U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-373, 50-374
License Nos: NPF-11, NPF-18

Report Nos: 50-373/96007, 50-374/96007

Licensee: Commonwealth Edison Company

Facility: LaSalle County Station, Units 1 and 2

Location: 2601 North 21st Road
Marseilles, IL 61341

Dates: June 23 - August , 1996

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EXECUTIVE SUMMARY

LaSalle County Station, Units 1 and 2
NRC Inspection Report 50-373/96007(DRP); 50-374/96007(DRP)

This integrated inspection report included aspects of licensee operations, maintenance, engineering and plant support. The report covers a 6 week period by the resident inspectors plus several announced inspections by regional specialist inspectors.

Plant Operations

- A maintenance work practice deficiency and a procedural weakness resulted in a significant plant transient during an Instrument Maintenance (IM) surveillance. Corrective actions for a previous event and a problem identification form (PIF) were not fully effective in preventing the main steam isolation valve (MSIV) isolation and reactor scram which occurred on June 26, 1996. This is considered a violation of 10 CFR 50, Appendix B, Criterion XVI (Section O1.2).

- Materiel condition of the containment air particulate and noble gas monitors was considered poor. In addition, an operator work-around was identified by the inspector (Section O1.3).

Maintenance

- A Technical Specification (TS) surveillance to verify the proper position of four manual primary containment isolation valves in each unit had not been conducted monthly as required because the surveillance procedure did not include these valves. The valves had been verified locked closed once per 18 months per an administrative procedure. Although ComEd had initiated a review of TSs required surveillances to ensure they were being properly accomplished, this problem was outside the scope of the review and was not previously identified (Section M1.1).

- Four human performance errors which occurred while performing OOSs were not significant when reviewed individually. However, the number of errors in a short time period indicated a continuing need for improvement in human performance (Section M1.2).

Engineering

- No significant engineering issues were documented in this inspection report. Significant engineering issues which occurred during this inspection period were documented in inspection reports 50-373/374-96008 and -96009. Both of these reports discussed details of the events related to the inadvertent injection of foam sealant into the core standby cooling system (CSCS) water tunnel.

Plant Support

- The inspectors reviewed a recent failure in the radwaste evaporator system which caused a large spill. The inspectors concluded that there was no formal maintenance and operational trending program for the floor drain and chemical waste processing systems. This could affect long-term evaporator operations. No problems were observed with the licensee's initial response to the evaporator spill event or with the radiological planning for the evaporator room cleanup (Section R1.1).

- Human performance errors in the area of fire protection continued to occur. Corrective actions for previous missed fire watches had not been fully effective. The failure to perform a Technical Specification fire watch is considered a violation (Section F1.1).

- Implementation of the Vehicle Barrier System was reviewed and determined to be adequate. The need for some administrative actions, barrier modifications, and additional analyses were noted (Section S1.1).

Report Details

Summary of Plant Status

Unit 1 operated at or near full power until June 19, 1996, when power was reduced to about 77% due to low service water header pressure. Full power was achieved again on June 20. On June 24, power was again reduced to about 77% due to low service water header pressure. On June 26, at 2056 hours, an automatic reactor scram occurred due to the closing of the main steam isolation valves (MSIV) during a surveillance. On June 28, a reactor startup commenced; however, later that day, Unit 1 was manually scrammed due to the core standby cooling system (CSCS) being declared inoperable. Unit 1 returned to service on July 14 and remained at or near full power for the remainder of the inspection period.

Unit 2 operated at or near full power until June 19, 1996, when power was reduced to about 77% due to low service water header pressure. Full power was achieved again on June 20. On June 24, power was again reduced to about 77% due to the low service water deader pressure. At midnight on June 29, a shutdown of Unit 2 began after the CSCS system was declared inoperable. Unit 2 was returned to service on July 16, and remained at or near full power for the rest of the inspection period.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

The inspectors conducted frequent reviews of ongoing plant operations. In general, operations in the control room were conducted in a professional manner with good decorum and communication practices.

The inspectors observed portions of both units' shutdowns and startups, and control room response to abnormal conditions. No problems were identified in control room operations during this inspection period.

O1.2 Automatic Reactor Scram During Surveillance Testing

a. Inspection Scope (71707)

The inspectors reviewed the circumstances surrounding the Unit 1 automatic reactor scram on June 26, 1996. The inspectors observed the initial root cause investigation effort and the Plant Operations Review Committee (PORC) startup review meeting.

b. Observations and Findings

On June 26, 1996 at approximately 8:56 p.m., a MSIV isolation was received on Unit 1 while instrument maintenance (IM) department

personnel were performing LaSalle Instrument Surveillance (LIS)-MS-102, "Unit 1 Main Steam Line High Flow MSIV Isolation Calibration." The MSIV isolation resulted in an automatic reactor scram. All systems functioned as expected during the shutdown and no anomalies were observed.

There are four instrument racks associated with the main steam line hi flow detection instrumentation. Each instrument rack contains one primary containment isolation system (PCIS) subchannel. Each PCIS subchannel consists of four Static O-Ring (SOR) differential pressure hi flow switches, one from each main steam line. These subchannels are A1 (A switches), B1 (B switches), A2 (C switches), and B2 (D switches). The switches are configured in a one-out-of-two twice logic. To trip a PCIS subchannel from the high flow switches, at least one switch in a channel must trip on high flow. To receive a full MSIV isolation, one of the A or C channels must trip along with one of the B or D channels.

A half isolation trip was in place on the A2 channel during the calibration of the C switch. An IM technician had just completed actions for prepressurizing the switch to near reactor pressure, and was in the process of throttling open the switch's high side isolation valve when a trip was received from the PCIS Channel B2. The combination of these trips caused the MSIV isolation.

The root cause of the event was an IM work practice deficiency in the technique for prepressurizing instruments. A contributing factor was a procedural weakness. The procedure did not include steps to reset the main steam high flow isolation trip channel prior to returning the instrument to service. This action would have reduced the probability of receiving a MSIV isolation from a pressure spike induced while valving in the instrument.

A previous MSIV isolation and reactor scram occurred on December 12, 1994, during the same surveillance procedure. The root cause of this previous event was an equipment failure; specifically, a SOR switch had failed. The root cause report and corrective actions for this event focused on the failed switch. The instrument maintenance calibration procedure was not identified as a possible contributing cause. In retrospect, the corrective actions for the December 12, 1994, were appropriate for the failed switch, but too narrowly focused.

On March 6, 1995, a Problem Identification Form (PIF) was written by a reactor operator identifying a potential problem with the methodology of performing LIS-MS-102. The PIF outlined the basic scenario which caused the MSIV closure and the reactor scram of June 26, 1996. Specifically, the potential for a MSIV isolation due to a pressure spike while valving in a hi flow switch. In the PIF, the operator also presented a solution to prevent the event from occurring. The event screening committee which reviewed this PIF forwarded it to the "Scram Reduction Committee" for appropriate review and action. However, no action was taken to revise the procedure.

The failure to take adequate corrective actions on these two previous issues described above, resulted in a significant condition adverse to quality on June 26, 1996; specifically, a MSIV isolation and reactor scram. This is a violation of 10 CFR 50, Appendix B, Criterion XVI (VIO 373/374-96007-01).

c. Conclusion

A maintenance work practice deficiency and a procedural weakness resulted in a MSIV isolation and reactor scram during an IM surveillance. Corrective actions for a previous event and a PIF were not fully effective in preventing the MSIV isolation and reactor scram which occurred on June 26, 1996.

O1.3 Unplanned Entry Into Technical Specification (TS) 3.0.3

a. Inspection Scope (71707, 62703)

The inspector reviewed the circumstances surrounding the entry into TS 3.0.3 following the loss of containment air particulate and noble gas monitor 2PL75J, while monitor 2PL15J was inoperable for calibration. The inspector interviewed personnel involved in the event and reviewed licensee documentation of the event.

b. Observations and Findings

On July 22, 1996, the licensee entered TS 3.0.3 due to insufficient operable instruments to monitor Unit 2 containment leakage as required by TS 3.4.3.1. This event was initiated by the loss of the containment air particulate and noble gas monitor 2PL75J due to the tripping of the sample pump. At the time, containment air particulate and noble gas monitor 2PL15J was removed from service for the performance of LIS-PC-206, "Containment Air Particulate and Noble Gas Monitor Calibration." IMD technicians were able to restart the monitor 2PL75J after it tripped, which returned it to an operable status. TS 3.0.3 was exited 24 minutes after its entry.

Materiel condition problems and work control weaknesses were contributing factors to this event. The inspector conducted a review of twelve PIFs written over the previous eleven months that were associated with the 2PL15J and 2PL75J containment air particulate and noble gas monitors. Several examples of material condition problems were noted. In recent examples, the 2PL75J monitor control room indication failed downscale, the 2PL75J indication was observed to be spiking, the 2PL15J indication was observed to be spiking, and the 2PL15J or 2PL75J sample pumps were routinely tripping following particulate filter change out.

The inspector also noted a materiel condition problem with the containment cooler condensate flow rate monitoring system. This system was inoperable at the time of the event. If operable, it would have provided sufficient instrumentation such that entry into TS 3.0.3 would not have been necessary. The inspector later learned that the

containment cooler condensate flow rate monitoring system had been inoperable for a significant period of time and had been referred to engineering for determination of corrective action.

The inspector concluded that weaknesses in the work control process contributed to the event. The 2PL15J monitor calibration work was approved and started without consideration of maintenance personnel availability to complete the work. This oversight resulted in the inoperable condition of the 2PL15J monitor at the time of the event and lead to the TS 3.0.3 entry.

Problems similar to the event of July 22, 1996 recurred on July 31, 1996, and again on August 1, 1996. The licensee removed the 2PL15J monitor from service to allow for the operation of the post accident sampling system for testing. In these cases, the licensee considered the 2PL15J monitor operable and available for use. The 2PL75J monitor subsequently tripped, leaving the unit without any containment particulate or gaseous activity monitors in operation. The control room operator promptly started the 2PL15J monitor each time.

The inspector identified two operator workarounds. First, the operator is required to remove one of the containment air particulate and noble gas monitors from service, prior to operating the post accident sampling system. Failure to do this results in the tripping of the associated containment air particulate and noble gas monitoring system. Second, the containment air particulate and noble gas monitors routinely trip following particulate filter paper replacement. The inspector was informed by the licensee that the first workaround was on the workaround list but the second was not. The licensee informed the inspector that the second workaround would be placed on the list, and so would the containment cooler condensate flow rate monitoring system.

c. Conclusion

Materiel condition of the containment air particulate and noble gas monitors was considered poor based on the problems discussed above and the historical performance. In addition, an operator work-around was identified by the inspector.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Failure to Conduct a Technical Specification Required Surveillance

a. Inspection Scope (61726)

The inspectors reviewed the circumstances surrounding a missed TS surveillance, including the reason it was missed and how it was identified.

b. Observations and Findings

On August 2, 1996, an issue was identified by ComEd personnel concerning which valves must be checked to verify primary containment integrity in accordance with TSs. As a result, a review was conducted and it was identified that eight manual primary containment isolation valves (four on each unit) were not verified to be in the correct position once per 31 days as required.

These eight valves were not included in the monthly surveillance procedure that is conducted to satisfy TS Surveillance Requirement 4.6.1.1.a. These eight manual valves isolate one of the two narrow range suppression pool sightglasses. Although these valves had not been checked monthly, they had been verified locked closed once each 18 months per an administrative surveillance.

The failure to conduct the required surveillance in accordance with TS 4.6.1.1a is a violation (VIO 373/374-96007-02). The root cause and corrective actions will be followed up during the review of the response to the violation and the LER.

ComEd had done a complete review of TS surveillances in November 1995 because several surveillances had been missed. The review was directed at verifying that a procedure existed for conducting all required surveillances, and verifying the frequency for conducting these procedures was correct and was being appropriately tracked. The review did not include reviewing the content of the surveillance procedures to ensure they completely satisfied the TS surveillance requirements; thus, the problem discussed above was not discovered.

c. Conclusion

A TS surveillance to verify the proper position of eight manual primary containment isolation valves had not been conducted monthly as required because the surveillance procedure did not include these valves. However, these valves were verified locked closed once per 18 months per an administrative procedure. Although ComEd had performed a review of TS-required surveillances to ensure they were being properly accomplished, this problem was outside the scope of the review and was not previously identified.

M1.2 Several Human Performance Errors in Performing Out-of-Services (OOS)

a. Inspection Scope (62703)

The inspectors reviewed several OOS problems which occurred during the inspection period.

b. Observations and Findings

The Operations Manager initiated an Out-of-Service (OOS) standdown due to several human performance errors that occurred. The following is a summary of the events.

On July 18, an operator incorrectly hung an OOS on the wrong control switches in the radwaste control room. This was identified by another operator during a walkdown before performing a radwaste water transfer.

On July 22, while hanging an OOS on a fire protection circuit, the operators in the control room received several alarms that were unexpected, indicating that more fire detection circuits than planned had lost power. This event is described further in Section F1.1 of this report.

On July 22, while clearing an OOS on plant service water to the stator cooling system, an error resulted in a transient which challenged temperature limits on the Unit 1 main turbine bearings.

Also on July 22, during the preparation of an OOS on the OB control room ventilation system, an instrument related to the U2 standby gas treatment system was also taken OOS. This was not a planned evolution and resulted in a potential challenge to the operability of an engineered safety feature.

During the standdown, all operating crews were briefed on these events and performance expectations were reiterated.

c. Conclusion

Individually, the four human performance errors which occurred while performing OOSs were not safety significant. However, the number of errors in a short time period indicated a continuing need for improvement in human performance.

III. Engineering

Engineering issues were the focus of separate special inspection during this inspection period. An NRC Augmented Inspection Team performed a review of the circumstances surrounding the injection of foam sealant into the CSCS system. This review is documented in inspection report 50-373/374-96008. Engineering performance related to the foreign materiel in the essential service water tunnel is also documented in inspection report 50-373/374-96009.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 OWZ Evaporator Event (83750)

a. Scope - (Open) Followup on IFI 373/374-96006-05(DRS)

The inspectors reviewed the licensee's maintenance of the liquid radwaste evaporators and a June 15, 1996 event involving the licensee's OWZ evaporator. Items specifically reviewed included:

- The evaporators' maintenance histories;
- Licensee procedures concerning evaporator operation;
- The licensee's problem identification form (PIF No. 96-1715) documenting the June 15, 1996 event; and
- A Deviation Report (DVR No. 88-085) documenting a similar event in 1988.

The inspectors also interviewed selected members of the licensee's radwaste operations, system engineering and radiation protection groups.

b. Observations and Findings

- System Operation and Maintenance

The licensee has three evaporators (1WF, 2WF and OWZ) for cleanup of liquid radwaste from the floor drain and chemical waste systems. Only one of the evaporators is normally needed to handle liquid radwaste processing. The station evaporators were to be replaced with a vendor system, which was to be installed in 1995. Several problems identified during preoperational testing delayed installation, which is now scheduled for the end of 1996. Until installation of the vendor system, the station evaporators remained the primary system for processing liquid radwaste.

The station evaporators were maintained under an informal program developed by the radwaste coordinator. Under this program, each evaporator was sequentially removed from service to perform necessary maintenance and component inspection. However, operational parameters (i.e. evaporator temperature, pressure, flow rates, etc) were not trended and therefore, not used to measure system performance. The radwaste coordinator and system engineer take corrective actions for deviations from normal operation based on their familiarity with the evaporators.

The inspectors were concerned that the lack of a formal maintenance and operational trending program could impact long-term evaporator operation, if the vendor problems were not resolved. The existing informal program appeared adequate, but relied on personal knowledge rather than a formal process.

The Updated Final Safety Analysis Report (UFSAR) accurately described radwaste processing activities as they were being performed at the facility. The licensee was performing a 10 CFR 50.59 analysis for the specific vendor process to be used and indicated that the UFSAR would be revised after the analysis was completed.

- Evaporator Spill Event

On June 15, 1996, a spill of about 3600 gallons of contaminated water and sludge occurred in the OWZ evaporator room and an adjacent hallway. Radiation levels in the evaporator room increased to 5 rem/hr (normally 0.05 rem/hr) and contamination levels in the hallway exceeded 1 million dpm (smearable). An NRC inspection performed June 16-18, 1996, reviewed the licensee's immediate response to the event and the cleanup of the hallway outside the evaporator room; no problems were identified.

Although the licensee was still investigating the root cause, a preliminary inspection of the evaporator (via remote camera) indicated apparent damage to a gasket located on the evaporator heating element. In 1988, similar damage (caused by overpressurization of the evaporator system) also resulted in leakage from the OWZ evaporator. The inspectors verified that corrective actions for the 1988 event were in place and that no overpressurization had occurred.

During the 1988 event, cracks in the evaporator room wall allowed water to leak through and flow down the exterior of the radwaste building. Although the cracks were repaired, the licensee again observed leakage on the exterior wall during the current event. A radiological survey of the affected area did not identify any contamination, but the survey did find several other areas of the wall where residual contamination from the 1988 event had apparently leached onto the exterior surface. This contamination ranged from 3,000 to 5,000 dpm (smearable). The affected areas were decontaminated and coated with a sealant to prevent further leaching.

The licensee was decontaminating the evaporator room to allow for subsequent disassembly of the evaporator to identify the source of the leakage. The inspectors reviewed the ALARA plans for the cleanup; no problems were identified. These plans included positioning workers outside the radwaste building to verify that no water leakage occurred during the cleanup.

c. Conclusions

The inspectors concluded that there was no formal maintenance and operational trending program for the floor drain and chemical waste processing systems. This could affect long-term evaporator operations. No problems were observed with the licensee's initial response to the evaporator spill event or with the radiological planning for the evaporator room cleanup. The licensee was still investigating the root cause of the event.

F1 Control of Fire Protection Activities

F1.1 Failure to Perform a Tech Spec Required Firewatch

a. Inspection Scope (71750)

The inspectors reviewed the circumstances surrounding a missed firewatch event and discussed the event with the fire protection group.

b. Observations and Findings

At 6:00 a.m. on July 31, 1996, a fire protection inverter was taken OOS for scheduled maintenance. The OOS and associated fire impairment were prepared and reviewed prior to taking the inverter OOS. The individuals that prepared and reviewed the OOS and associated fire impairment failed to recognize that the OOS would cause all power to be lost to the Unit 2 main fire detection control panel and the control room remote annunciator panel. Fire suppression capability was not affected.

When the OOS was implemented, the appropriate fire watches were not established as required by the action statement of Technical Specification 3.3.7.9. This is considered a violation (VIO 374-96007-03).

At 9:00 a.m. an operator recognized that power to the main fire detection control panel had been lost and immediately notified the fire marshal. The fire marshal immediately established the fire watches. The power to the main fire detection control panel was restored at approximately 7 p.m. that day when the scheduled maintenance was completed.

ComEd's investigation determined this incident resulted due to a human performance error on the part of the personnel writing and reviewing the OOS and the fire impairment.

This event was not isolated in that several fire watches had been missed in 1996. Two of these missed fire watches were required by TSs and therefore documented in LERs. Other missed fire watches were not required by TSs and were not reportable. However, they were still significant in that human performance with regards to conducting fire watches was weak. Corrective actions for the previously missed fire watches appeared to be too narrow in scope to have prevented this current event.

c. Conclusions

Human performance errors in the area of fire protection continued to occur. Corrective actions for previous missed fire watch had not been fully effective. The failure to perform a TS fire watch is considered a violation.

S1 Conduct of Security and Safeguards Activities

S1.1 Temporary Instruction 2515/132, "Malevolent Use of Vehicles at Nuclear Power Plants"

a. Inspection Scope (TI 2515/132)

Areas examined included the licensee's provisions for land vehicle control measures to protect against the malevolent use of a land vehicle and to determine compliance with regulatory and licensee commitments.

b. Observations and Findings

(1) Vehicle Barrier System

The inspector found that the features and structures that form the Vehicle Barrier System (VBS) met the design characteristics established by the NRC. The vehicle barrier components and the location of the barrier were as described in the revised summary description of the VBS which the licensee submitted to the NRC in February 1996.

A visual walkdown performed by the inspector confirmed that the general type of vehicle barrier described in the VBS summary description had been installed and that the barrier was continuous.

Some observations were noted that require analysis or actions by the licensee's staff. The observations are noted below and will be tracked as an inspection followup item (IFI 50-373,374-96007-04). The specific VBS locations for the below noted observations are considered Safeguards Information and exempt from public disclosure.

(a) Spacing between some barriers exceeded recommendations.

(b) Some barrier connectors at some locations were not secured to prevent manipulation with hand held tools.

(c) A separate engineering analysis had not been completed to confirm that structural features for a small portion of the VBS was adequate to act as an effective vehicle barrier.

(2) Bomb Blast Analysis

Inspector field observations of standoff distances were consistent with those documented in the summary description. The licensee confirmed that the calculation of minimum standoff distance was based on NUREG/CR-6190 or an independent engineering analysis. Six actual measurements were completed to confirm that the minimum standoff distances, as documented in the summary description, were the actual distances provided by the as-built VBS.

The licensee identified standoff distance for one location within the VBS required additional analysis based upon the inspector's

determination that a land vehicle could approach closer to the building containing vital equipment than the licensee's initial analysis indicated. This issue will be monitored as an Inspection Followup Item (IFI 50-373/374-96007-05).

(3) Procedural Controls

The licensee appropriately defined criteria for maintenance, surveillance, and compensating for the VBS in Corporate Nuclear Security Guideline No. 4, "Operational Planning and Maintaining Integrity of Vehicle Barrier Systems (VBS), Revision 0, dated February 1996. Some administrative issues required further action by the licensee and are described below. Resolution of these administrative matters will be tracked as an Inspection Followup Item (IFI 50-373/374-96007-06).

(a) Some building barriers that act as part of the VBS were not included within the VBS description.

(b) A surveillance procedure for testing and inspection of the VBS was required.

(c) The need to advise the NRC Region III office concerning barriers that have to be compensated for, in excess of 30 days, was not included in the procedure for VBS compensatory measures.

(d) NRC review comments, dated June 26, 1996, pertaining to the VBS addressed in Revision 54 of the security plan, need to be resolved.

Discussions with the Site Security Administrator, security staff, and a Senior Reactor Operator confirmed that procedures necessary to safely shutdown the units after a bomb blast were reviewed and found to be adequate.

c. Conclusion

The licensee's provisions for land vehicle control measures met regulatory requirements and licensee commitments. The VBS program was consistent with the summary description submitted to the NRC; installed components were identified in NUREG/CR-6190 or the licensee's engineering analyses, and appropriate procedures had been developed and implemented. The need for some additional administrative actions, analysis, and barrier modifications were noted and will be tracked as Inspection Followup Items.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the results of these inspections to ComEd management listed below at an exit meeting on August 7, 1996. ComEd 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

*J. Brons, Acting Site Vice President
*D. Ray, Station Manager
*L. Guthrie, Operations Manager
P. Smith, Maintenance Superintendent
*R. Fairbank, System Engineering Supervisor
P. Antonopoulos, Site Engineering Manager
*D. Boone, Health Physics Supervisor
*R. Crawford, Work Control Superintendent
*J. Burns, Regulatory Assurance Supervisor

* Present at exit meeting on August 7, 1996.

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
IP 83750 Occupational Exposure
TI 2515/132: Malevolent Use of Vehicles at Nuclear Power Plants

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

373/374-96007-01	VIO	Failure to take corrective actions on a significant condition adverse to quality (MSIV isolation and reactor scram)
373/374-96007-02	VIO	Failure to perform a Tech Spec surveillance to verify the position of manual containment isolation valves
373/374-96007-03	VIO	Failure to perform a Tech spec required fire watch
373/374-96007-04	IFI	VBS Barrier Modifications and Analysis
373/374-96007-05	IFI	Analysis of VBS Standoff Distance
373/374-96007-06	IFI	Administrative Requirements Pertaining to the VBS

Items Discussed

373/374-96006-05	IFI	Root Cause of the Radwaste Evaporator Failure

LIST OF ACRONYMS USED

ALARA As Low As Reasonably Achievable

CSCS Core Standby Cooling System

DRP Division of Reactor Projects
DRS Division of Reactor Safety

IDNS Illinois Department of Nuclear Safety
IM Instrument Maintenance
IR Inspection Report
IFI Inspection Follow-up Item

LER Licensee Event Report
LIS LaSalle Instrument Surveillance

MSIV Main Steam Line Isolation

NRC Nuclear Regulatory Commission

OOS Out of Service

PCIS Primary Containment Isolation System
PIF Problem Identification Form
PORC Plant Operations Review Committee
PDR NRC Public Document Room

SOR Static O-Ring

TI Temporary Instruction
TS Technical Specification

UFSAR Updated Final Safety Analysis Report

VBS Vehicle Barrier System