Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

April 5, 1991

Mr. A. Bert Davis
Regional Administrator
U.S. Nuclear Regulatory Commission
799 Roosevelt Road-RIII
Glen Ellyn, Il 60137

Subject: LaSalle County Station Units 1 and 2
Response to Notice of Violation
Inspection 50-373/91002; 50-374/91002
NRC Docket Nos. 50-373 and 50-374

Reference: W.D. Shafer letter to Cordell Reed dated March 8, 1991 transmitting NRC Inspection Report 50-373/91002; 50-374/91002

Dear Mr. Davis:

Enclosed is Commonwealth Edison Company's (CECo) response to the subject Notice of Violation (NOV) which was transmitted with the referenced letter and Inspection Report. The NOV cited one level IV and one level V violation. The level IV violation was regarding a personnel error which resulted in isolation of the emergency and backup supply of one header of the instrument nitrogen system to three of seven automatic depressurization system (ADS) valves. The level V violation concerned a failure to mark and date control room chart recorders for at least a period of two weeks.

CECo understands the significance of these events as well as the need for effective corrective actions to prevent recurrence. CECo's response to the cited violations is provided in the following attachment.

If your staff has any questions or comments regarding this response, please refer them to this office.

Very truly yours,

T.J. Kovach
Nuclear Licensing Manager

GAD/TJK/lmw

Attachment

cc: J. Hickman/B. Siegel, Project Manager - NRR
T. Tongue, Senior Resident Inspector
NRR Document Control Desk

ZNLD866/1

150117

IE01

ATTACHMENT

IR 50-373/91002-01; 374/9002-04

VIOLATION:

10 CFR 50, Appendix B, Criteria V, states, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

LaSalle Station Administrative Procedure LAP 1600-3, "Charts and Chart Recorders," Revision 7, September 1, 1990, Step F.3 states, "Control room charts shall be labeled and verified to be marking clearly daily (on the midnight shift, if possible) by a line noting the time and date."

Contrary to the above, on January 23, 1991, the Control room chart recorders had not been marked in any manner for a period of at least two weeks. This resulted in lack of confidence in the validity of the recorder data and the ability to reconstruct an event or occurrence from that data.

This was a Severity Level V violation.

CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED:

All charts were immediately stamped when the issue was identified by the NRC Resident Inspector.

LaSalle Station initiated a full investigation as to the root cause of the incident. The investigation identified weaknesses in the method of verifying the time-date stamping mechanism of control room chart recorders that was used during the two-week period prior to January 23, 1991. During this period, there appeared to be an over-reliance on memory as a reminder to perform specified NSO duties. In response to this incident a letter was issued to the Shift Engineers requiring them to review the event with the NSOs and to evaluate if other NSO duties were not being performed correctly. The Shift Engineers completed the tailgates and provided the Assistant Superintendent of Operations with their findings. No additional discrepancies were identified.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATION:

LOS-AA-D1, Unit Daily Surveillance, has been revised (Revision 25) as a corrective action to avoid further violations. A box has been added to LOS-AA-D1 to be checked daily indicating that control room chart recorders have been marked with a line indicating date and time. For those chart recorders which automatically date and time stamp the charts, the charts are checked by station personnel to verify the automatic feature is operating correctly. This corrective action ensures that the operator is reminded daily to date and time mark the charts (or verify the automatic feature where applicable). Revision 25 of LOS-AA-D1 has been approved and implemented.

DATE OF FULL COMPLIANCE:

Full compliance has been achieved.

IR 50-374/91002-03

VIOLATION:

Technical Specification 3.5.1.a. and b. for emergency core cooling system (ECCS), Divisions 1 and 2 requires that at least six of the seven automatic depressurization system (ADS) valves be operable in Operational Condition 1, 2, and 3 when reactor steam dome pressure is greater than 122 psig. Otherwise, be in hot standby within the next 12 hours and Cold Shutdown within the following 24 hours.

Contrary to the above, during the period of June 4, 1990 through October 16, 1990, the backup nitrogen supply north bank manual isolation valve was shut, resulting in isolation of the emergency and backup supply of one header of the instrument nitrogen system tc three of the seven ADS valves. This rendered the three ADS valves inoperable.

This was a Severity Level IV violation.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

The affected valve, 2IN090, was immediately opened. The Unit 1 and Unit 2 Instrument Nitrogen System lineup was checked and verified to be normal.

As stated in the Inspection Report, a review of records and computer alarm printer data showed that there were no low pressure alarms on the IN supply to the ADS system during the time in question. This verifies that the check valves were holding and that there was sufficient nitrogen in the accumulators to operate the valves if they had been called upon. This included the period on October 16, 1990 when the IN compressors were not operating at rated pressure.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATION:

LaSalle operating procedure, LOP-IN-01, Drywell Pneumatic System Startup and Operation, was revised (Revision 9) to require a documented sign-off for the required position of the ADS Bottle Bank Valves. LaSalle operating procedures related to plant safety systems and their support systems were reviewed to determine the need for changes following a review of the event. No other areas were identified as requiring procedure changes.

As listed in the Inspection Report, normal station operating practice to verify valve position is the manual attempt to move a valve handwheel in the shut direction. In this instance LaSalle Station personnel apparently relied upon a visual check of valve position as verification. To prevent a recurrence, tailgates and training were performed with operating personnel to reinforce LaSalle requirements regarding the proper methods of position verificat on for manually operated valves.

Another possible root cause listed in the Inspection Report was the difficult operation of valve 2IN090. As a result, a "cheater" bar may have been employed to manually operate the valve. In order to improve operation, valve 2IN090 packing adjustment or replacement will be performed at the next available scheduled or forced unit outage. This is being tracked via a work request that is currently in the Mechanical Maintenance Department.

DATE OF FULL COMPLIANCE:

Full compliance has been achieved.