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ComEd

September 24, 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. 373/374-96-05
NRC Docket Numbers 50-373 and 50-374.

References:
1. J. L. Caldwell letter to Mr. J. C. Brons, Dated August 19, 1996, Transmitting NRC Inspection Report 373/374-96-05

2. W. T. Subalusky letter to US NRC, Dated August 29, 1996, Transmitting Extension of Response Date

The enclosed attachment contains LaSalle County Station's response to the Notice of Violation, that was transmitted in Reference 1. Reference 2 documented the granting of ComEd's request for an extension to respond until September 25, 1996. The attachment to this letter contains the immediate corrective actions taken as well as long term corrective actions to preclude recurrence of these violations.

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

Respectfully,

W. T. Subalusky
Site Vice President
LaSalle County Station

Enclosure

cc: A. B. Beach, NRC Region III Administrator
M. P. Huber, NRC Senior Resident Inspector - LaSalle
D. M. Skay, Project Manager - NRR - LaSalle
DCD - Licensing (Hardcopy: Electronic:)
Central File

ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
373/374-96-05

VIOLATION: 373/374-96-05-01

Title 10 to the Code of Federal Regulations, Part 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective equipment, and non-conformances are promptly identified and corrected.

Contrary to the above,

a. On April 6, 1996, a condition adverse to quality, specifically, a degraded support on the Reactor Core Isolation Cooling (RCIC) system, was identified by an operator and was not promptly corrected. The support was not evaluated by engineering until April 21 and not repaired until April 22, 1996.

b. On December 26, 1990, a design deficiency was identified on the 2B Diesel Generator (DG), specifically, the motor on the motor-driven fuel pump was undersized, and a temporary alteration was made to the DG as a compensatory action. As of May 24, 1996, the design deficiency had not been corrected and the temporary alteration remained in place.

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

REASON FOR VIOLATION: 373/374/96-05-01

LaSalle County Station agrees that the two cited events are examples of untimely corrective actions.

a. RCIC degraded pipe support:

The degraded pipe support strut was not promptly evaluated and corrected due to poor personnel performance; both at the initiation and review of the Action Request (AR). The AR failed to identify that the support was on the pump discharge header for the Reactor Core Isolation Cooling (RCIC) system and the operations reviewer did not request a prompt evaluation by Engineering. The identification of the support was insufficient in that the description, system and equipment piece number were not provided on the AR by the initiator and subsequent evaluation of the AR did not determine this. Engineering personnel were not requested to perform the evaluation on the degraded support with regard to system operability until fifteen days later. The support was then promptly evaluated and the degraded condition corrected.

b. Temporary alteration on the diesel generator:

The temporary alteration was installed on December 26, 1990. Due to problems encountered in obtaining the necessary equipment, the work was not originally scheduled for completion until L2R06 in early 1995. During L2R06, management decided that the work could be performed on-line and was therefore deleted from the outage scope and rescheduled for the next on-line system window in December 1995. Just prior to performing the work during the on-line system window, it was determined that the work should be again deferred due to uncertainty in completing the work within the applicable Technical Specification time clock. The cumulative effect of the multiple deferrals resulted in the untimely resolution of this temporary alteration. The cause for these deferrals is inadequate planning and prioritization of the work, insufficient management attention to resolving a long term problem, and a general weakness in the review for closing of temporary alterations.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

a. RCIC degraded pipe support:

On April 22, the AR request was forwarded to the Site Support Programs Engineer for evaluation and he inspected the pipe support that same day. The engineer determined that a possible operability concern existed. A work package was developed and the strut was adjusted to obtain the proper alignment with the pipe. This was completed on April 22. An operability evaluation of the as-found condition concluded that the RCIC system remained operable with the support misaligned.

b. Temporary alteration on the diesel generator:

The temporary alteration has been removed and the permanent modification is in progress.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

a. RCIC degraded pipe support:

Station procedure, LAP-1300-1, Action/Work Request Processing, has been revised to specify quality and content standards for ARs. The Action Request screening process has been improved by establishing a multi-disciplined review of Operating (Senior Reactor Operator), Engineering (Design), Work Control, and Maintenance Lead Work Analysts. The purpose of the screening is to ensure proper evaluation of the work impact on the plant considering safety classification of the structures, equipment, design basis requirements, and post maintenance requirements. These roles and responsibilities of the screening committee have been included in the August 29, 1996, revision 57 of LAP-1300-1. The Work Control Superintendent has monitored the

screening committee performance and has observed an improvement in the quality of the Action Requests written and the processing of the documents.

b. Temporary alteration on the diesel generator:

By the completion of L1R09 and L2R08, no temporary alterations older than one refueling outage will be in effect without the concurrence of the Site Vice President and Station Manager. Engineering will provide project management to assure that these commitments are successfully accomplished.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved when the alignment of the strut was corrected on April 22, 1996.

Full compliance was achieved with the removal of the temporary alteration of the 2B Diesel Generator on September 21, 1996.

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VIOLATION: 373/374-96-05-06

Title 10 to the Code of Federal Regulations, Part 50, Paragraph 50.59 requires, in part, that a licensee may make changes in the procedures as described in the safety analysis report providing a determination is made and documented, including the bases for the determination, that the change does not involve an unreviewed safety question.

Contrary to the above, the procedure for operation of the traversing incore probe (TIP) system was changed in 1991 in a manner different from described in the safety analysis report, in that the TIPs were allowed to remain in the drywell for up to 72 hours after operation in the reactor core, even though the safety analysis description stated that the penetration would be open an average of 15 hours per month. This change was authorized by a safety evaluation screening which did not recognize the existence of the 15 hour criterion and consequently did not include a documented basis for the determination that the change did not involve an unreviewed safety question.

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

REASON FOR VIOLATION: 373/374/96-05-06

LaSalle County Station agrees that when LOP-NR-06, Transversing Incore Probe (TIP) Operation, was revised in 1991, the station did not perform an adequate review of the Updated Final Safety Analysis Report (UFSAR).

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

Upon identification that procedure LOP-NR-06 did not agree with the UFSAR, the TIP system was taken out-of-service. An accelerated procedure change was prepared. The procedure was revised on May 20, 1996.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

LaSalle County Station has implemented several enhancements to the 50.59 process to ensure that an adequate review of the LaSalle UFSAR has been performed. These enhancements include changes to the administrative procedure, formal training by the LaSalle training department to all preparers and approvers on the 50.59 process as well as how to ensure the change being addressed is within the bounds of the UFSAR. Also, an independent safety review team has been formed to review all 50.59s and screenings to ensure of their technical adequacy.

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DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved on May 20, 1996 when procedure LOP-NR-06 was revised to be in agreement with the UFSAR.

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RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
373/374-96-05

VIOLATION: 373/374-96-05-09

10 CFR 26.20 states written policies and procedures must address fitness for duty. Further, 10 CFR 26.20 requires that the licensee's fitness for duty policy address factors that could affect fitness for duty such as mental stress, fatigue, and illness.

The licensee's Fitness For Duty Policy states, in part, that it is the intent of the policy to provide reasonable assurance that nuclear plant personnel are not mentally or physically impaired in any way which adversely affects their ability to safely and competently perform their duties.

LaSalle Administrative Procedure 1100.25, "Testing for Cause," paragraph 8.a, requires any observed behavior of a contractor or vendor indicating degradation in performance, impairment, or change in behavior, be reported to the contractor's supervisor.

Contrary to the above, on April 27 and 28, 1996, two security officers observed behavior on the part of a third officer that indicated a degradation in performance, or a change in behavior, and failed to notify supervision of their observations in a timely manner. The observed behavior involved vandalism to company property (non-safety related) and verbal explanations for such actions.

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

REASON FOR VIOLATION: 373/374/96-05-09

LaSalle County Station agrees that two security officers failed to make a timely report to the Security Force Supervisor of observations concerning the mental stability of an armed security officer exhibiting improper behavior. The failure to report is a violation of the Fitness For Duty Policies. The vandalism had no effect on plant safety. The significance of the violation was that two security officers were concerned with the armed officer's behavior, but these observations were not reported to management in a timely manner.

10 CFR 26.20 states written policies and procedures must address fitness for duty. Further, 10 CFR 26.20 requires that the license's Fitness for Duty policy address factors that could affect fitness for duty such as mental stress, fatigue, and illness.

ComEd's Fitness For Duty Policy states, in part, that it is the intent of the policy to provide reasonable assurance that nuclear plant personnel are not mentally or physically impaired in any way which adversely affects their ability to safely and competently perform their duties.

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The failure to report, to the Security Force Supervisor, observations concerning the mental stability of an armed security officer is a violation of the Fitness For Duty Policies and procedures and Section 1.3.3 Appendix B of the Physical Security Plan.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

On May 4, 1996, the officer who was vandalizing the facility was relieved of his duties and his unescorted access to the facility placed on administrative hold. The other two officers who either observed the vandalism or discussed it were counseled on the Fitness for Duty policy and notification requirements.

On May 7, 1996, mandatory Security Force stand down meetings were held by the contract Security Force Vendor to communicate that a Fitness for Duty issue had not been communicated to management in a timely manner. Expectations, communication issues, policies were also reviewed at this meeting.

On May 17, 1996, the quarterly management/guard force meeting was held at which time the importance and expectation of reporting events was re-emphasized.

On July 24, 1996, a mandatory Supervisor's meeting was conducted by the contract Security Force Vendor at which time the following topics were presented: procedural adherence, professionalism, communications, reporting events, Fitness For Duty issues, safety and conservative decision making.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

Following these corrective actions, security force members have responded positively and have self identified concerns within the security organization. Site Security Force Management has observed the increased use of self reporting through the exercising of chain of command.

Ongoing effectiveness will be monitored through the continuation of supervisory meetings and quarterly management/guard force meetings with emphasis on self reporting of events, Fitness For Duty issues, and communications between management and guard force personnel.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved on May 17, 1996 when the contract security force vendor terminated the employment of the officer involved in the vandalism.