a "pigtail" when one is used. Additional emphasis was placed on the need to ensure that they are fully knowledgeable of the location of the connector prior to proceeding with the connection.

The Instrument Maintenance Department personnel were tailgated on the need for, and proper process of second verification.

The Nuclear Engineer group was tailgated on the need for, and proper process of second verification. Since the group normally conducts pre-job briefings and a review of group experiences prior to LPRM connector verification, the Nuclear Engineers involved in these two occasions were counselled by the group leader on the events and performance expectations.

THE CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

No further action is required.

THE DATE WHEN FULL COMPLIANCE WILL BE REACHED

Full compliance was achieved when the LPRMs were correctly connected.