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August 2, 1996

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D.C. 20555

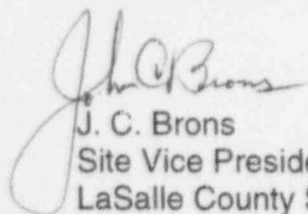
Subject: LaSalle County Station Units 1 and 2
Response to NRC to Notice of Violations
Inspection Report Nos. 50-373/96004; 50-374/96004
NRC Docket Numbers 50-373 and 50-374.

Reference: H. B. Clayton letter to R.E. Querio,
Dated July 3, 1996, Transmitting
NRC Inspection Report 50-373/96004,
50-374/96004

The enclosed attachment contains LaSalle County Station's response to the Notice of Violations, that was transmitted in the Reference letter. The attachment to this letter contains the immediate corrective actions taken as well as longer term corrective actions which will be effective in precluding recurrence of these violations.

If there are any questions or comments concerning this letter, please refer them to me at (815) 357-6761, extension 3600.

Respectfully,


J. C. Brons
Site Vice President
LaSalle County Station

Enclosure

cc: H. J. Miller, NRC Region III Administrator
M. P. Huber, NRC Senior Resident Inspector - LaSalle
D. M. Skay, Project Manager - NRR - LaSalle
DCD - Licensing (Hardcopy: Electronic:)
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**ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
50-373/96004, 50-374/96004**

VIOLATION: 373(374)/96004-01

10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures be established to assure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. The identification of the significant condition adverse to quality, the cause of the condition, and the corrective action taken shall be documented and reported to the appropriate levels of management.

As of April 9, 1996, the licensee failed to assure that corrective action was taken to preclude repetition of a significant condition adverse to quality. Specifically, on May 3, 1995, the Unit 2, Division III, emergency core cooling system (ECCS) inadvertently started and injected into the reactor vessel while personnel were valving the Division III reactor vessel level indicating system (RVLIS) into service. The licensee's corrective actions for this event were documented in licensee event report 374/95009. However, on April 9, 1996, a repeat event occurred when the Unit 1, Division III, ECCS injected into the reactor vessel while the associated RVLIS system was being valved into service. Consequently, the licensee's corrective actions taken in response to the May 1995 event were insufficient to prevent recurrence.

VIOLATION: 373(374)/96004-03

10 CFR 50.59(b)(1), requires, in part, that licensees maintain records of changes in the facility "to the extent that these changes constitute changes in the facility as described in the safety analysis report." These records must include a written safety evaluation which provides the bases that the change does not involve an unresolved safety issue.

The LaSalle Updated Final Safety Analysis Report (UFSAR), Section 2.3.3.1, "Onsite Meteorological Measurements Program" referenced the location of the onsite meteorological tower as being consistent with NRC Regulatory Guide (RG) 1.23 and American National Standards Institute/American Nuclear Society (ANSI/ANS-2.5) guidance regarding distance from potentially interfering structures. The distance from the nearest obstructing building to the onsite meteorological tower was less than the minimum distance specified in the guidance contained in RG 1.23 and ANSI/ANS-2.5.

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VIOLATION: 373(374)/96004-07

Technical Specification 6.2.A.g requires implementation of written procedures for the fire protection program.

Procedure LAP-900-10, "Fire Prevention Procedure for Welding and Cutting," Revision 14, requires combustibles and flammable/combustible liquids be removed or covered with a fire-retardant tarp within 35 feet of hot work operations (grinding, welding, and cutting).

On April 4, 1996, two instances of hot work activities were observed that did not have combustibles removed or covered within 35 feet of these work sites.

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REASON FOR VIOLATION: 373(374)/96004-01

LaSalle County Station agrees that the April 9, 1996, Unit 1, Division III spurious ECCS start and injection into the reactor vessel was a significant event adverse to quality. This event was similar to the Unit 2 Division III event of May 3, 1995, where a spurious ECCS start and injection into the reactor vessel occurred. During the April 9 event, the Instrument Mechanics had completed valving into service the associated reactor vessel level indicating system (RVLIS) and were in the process of leaving the work area when the spurious initiation occurred. The cause of the April 9 injection has been determined to be procedure deficiencies. The corrective action for the May, 1995 event, to revise the valving sequence to use needle valves to control pressure prior to placing the RVLIS into service, was completed prior to the April 1996 event.

The investigation following the April 9, 1996, injection into the vessel has determined that the probable cause of the event was inadequate venting of the Control Rod Drive (CRD) System prior to declaring the RVLIS system inservice. The CRD system had been out of service and drained during the outage. While performing the backfilling operation, the Instrument Mechanics had noted a large amount of air being vented and although the panels had been vented to achieve a solid water system, trapped air traveling through the CRD system is considered to be the cause of a hydraulic spike of the level instruments which caused the spurious actuation. The design of the instrument sensing lines is a contributing factor in that a spike on a single sensing line can cause actuations of this type.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

A procedure deficiency identification was submitted for all RVLIS refilling procedures. To preclude recurrence of this event, these procedures will be revised prior to next usage which will be during the next refueling outage. Specifically, these corrective actions will increase the vent time to assure that trapped air from the CRD system has been removed. The Engineering Department is assisting the Instrument Maintenance Department in developing these instructions.

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CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

The Instrument Maintenance Department and Engineering Department will perform a comprehensive review of these 12 procedures for backfilling the RVLIS panels for conditions which could result in invalid scrams or Engineered Safety Features actuations, identify actions to preclude their occurrence, and revise the procedures by September 30, 1996.

Instrument Maintenance Department personnel who operate this panel will review the revised procedure prior to restoring the panels to service during the Fall 1996 refueling outage.

LaSalle County Station Engineering will conduct a study of the instrument sensing line configurations to reduce the probability of invalid actuations of the Engineered Safety Features. Issues to be considered include:

- Separate sensing lines and root valves for each instrument;
- Use of transmitters/trip units with electronic damping in those installations where switches are still used;
- Use of time delays in the actuation circuitry;
- Extension of calibration cycles of instruments;
- Reduction in the number of valve manipulations;
- Use of different valve manifolds designs (i.e. anti-surge);
- Use of different sensing line configurations at the instrument rack;
- Benchmark industry/GE experience of plants which have solved sensing line problems and incorporate lessons learned in our design.

A comparable study has been performed on "ringing" in sensing lines after a turbine trip, and a similar methodology will be used. The engineering study will be completed by June 30, 1997.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved when the procedure deficiencies were issued on the procedures for backfilling the RVLIS panels on July 29, 1996.

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REASON FOR VIOLATION: 373(374)/96004-03

LaSalle agrees that an adequate safety screening to evaluate the impact of additional buildings on the meteorological tower was not conducted. The new service building was constructed under a work request and not a formal engineering work package. This resulted in an inadequate engineering review of the FSAR, ANSI/ANS-2.5, and Regulatory Guide 1.23. A safety evaluation screening, LAP-1200-13 "Safety Evaluations", Attachment B "Safety Evaluation Screening" was not completed to determine the effect of the new building on the Protective Action Recommendations (PARs). The individuals who reviewed the meteorological study completed in October, 1992, failed to identify the impact of the new service and security buildings on the 10 meter wind indicators and that a condition was created where the 10 meter wind direction and speed indicators would be operated outside of the plant's design basis.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

An Operability Assessment has been performed to specifically address the issue of the meteorological tower not conforming with the UFSAR requirements. A safety evaluation was performed on January 26, 1996, in accordance with 10 CFR 50.59 to resolve Regulatory Guide 1.23 and ANSI/ANS non-conformance. No corrections of public dose estimates performed using the Offsite Dose Calculation Manual (ODCM) were necessary. The only instrument value used for this ODCM calculation from the 10 meter platform of the meteorological tower is the temperature sensor. All evaluations and studies have determined that the temperature values are unaffected by site structures. Generating Station Emergency Plan (GSEP) procedure L2P-1200-5, "GSEP Guidelines for Recommended Offsite Protective Actions," was revised on June 10, 1996 to expand the previous use of a minimum of three affected downwind sectors when making PAR recommendations to use a minimum of five sectors for ground level releases to ensure any inaccuracies created by the existing site structures are bounded.

The following procedures have been implemented since the new service building was erected which define the process to be used in implementing changes to the plant: LAP-1300-18, "Roadmap To Plant Changes"; LAP-1300-19, "Controlled Design Changes"; and LAP-1300-20, "Non-Power Block Changes."

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This new process requires that an Engineering Request (ER) be initiated and either a controlled design change or a Non-Power Block design change be performed. A Non-Power Block Screening Criteria form is completed by individuals qualified to prepare and approve 10 CFR 50.59 Safety Evaluations. This screening is similar to the screening used to determine if a 10 CFR 50.59 is required and identifies whether the UFSAR or other documents would be impacted by the change. If a change is determined to be a controlled design change, the 10 CFR 50.59 process would apply. As a result, screening for the requirements of 10 CFR 50.59 Safety Evaluations will occur in either case.

LAP-1300-18 also states that the Technical Review Committee (TRC) is responsible for determining the process to be used for implementing a plant change. The TRC is a formal standing committee of senior plant personnel who are knowledgeable of the plant and regulatory requirements.

The Updated Final Safety Analysis Report (UFSAR) has been changed to reflect the existing spacing conditions of the meteorological tower.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

The final resolution will be to re-locate the 10 meter wind speed and wind direction meteorological sensors to an additional meteorological tower to be constructed at a distance from site buildings in conformance with the ANSI/ANS-2.5 guidance. The new tower will be operational by September 30, 1997.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Compliance was achieved when a safety evaluation was performed on January 26, 1996, in accordance with 10 CFR 50.59 to resolve Regulatory Guide 1.23 and ANSI/ANS non-conformance. Generating Station Emergency Plan (GSEP) procedure LZP-1200-5, "GSEP Guidelines for Recommended Offsite Protective Actions," was revised on June 10, 1996 to expand the previous use of a minimum of three affected downwind sectors when making PAR recommendations to use a minimum of five sectors for ground level releases to ensure any inaccuracies created by the existing site structures are bounded.

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REASON FOR VIOLATION: 373(374)/96004-07

In each case described in the violation, the responsible parties in charge of the work did not adhere to the precautions in the procedure. In particular, the individuals performing the work did not remove or protect combustibles within 35 feet, did not leave the area in a safe condition, and in one case, the firewatch person was not stationed in the proper location. These incidents are a violation of LaSalle County Station's hot work procedure LA^P 900-10, "Fire Protection Procedure for Welding and Cutting."

The reason for the violation is a human performance issue. The individuals involved in these incidents failed to follow approved station procedures and did not maintain their work environment in a safe condition.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

The Fire Protection Group immediately held training sessions with appropriate maintenance and contractor personnel to re-emphasize the importance of the fire protection precautions and importance of adherence to station procedures. To reduce the probability of recurrence, LaSalle's hot work procedure, LAP 900-10, has been revised to clearly communicate that leaving a work site in a safe condition includes turning off the welding machine and ensuring gas bottles are closed and their hoses bled off. This procedural revision is part of the training provided for the qualification of personnel who perform welding and cutting work.

First line supervisors responsible for the pre-job inspections are enforcing adherence to the procedure and have heightened their awareness to seek assistance from the Fire Protection Group if questions arise. Random checks, by the fire marshals, indicate that pre-job setups have improved and no further issues regarding inadequate removal/protection of combustibles have been identified. In addition, LaSalle's hot work administrator is increasing his communications and involvement with the Fire Protection Group in order to resolve generic issues which arise in the field.

The actions taken immediately following the event were completed on June 27, 1996.

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CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

The Fire Protection group has verified that a process is in place whereby contractor personnel involved in cutting and welding activities are trained on LaSalle's hot work procedure before engaging in any hot work activities.

A working group of Fire Protection personnel representing all ComEd stations has been formed. This group has identified a number of improvements needed in the area of hot work activities such as increased Fire Protection presence in the field, the development and training of a proper job set-up, and revision of procedures to provide acceptable alternatives in the use of worker's equipment necessary to perform the work. The working group will continue to identify other enhancements as they complete their review of hot work activities. The review of fire protection program with regard to hot work activities will be completed by December 31, 1996.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved on April 4, 1996.