

Commonwealth Edison Company
LaSalle Generating Station
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Tel 815-357-6761

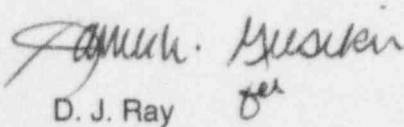


September 27, 1996

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

Licensee Event Report #96-010-00, Docket #050-373 is being submitted to your office in accordance with 10 CFR 50.73(a)(2).

Respectfully,


D. J. Ray

Station Manager
LaSalle County Station

Enclosure

cc: A. B. Beach, NRC Region III Administrator
M. P. Huber, NRC Senior Resident Inspector - LaSalle
C. H. Mathews, IDNS Resident Inspector - LaSalle
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INPO - Records Center

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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1): LaSalle County Station Unit One										DOCKET NUMBER (2) 05000373		PAGE (3) 1 of 10			
TITLE (4) Inadequate Standards for Technical Specification Clarifications Resulted in Violations of Technical Specifications and Design Basis															
EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)						
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME LaSale County Station Unit Two			DOCKET NUMBER 0500374			
08	29	96	96	010	00	09	27	96	FACILITY NAME			DOCKET NUMBER			
OPERATING MODE (9)		0		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)											
POWER LEVEL (10)		100													
			<input type="checkbox"/> 20.2201(b)			<input type="checkbox"/> 20.2203(a)(3)(i)			<input type="checkbox"/> 50.73(a)(2)(iii)			<input type="checkbox"/> 73.71(b)			
			<input type="checkbox"/> 20.2203(a)(1)			<input type="checkbox"/> 20.2003(a)(3)(ii)			<input type="checkbox"/> 50.73(a)(2)(iv)			<input type="checkbox"/> 73.71(c)			
			<input type="checkbox"/> 20.2203(a)(2)(i)			<input type="checkbox"/> 20.2003(a)(4)			<input type="checkbox"/> 50.73(a)(2)(v)			<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
			<input type="checkbox"/> 20.2203(a)(2)(ii)			<input type="checkbox"/> 50.36(c)(1)			<input type="checkbox"/> 50.73(a)(2)(vii)						
			<input type="checkbox"/> 20.2203(a)(2)(iii)			<input type="checkbox"/> 50.36(c)(2)			<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
			<input type="checkbox"/> 20.2203(a)(2)(iv)			<input checked="" type="checkbox"/> 50.73(a)(2)(i)			<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
			<input type="checkbox"/> 20.2003(a)(2)(v)			<input checked="" type="checkbox"/> 50.73(a)(2)(ii)			<input type="checkbox"/> 50.73(a)(2)(x)						
LICENSEE CONTACT FOR THIS LER (12)															
NAME Linda M. Shearer, Regulatory Assurance									TELEPHONE NUMBER (Include Area Code) (815) 357-6761 Extension 2777						
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)															
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS					
SUPPLEMENTAL REPORT EXPECTED (14)											EXPECTED SUBMISSION DATE (15)				
X	YES (If yes, complete EXPECTED SUBMISSION DATE)				<input type="checkbox"/>	NO							MONTH 02	DAY 05	YEAR 97

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines 16)

On August 29, 1996, LaSalle Station determined that 15 Technical Specifications (TS) clarifications resulted in past violations of the TS or placed the plant in conditions outside design basis for a short time whenever a situation developed in which the administrative guidance of these clarifications had actually been used.

The root cause was inadequate standards for the preparation and approval of TS clarifications. Compliance with licensing and design basis intent was deemed acceptable, rather than adherence to the literal wording and intent. An inadequate Onsite Review program failed to ensure high technical standards. The corrective actions program failed to detect and/or to prevent these problems. The immediate corrective actions were deletion of 14 clarifications on August 29, 1996 and revision of 1 clarification on August 30, 1996. A temporary Independent Safety Review Overview Group was established to perform an independent review of approved safety evaluations to raise standards. Future corrective actions include training, and changes to Corrective Actions Program, TS clarification procedure, and Onsite Review process. Implementation of Improved Technical Specifications is scheduled for December 31, 1997. This will improve clarity and flexibility of LaSalle's TS.

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PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as [XX].

A. CONDITION PRIOR TO EVENT

Unit(s): 1/2 Event Date: 08/29/96 Event Time: 2054 Hours
Reactor Mode(s): 1/1 Mode(s) Name: Run/Run Power Level(s): 100%/83%

B. DESCRIPTION OF EVENT

As a result of a recent NRC Engineering Support Inspection at Zion Station, Engineering and Regulatory Assurance performed a review between August 26 and August 29, 1996, of the active LaSalle TS Clarifications book for Units 1 and 2. The results were presented to Station Senior Management at the Plant Operation Review Committee held August 30, 1996.

The team determined that most of the TS clarifications were consistent with the Technical Specifications literal wording and licensing/design basis. However, the team could not confirm through engineering judgment that the interpretations met design and licensing basis for the 17 of the 43 clarifications (written between 1987 - 1995). On August 29, 1996, 2054 hours, 16 of those 17 were promptly deleted. One was appropriately revised and approved August 30, 1996. The Operations Manager ensured that the Operating Shift Managers were immediately made aware of the changes and discussed potential for impact on plant operation and compliance with TS.

The 17 TS clarifications were further reviewed by Regulatory Assurance to determine if any potential violations of TS or if any conditions outside design basis had occurred, and to determine the root causes. Of the 17 clarifications, 15 were issued instead of submitting a TS amendment request to correct information or to implement new requirements, or were less conservative than the literal wording of the LaSalle Technical Specifications, or did not fully meet design basis; 2 were no longer needed. Interviews of Operating and Engineering personnel confirmed that these 15 clarifications had been actually been implemented or used in the past.

A more in-depth review of these clarifications will be performed and documented in a supplement to this report by February 5, 1997.

This event is reportable per 10CFR50.73 (a)(2)(i)(B) due to the violation(s) or potential violation(s) of the Technical Specifications and 10CFR50.73 (a)(2)(ii)(B) due to having been in a condition outside the design basis of the plant.

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C. CAUSE OF EVENT

The need for written TS clarifications at LaSalle resulted from inconsistent implementation of a few poorly worded TS sections. The root cause of this event was inadequate standards for the preparation and approval of TS clarifications. Management accepted the TS clarifications as long as licensing and design basis intent was met rather than adherence to the literal wording and intent.

Contributing factors were:

1. The process to change Technical Specifications is complex, time consuming, and too slow to support Station needs.
 - a. The management priority to correct and continuously maintain the licensing and design basis documents current was inadequate.
 - b. The annual review of TS clarifications for applicability did not include requirements to submit requests for amendment to the TS wording to allow deletion of TS clarifications. Some clarifications were over 9 years old.
2. Although implementation of literal compliance with TS had been part of licensed operator training, this same rigor for literal compliance with TS was not applied to development and review of TS clarifications and associated safety evaluation work.
 - a. Initial preparation of some of the TS clarifications and evaluation of license and design basis was inadequate. This was due to a combination of inadequate procedures, inadequate training, and not being familiar with increasing performance standards.
 - b. In some cases, OSR failed to perform adequate independent searches or rigorous reviews. It appears that some underestimated the task complexity, scope, or depth of the review work involved. Tunnel vision and mindset led to approval of these TS clarifications without assessing the situation.
3. A contributing cause to this event was inadequate root cause analyses of related problems in the past and/or ineffective corrective actions. There was evidence that the Station had previous problems in licensing/design basis work. When the Station became aware of problems in its ability to perform safety evaluation work, it did not go back and revisit a sampling of the safety evaluation work related to implementation of the TS clarifications to determine if the clarifications were thoroughly justified and met the expected standards. The Station has had several indications over the time period that these clarifications were written (1987-1995), management did not consistently hold people accountable for strict adherence to the literal wording of controlled documents, such as procedures. There were several events which had as a root cause or contributing cause inadequate or deficient procedures. This was an indication that the Station needed to improve its OSR/technical reviews.

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D. ASSESSMENT OF SAFETY CONSEQUENCES

Using a more conservative philosophy that TS clarification compliance requires adherence to not only intent but also literal wording, the Regulatory Assurance review determined that 15 of the TS clarifications should be reported because implementation of them could have been considered to be less conservative than the literal wording of TS, or violations of the literal wording TS, or could have placed the plant in a condition outside design basis.

None of these violations resulted in any significant consequences or risk to the health and safety of the public. See Attachment A for a summary of the individual TS clarifications and the related safety analyses for each. The supplement to this LER will address the implications of consequences if these TS clarifications had been implemented under more severe credible plant conditions.

E. CORRECTIVE ACTIONS

The immediate corrective actions upon discovering that some TS clarifications may have resulted in potential deviation or violation of licensing or design basis were:

1. The Station immediately deleted the clarifications in question on August 29, 1996 and revised 1 clarification to ensure proper interpretation and implementation on August 30, 1996.
2. The teams results were submitted to senior management review at the Plant Operations Review Committee (PORC) August 30, 1996.
3. The Operations Manager immediately communicated item 1 to the Shift Managers August 29, 1996 and August 30, 1996, including a detailed review for impact on plant operation. A formal letter was issued Sunday, September 1, 1996 to Operating.
4. The Site Vice President and Engineering Manager established a temporary Independent Safety Review Overview Group on August 26, 1996 to perform an independent review of approved safety evaluations and engineering evaluations supporting operability determinations prior to implementation of the change being submitted, as a method to raise standards.
5. On September 13, 1996, the Station Site Vice President issued ComEd's nuclear policy, NOP-OA.38, "Nuclear Safety Policy," revision 0, to reinforce senior management expectations on conservative decision making, emphasize nuclear power plant operational safety culture, and rigorous adherence to procedures.

Long term corrective actions to prevent reoccurrence are:

1. TS clarifications that were in effect as of August 25, 1996 and any subsequent additions or revisions will be considered during development of Improved Technical Specifications (ITS) wording to ensure the ITS is clearly worded, complete, reasonable, and does not conflict with design bases or other TS sections (can be implemented directly as worded). The clarity and flexibility of ITS will minimize the need for new TS clarifications. The current active

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clarifications will be deleted when the ITS are implemented which is scheduled for December 31, 1997.

2. Regulatory Assurance will lead an evaluation of TS interpretations that have been incorporated in written guidance such as procedures. This team of Engineering, Operating and Regulatory Assurance personnel will review the clarifications to ensure that any TS clarification guidance used meets the literal wording of the TS, not just the intent of licensing and design bases. This evaluation will be completed by December 31, 1996. The supplement to this LER report will include an action plan to review the other closed TS clarifications.
3. The initial safety analysis of each of the clarifications which were considered violations will have an in-depth review of the safety analysis performed by an interdisciplinary team led by Regulatory Assurance including Operating and Engineering by December 31, 1996. The results will be submitted as a supplement to this report.
4. The Station will evaluate the following processes for improvements described below by December 31, 1996.
 - a. Regulatory Assurance will evaluate and revise procedures related to preparation, approval and periodic reviews of the TS clarifications process.
 - b. Engineering will evaluate processes related to safety evaluation, technical reviews and OSR for improvement. These improvements include definition of responsibilities of program owners and participants and in participant qualification and selection criteria for a given document.
5. Training will be provided by March 31, 1997, on lessons learned from this event for people who prepare and review TS clarifications and safety evaluations.
6. Regulatory Assurance will implement long term improvements in the corrective actions program by June 30, 1997.

F. PREVIOUS OCCURRENCES

LER NUMBER	TITLE
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No previous LaSalle LERs related to TS clarifications being in violation of TS or outside design basis were found.

The following LERs involve LaSalle events in which inadequate reviews of design and/or licensing basis were the root cause or a contributing cause.

LER 373/96-009-00	Missed Technical Specification Surveillance on Primary Containment Manual Valve Positions as a Result of an Inadequate FSAR Review
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The causes of the event above were an inadequate Onsite Review of amendment 63 to the FSAR and an inadequate administrative procedure. The procedure for TS amendment requests is being revised.

A contributing cause of failing to identify the missed surveillance during the UFSAR changes or the TS surveillance review is that the wording and layout of the primary containment isolation valve TS surveillance requirements is unclear. LaSalle is in the process of converting the LaSalle County Station Technical Specifications to the new Standard Technical Specifications per NUREG 1434. This effort is still in progress, but when completed will reduce the need for TS clarifications.

Both of the corrective actions to the LER above will help prevent the need to write future TS clarifications.

LER 37/95-003-00 Potential Traversing In-Core Probe Containment Isolation Design Concern

The corrective actions to the LER above did not prevent a repeat event of being in a condition outside design basis of the plant. The corrective actions implemented were limited in scope to TIP ball valves modifications because the root cause was not determined, and thus not corrected.

LER 373/95-015-00 Missed Technical Specification Fire Protection Valve Surveillance Due to Insufficient Review of Technical Specification Fire Surveillances During the Modification Process

The corrective actions to the LER above did not prevent a repeat event of inadequate Onsite Reviews of TS requirements because the corrective actions scope was too narrow. The Station did not recognize the need to include all Onsite Review participants in the training on this event, nor did it establish a method to evaluate a sampling of previously completed paperwork on non-mod related safety evaluations for impact on safety and adherence to licensing and design basis.

G. COMPONENT FAILURE DATA

Since no component failure occurred, this section is not applicable.

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Attachment A

Summary of Safety Analyses

1. TS 4.1.3.5.b. Clarification 01-87, page 8 (Control Rod Drive) (CRD) [AA] Accumulator Operability) allowed LaSalle Station to consider a CRD scram accumulator operable when its visual alarm feature failed if, within 8 hours and every 8 hours thereafter, a person verified that the indicated pressure (of the accumulator) was greater than or equal to 940 psig and/or verified there was no water leakage for the affected Control Rod. The review team determined that the visual alarm is a functioning component needed to meet the operability definition for CRD accumulators. There was minimal risk to the health and safety of the public due to the compensatory actions taken by the operators to assure that the affected CRD accumulator would function as designed, meeting the intent of the TS bases. A request for TS amendment should have been submitted.
2. TS 3.1.3.6 Clarification 01-87, page 9 (Uncoupled Control Rods) was written to be used as a contingency due to having one uncoupled rod. It allowed the Station to continue operation as if all Control Rods were coupled when an uncoupled Control Rod was declared inoperable, remained fully inserted and electrically disarmed, and as long as the requirements for the number and location of inoperable Control Rods in TS 3.1.3.1. were met. There was minimal risk to the health and safety of the public due to the affected Control Rod being fully inserted and declared inoperable since the Station followed the action statements in TS, and there was no case found where a condition existed with multiple uncoupled rods.
3. TS 4.11.2.7.2.b Clarification 01-87, page 18 (Off Gas sampling - Pretreatment noble gas increase > 50%) The clarification allowed the Station to waive sampling if short duration (less than 1 hour) increases in release rates as indicated by Off Gas Pretreat noble gas readings were known to be not related to the condition of the fuel or thermal power changes. Literal compliance with the TS as currently worded would not have provided any additional margin of safety to the health and safety of the public because sampling after such short duration increases would not be likely to have detected any anomaly, since it is likely that the reading would have returned to normal by the time the sampling was accomplished, and because the increase was due to causes other than failed fuel (such as an electronics spike, a source being in the vicinity of the detector, etc.) In addition, the station has multiple indications of failed fuel and changes in release rates, such as main steam high rad monitors, wide range gas monitor, etc. to confirm that offsite releases were within limits. A request for TS amendment should have been submitted.

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4. TS 4.5.1.d.1 Clarification 04-87 (Automatic Depressurization System) (ADS) [SB] Bottle Bank Pressure Switch) allowed when ADS bottle bank low pressure alarm switches were out of service for surveillance or for maintenance, that ADS was not considered to be inoperable if special logs were maintained to record the pressure verified locally by operator with alarm function inoperable. The review team determined that the alarm is a functioning component required to meet the operability definition for ADS accumulators. There was minimal risk to the health and safety of the public due to the compensatory actions taken by the operators to assure ADS would function, meeting the intent of the TS bases. A request for TS amendment should have been submitted.
5. TS 3.6.4 Clarification 07-88 (Drywell Vacuum Breakers position indication) allowed the Station to call the Drywell Vacuum Breakers and position indication operable when one of two power supplies to a single Drywell Vacuum Breaker position indication was not available. The guidance for use of 3.0.5 was nonconservative. The review team determined that both power supplies to both position indications should be operable functioning components to meet the operability definition for Drywell Vacuum Breakers and position Indication. There was minimal risk to the health and safety of the public due to at least one power supply and therefore one position indication being available and the (mechanical) vacuum breaker remained capable of opening and closing.
6. TS 3.3.7.1 Clarification 13-89 (Control Room Ventilation) (VC) [VI] (Radiation Monitors) informed the operator that TS 3.7.2 was the governing specification if the train was inoperable (e.g. OOS) then the rad monitor instrumentation was not required to be operable. Thus the operator would not start the other train in pressurization mode as required by TS 3.3.7.1. There was minimal risk to the health and safety of the public due to not operating an Emergency Makeup (EMU) train with inoperable rad instrumentation. If minimum rad instrumentation was not operable, the action was followed for EMU train being inoperable. (Note affected Control Room/Auxiliary Electric Room Ventilation (VC/VE) system is not operated when EMU train is inoperable.) No cases were found when there was any valid radioactivity concern at the EMU air intake and there was no risk to the habitability of the Control Room.
7. TS violation of literal wording TS 3.7.1.1 Clarification 01-90 (Residual Heat Removal (RHR) [BO] Service Water power sources) allowed the Station to call RHR operable in the shutdown cooling mode if there was 22 feet of water above the reactor vessel flange and the associated RHRSW (RHR Service Water) subsystem was operable with a single power supply, which is less conservative than the literal wording. The review team determined that both power supplies to RHRSW subsystems must be operable to meet the literal TS 3.7.1.1. wording for operability of RHRSW in conditions 4 and 5. There was minimal risk to the health and safety of the public due to a system having one power source available for operability (same as associated RHR pump in operating condition 5). The risk of having only one RHR system is allowed in T/S 3.9.11.1. No additional risk was created by allowing an inoperable RHR system's service water system to be inoperable. Although the flexibility is technically acceptable and other TS sections have power source "notes" similar to that in this clarification, the confusing wording and apparent conflicts between TS 3.7.1.1 and 3.9.11. along with the absence of a typical note concerning normal and emergency power supplies in condition 5 should have been resolved by a request for TS amendment.

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8. TS 4.7.2 Clarification 07-90 (VC - control room boundary penetrations) allowed the Station to call Control Room Ventilation operable during work activities that caused an opening in the VC pressurization boundary (such as a hole in the floor or breaking fire seals) if a means was established to return the boundary to a closed status in a reasonable amount of time upon VC emergency train operating, thus avoiding entry into 3.0.3. This interpretation did not have corresponding rigorous engineering testing or calculations nor design bases documentation to ensure that the Control Room and Auxiliary Electric Rooms could be maintained at the required pressure and flow rates with holes in the boundary. There was minimal risk to the health and safety of the public due to preplanned compensatory actions to ensure a hole could be sealed upon VC Emergency Makeup train actuation.
9. TS 3.1.5 Clarification 09-90 (Standby Liquid Control (SBLC) [BR] power supply) allowed the Station to call the Standby Liquid Control system operable when the second power supply was not available. The review team determined that both power supplies should be operable to meet the most conservative interpretation of operability definition for SBLC. There was minimal risk to the health and safety of the public due to at least one power supply being available to each SBLC train. This did not meet literal wording of TS although the flexibility is technically acceptable and other TS sections have power source "notes" similar to that in this clarification. A request for TS amendment should have been submitted.
10. TS 3.8.1.1, 3.8.1.2, 4.8.1.1.1 Clarification 10-90 (Offsite Lines) allowed the Station to use the 138 KV lines as a third offsite power source without adequate engineering testing or analyses to confirm they could adequately supply shutdown loads as required. The UFSAR does not include the 138 KV line in the discussion of offsite power sources. There was minimal risk to the health and safety of the public since the Station did not experience the need to actually use the 138 KV lines power supply during a situation when full S/D load demand was present. The UFSAR should have been changed after appropriate analyses.
11. TS 3.3.7.5, 3.5.3, 3.6.2.1 Clarification 13-90 (Suppression Pool Level Alarm actions) [CG] allowed the Station to consider suppression pool wide range water level instrumentation channels to be operable and that there was no need to enter the action statements for TS 3.5.3 or 3.6.2.1 when one or more of the high and/or low suppression pool water level alarms became inoperable. A policy using a special log was initiated and suppression pool level was to be verified to be within TS limits at least once per shift by remote or local indication in these cases. The review team determined that the alarm is a functioning component needed to meet the operability definition. Upon deletion of this clarification, Unit 2 entered an 8 hour shutdown timeclock per TS 3.6.2.1 Action d. on loss of narrow range alarm functions due to inoperable excess flow check valve associated with both suppression pool high level alarms. The repair was completed, tested and declared operable within the allowed time. There was minimal risk to the health and safety of the public due to the compensatory actions taken by the operators to assure that the suppression pool level met TS level limits, meeting the intent of the TS bases and due to the short time in which the situation existed. A request for TS amendment should have been submitted.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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12. TS Table 1.2 Footnote Clarification 01-91 (Mode Switch to Run - rod insert verification) allowed administrative control using an out-of-service in place of a second licensed operator or other technically qualified member of the unit technical staff to ensure that control rods remained fully inserted when the reactor mode switch was placed in Run or Startup/Hot Standby to test the switch interlock functions. There was minimal risk to the health and safety of the public since the Station used an alternative method to ensure rods were maintained fully inserted via OOS on the withdrawal button. A request for a TS amendment should have been submitted.
13. TS 3.4.3.1, 3.4.3.2. Clarification 02-92 (Reactor Coolant System leakage) rev 0 stated that when a portion of the leakage detection instrumentation was inoperable, TS 3.4.3.1 and the Action statement of TS 3.4.3.1 should apply. As long as TS 3.4.3.1 did not require the unit shutdown due to inoperable leakage detection instrumentation, there was sufficient instrumentation to monitor reactor coolant system leakage per TS 3.4.3.2. The instruments used to perform TS 4.4.3.2.1 surveillance was dependent on the operable instrumentation of TS 3.4.3.1. This clarification was revised to ensure that when declaring instruments inoperable, applying 4.0.2 and 4.0.3 is the appropriate action. A request for TS amendment should have been submitted.
14. TS 3.6.5.1 Clarification 2-95 (Secondary Containment Integrity holes) allowed waiving the 4 hour timeclock for Secondary Containment integrity as long as the total hole area size or combination of hole area sizes did not exceed a given value based on leak rate testing and some design calculations. The controls and documentation to support the license basis were weak. There was minimal risk to the health and safety of the public due to limiting total hole size to ensure operability of Secondary Containment. Since there was no guidance on holes in Secondary Containment for maintenance or testing purposes, a UFSAR amendment should have been submitted.
15. TS 3.7.2, 3.7.7 Clarification 06-95 (VC/VE Emergency Filtration System vs. Refrigeration) interpreted the lack of refrigeration for the Control Room as not required for habitability and thus did not affect operability of the Control Room and Auxiliary Electric Equipment Room Emergency Filtration Ventilation (VC/VE) systems. However, the UFSAR does include the refrigeration equipment in the design basis. There was minimal risk to the health and safety of the public because the control room habitability was ensured by compliance with T/S 3.7.7 actions. Changes should have been submitted to resolve the apparent conflict between the TS and design basis or UFSAR.