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ComEd

October 23, 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. 50-373/374-96007

Reference: J. L. Caldwell letter to Mr. W. T. Subalusky, dated September 23, 1996, Transmitting NRC Inspection Report 373/374-96007

The enclosed attachment contains LaSalle County Station's response to the Notice of Violation, that was transmitted in the Reference letter. The attachment to this letter contains the immediate corrective actions taken as well as long term corrective actions to preclude 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,

W. T. Subalusky
Site Vice President
LaSalle County Station

Enclosure

IE01

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
373/374-96007

VIOLATION: 373/374-96007-01

10 CFR, Appendix B, Criterion XVI, states in part that measures shall 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.

Contrary to the above, corrective actions for the December 24, 1994, main steam isolation valve closure and corrective actions for a problem identification form written on March 6, 1995, were not effective in preventing the recurrence of a significant condition adverse to quality, specifically, a main steam isolation valve closure and a reactor scram which occurred on June 16, 1996.

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

REASON FOR VIOLATION: 373/374-96007-01

LaSalle County Station agrees that the cited events are an example where the corrective actions to prevent recurrence of a significant condition adverse to quality were not effective.

The root cause analysis of the spurious MSIV isolation and reactor scram which occurred on December 12, 1994, focused on an equipment failure of the Static O-Ring (SOR) switch. The instrument maintenance calibration procedure was not identified as a possible contributing cause. LaSalle agrees that the root cause analysis was too narrowly focused on the equipment problem and did not adequately address the procedure and human factors issues.

In March 1995, a Problem Identification Form (PIF) was written by a reactor operator identifying a potential problem with the methodology of performing a maintenance procedure for Main Steam Line High Flow MSIV Isolation Calibration. The PIF was reviewed by the Event Screening Committee, categorized as not significant, forwarded to the system engineer for review, and the PIF was closed. By closing the PIF, the tracking to resolution of the issue was lost. No documentation on the resolution of this concern has been located. The Instrument Maintenance Department was not assigned an action to review the concern.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

The procedure change addressing the potential problem with the former methodology of performing the Main Steam Line High Flow MSIV Isolation Calibration procedure was completed on July 26, 1996. This change resets the isolation trip prior to valving the instrument flow switch back in service.

ATTACHMENT
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NRC INSPECTION REPORT
373/374-96007

On September 17, 1996, the Control System Technicians were trained on the proper techniques to use in valving instruments back into service. The training emphasized the risks involved when instruments are not properly pressurized and the appropriate precautions which must be taken.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

In the first quarter's 1997 training module for the engineering department, the training department will include a lessons learned module discussing the consequences of a narrowly focused root cause using the example of the MSIV isolations which occurred in December 1994 and June 1996.

The current process for evaluating and tracking the resolution of PIFs is different from the process in place in March 1995. Presently, PIFs are screened by senior managers and significant PIFs are assigned to the responsible organization for evaluation and action to prevent recurrence. Tracking of the issue is maintained until a written report is reviewed and approved for technical adequacy. Departments which are potentially affected by the issue, are provided with a copy of the PIF and the name of the department assigned the lead to review the PIF.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved on July 26, 1996, when the procedure change addressing the potential problem with the former methodology of performing the Main Steam Line High Flow MSIV Isolation Calibration procedure was completed.

ATTACHMENT
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373/374-96007

VIOLATION: 373/374-96007-02

Technical Specification Surveillance Requirement 4.6.1.1.a requires that primary containment integrity be demonstrated operable by verifying at least once per 31 days that all primary containment penetrations not capable of being closed by operable containment automatic isolation valves and required to be closed during accident conditions are closed by valves, blind flanges, or deactivated automatic valves secured in position.

Contrary to the above, on August 2, 1996, the licensee identified that four primary containment isolation valves on each unit (specifically, the manual isolation valves to each narrow range suppression pool sightglass) had not been verified closed once per 31 days since plant startup. These valves were locked closed and had been checked every 18 months per an administrative procedure.

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

REASON FOR VIOLATION: 373/374-96007-02

LaSalle County Station agrees that the cited events are an example of a violation of the LaSalle Technical Specifications (TS). The original reviews of the draft TS were performed prior to 1982 and during that time the TS table of primary containment isolation valves was created. The Final Safety Analysis Report (FSAR) Table 6.2-21, primary containment penetrations, which contained the valves that isolate each penetration, did not list the subject manual isolation valves. These eight manual containment monitoring isolation valves were not added to the FSAR until FSAR amendment 63, dated July 1983. The Unit 1 Operating License with the Technical Specifications was issued on April 17, 1982. The Unit 2 Operating License with the Technical Specifications was issued on December 16, 1983. TS table 3.6.3-1 listing the primary containment isolation valves was issued prior to the eight valves being listed as isolation valves in the FSAR. The Onsite Review 83-038 of FSAR amendment 63, approved January 13, 1984, did not identify any changes required to the TS. The valves were part of the original design but were not previously identified in the FSAR. The root cause was an inadequate Onsite Review of amendment 63 to the FSAR.

ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
373/374-96007

The license amendment request package to remove the table of primary containment isolation valves from TS was prepared during September 1994 and onsite reviewed and offsite reviewed during October 1994. The license amendment was approved on March 16, 1995. Upon approval of the amendments by the NRC, the table of primary containment isolation valves was relocated to UFSAR and the LaSalle Administrative Technical Requirements (ATRs). The TS amendments replaced reference to TS Table 3.6.3-1 with the words "primary containment isolation valves". To assure no "primary containment isolation valves" were omitted from the TS table, UFSAR Table 6.2-21 and Piping and Instrumentation Diagrams (P&IDs) were reviewed. The result of the review was to add the containment monitoring sightglass isolation valves to the new UFSAR Table 6.2-28.

In generating UFSAR Table 6.2-28, and the surveillance requirements of TS 3.6.3, Primary Containment Isolation Valves, the licensing engineer reviewed the impact of the valves that were added as a result of the UFSAR change. During the preparation of the UFSAR change documentation, the licensing engineer did not recognize that TS SR 4.6.1.1.a also should have been included in the review. Consequently, the effect of adding the eight manual isolation valves in compliance with TS SR 4.6.1.1.a was not included in the UFSAR change package. The failure of the preparer, Onsite Review and Offsite Review to identify the missed surveillance was primarily due to a lack of sufficient supporting documentation with the UFSAR change package. The Onsite Review of the new tables was completed May 2, 1995. The Offsite Review was completed June 29, 1995. A contributing cause was that the UFSAR change was done separately and about 6 months after the Onsite Review and Offsite Review of the proposed license amendment request that was submitted to the NRC for relocation of the TS table of primary containment isolation valves.

A contributing cause of not identifying the missed surveillance through the change that added UFSAR Table 6.2-28 was an inadequate procedure. LaSalle Administrative Procedure LAP-1200-12, "Preparation of Operating License and Technical Specification Amendment Requests", does not require a UFSAR change to be included in the TS amendment request. The Onsite Review and preparation of the UFSAR change did not include all necessary information that would aid in assuring an adequate review. The Onsite Review participants' experience and qualifications provided the expertise needed for an adequate review if the UFSAR change had been included with the TS Onsite Review.

During the fall of 1995, a Technical Specification Surveillance Review was performed to ensure that all TS Surveillance Requirements (SR) were adequately addressed by plant procedures. These manual isolation valves were reviewed with respect to TS 3.6.3 SRs. TS SR 4.6.1.1.a was reviewed against the associated surveillance procedure, LOS-PC-M1, "Primary Containment Integrity for Conditions 1, 2 and 3". These two reviews were not integrated to assure the list of the isolation valves in the ATRs was compared against TS SR 4.6.1.1.a and TS SRs 4.6.3. The scope of this review did not require reviewing component lists external to TS or integrated reviews. The cause of not identifying the

missed surveillance associated with these containment isolation valves during this TS surveillance review was the failure to include the review of the ATR or UFSAR tables of primary containment isolation valves due to the limited scope.

A contributing cause of failing to identify the missed surveillance during the UFSAR changes or the TS surveillance review was that the wording and layout of the primary containment isolation valve TS surveillance requirements is unclear. TS SR 4.6.1.1.a deals with primary containment isolation valves, but is part of the primary containment integrity TS 3.6.1, instead of the primary containment isolation valve TS 3.6.3. Also, TS SR 4.6.1.1.a wording is not clear with respect to the surveillance application to penetrations that do not have automatic isolation valves.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

1. The immediate corrective action was to perform the surveillance by verifying the four manual isolation valves on each unit were locked closed. This was performed satisfactorily by 1930 hours on August 2, 1996, allowing the units to exit TS 4.0.3 within the 24 hour allowance for conducting a missed surveillance.

2. All eight valves on each unit have been added to surveillance procedure LOS-PC-M1, which when conducted satisfies surveillance requirement 4.6.1.1.a. This was completed on August 12, 1996.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

1. LAP-1200-12, License Amendments, has been revised to require inclusion of UFSAR changes as part of the license amendment request Onsite Review package. Also, the procedure now requires that supporting documentation be included with Onsite Review package for the license amendment request. In addition, the Onsite Review is required to be reviewed by each effected department and system engineer(s) to determine implementation requirements, which include procedure changes, program changes and training requirements.

2. LaSalle is in the process of converting the LaSalle County Station Technical Specifications to the new Standard Technical Specifications per NUREG 1434. The new Standard Technical Specifications move the current TS SR 4.6.1.1.a from the primary containment integrity TS to the primary containment isolation valve TS. The proposed standard TS SR is clearer with respect to the routine monthly surveillance requirements. The portion of the current monthly position verification TS SR that deals with inoperable automatic isolation valves is moved to a primary containment isolation valve action statement for inoperable isolation valves.

3. An assessment of component lists associated with TS SRs will be conducted by the Regulatory Assurance Group to verify agreement with source documents, such as the UFSAR and plant drawings. This assessment will be completed by December 31, 1996.

4. The failure to identify the missed surveillance and the problem with the administrative procedures has been discussed with the July 1995 Onsite Review participants.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved when the required Technical Specification Surveillance Requirement was conducted by 1930 hours on August 2, 1996.

ATTACHMENT
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373/374-96007

VIOLATION: 373/374-96007-03

Technical Specification 3.3.7.9 requires in part that fire detection instrumentation for each fire detection zone be operable. The Action Statement of Technical Specification 3.3.7.9 requires that with the number of operable fire detection instruments less than the minimum operable requirement of Table 3.3.7.9-1, within 1 hour, a fire watch patrol must be established to inspect the zone(s) with the inoperable instrument(s) at least once per hour.

Contrary to the above, on July 31, 1996, at 6:00 a.m., the fire detection instrumentation for Unit 2 was inadvertently taken out of service and no fire watch was established until an operator identified the problem at 9:00 a.m.

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

REASON FOR VIOLATION: 373/374-96007-03

At 0600 hours on July 31, 1996, fire protection inverter 2FP03E was taken out-of-service (OOS) for scheduled maintenance. The OOS and associated fire impairment were prepared and reviewed prior to taking the inverter OOS. Although, compensatory measures were reviewed for implementation, none were established because the description of the fire protection equipment being taken OOS was evaluated not to be significant and was not governed by the Technical Specifications. The evaluation was correct for the given equipment identified but the affected equipment was incomplete.

The cause of the event was human error in the preparation of the OOS for the inverter resulting in an incomplete fire impairment permit. A fire impairment permit is the vehicle by which compensatory measures are identified and established when fire protection equipment is taken OOS or is otherwise impaired. When the OOS and associated fire impairment permit were prepared and reviewed for the 2FP03E inverter, the preparer and reviewers only identified evacuations sirens and lights as being affected by the OOS.

The Fire Protection Group's (FPG) role is to determine the appropriate compensatory measures based on the information provided on the OOS and/or impairment. In this event, compensatory measures were established based on the evacuation sirens and lights being affected. All OOSs (safety related and Technical Specification related) are double verified by the OOS writers. The individuals who prepared and reviewed the OOS and associated fire impairment failed to recognize the full impact of the OOS and the appropriate fire watches were not established as required by the "action statement" of Technical Specification 3.3.7.9 (Fire Detection Instrumentation). This is due to the fact that the electrical prints for main fire detection control panel 2FP04JA are not stand alone documents. Vendor literature needed to be reviewed in order to determine the full impact of the OOS. As a result of the OOS on inverter 2FP03E, power to main fire detection control panel 2FP04JA and the control room remote annunciator panel was lost .

ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
373/374-96007

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

Because of the multiple interactions of the Fire Protection System, it was decided that an electrical matrix which delineates the impact of an electrical FP OOS on the fire protection system, was needed to assist the OOS writers and Work Analysts who prepare the work packages. In the interim until this matrix was prepared, the Fire Protection Group (FPG) performed independent reviews of every OOS impacting the FP system. These reviews were performed during the entire month of August and no further discrepancies were found.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

1. Additional guidance has been provided to Operations personnel involved with hanging fire protection OOSs. This guidance describes actions to be taken by Operations to verify the correct system responses are received after the OOS is hung. As required, a reminder of this action is also placed on each Fire Protection Impairment Permit.

2. An electrical loads matrix has been prepared which delineates the impact of an electrical FP OOS on the FP system. This matrix will be used by the Work Analysts (WAs) and/or OOS writers during the preparation and review of work packages and their associated OOSs.

3. In addition, a Drawing Change Request (DCR) package has been prepared to provide additional information on the associated FP electrical drawings for the main detection panels. The DCR will revise the drawings to reflect the information currently found in vendor literature. This will be completed by October 30, 1996.

4. The corrective actions taken to resolve the human performance issue in the OOS area have been assigned to the Operations Department. The Operations Department is currently conducting a self assessment of this area to properly identify any weaknesses. The self-assessment will be completed by November 8, 1996. Although this assessment is not complete a number of actions have already been instituted. These actions include an additional Senior Reactor Operator (SRO) review of every OOS activity prior to being performed. This is in addition to the existing review performed by the Work Control Center (WCC) SRO.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on July 31, 1996, when the fire watch was established.