

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

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

Report Nos: 50-373/9F006, 50-374/96006

Licensee: ComEd

Facility: LaSalle County Station, Units 1 and 2

Location: 2601 N. 21st Road
Marseilles, IL 61341

Dates: May 25 - June 22, 1996

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EXECUTIVE SUMMARY

LaSalle County Station, Units 1 and 2
NRC Inspection Report 50-373/96006(DRP); 50-374/96006(DRP)

This integrated inspection report included aspects of licensee operations, maintenance, engineering and plant support. The report covers a four week period by the resident inspectors plus several announced inspections by regional specialist inspectors, including an inspection of the biennial emergency preparedness (EP) exercise by regional EP analysts supported by NRR EP specialists and an RP inspector.

Plant Operations

- Inspectors identified that the Unit 1 and 2 drywell post-accident H_2/O_2 (hydrogen/oxygen) monitors were not being operated consistent with the methods described in the updated final safety analysis report (UFSAR), and the changed mode of operation had not been analyzed as required by 10 CFR 50.59. This was a violation. (01.2)
- A control rod mispositioning event occurred on May 28, 1996, due to a personnel error. (04.1)
- On June 17, 1996, the number of operating shift crews was reduced from six to five, and shift length was changed to 12 hours for management personnel. Shift length remained at 8 hours for union personnel. (06)

Maintenance

- Trouble-shooting failed to find the cause of amperage and voltage oscillations on the Unit 1 Division 1 125 volt DC system. This was classified as an Inspection Follow-up Item. (M1.1)
- General Electric (GE) RMS-9 overcurrent trip devices on four 480 Volt GE breakers were not functioning properly, causing the circuit breakers to trip prematurely. This was classified as an Inspection Follow-up Item. (M2.1)
- The licensee performed a thorough audit on LaSalle's readiness to implement 10 CFR 50.65, the "maintenance rule". (M7)

Engineering

- A licensee-initiated review revealed several instances of differences between facility operations and the UFSAR. NRC Inspection Follow-up Items were initiated on these findings. (E2.1)

Plant Support

- Performance during the 1996 Emergency Preparedness exercise was good. Emergency classifications, offsite notifications and offsite protective action recommendations were correct and timely. Transfers of command and control of event response were orderly and timely. Many exercise participants were pre-staged in meeting rooms, so that the timeliness of their arrivals at assigned response facilities was unrealistic. The decision to evacuate non-essential personnel from the site was untimely. Some responders assigned to the Operational Support Center failed to demonstrate adequate concern for simulated, abnormal inplant radiological conditions. Several controllers of inplant teams provided information to a few teams in a improper manner. (P4)
- On June 15, 1995, a failure of the chemical waste (WZ) evaporator resulted in a spread of contaminated water and sludge to the evaporator room and surrounding hallways.
- On March 24, 1996, failure to perform a required hourly fire watch was evaluated and classified as a non-cited violation. (F8)
- Inspectors found an inadequate boundary to a contaminated area in the reactor building which was promptly corrected by Radiation Protection personnel. (R1)
- High pressure washer hoses extended under the reactor building truck-bay doors and were not removed when not in use, a poor radiological work practice. (R1)

Report Details

Summary of Plant Status

Unit 1 operated the entire inspection period at power levels up to 100 percent.

Unit 2 operated the entire inspection period at power levels up to 100 percent.

I. Operations

01 Conduct of Operations

01.1 General Comments (71707)

The inspectors conducted frequent reviews of ongoing plant operations. The inspectors also followed up on several plant events.

01.2 Poor Safety Focus in Operation of the Drywell H₂/O₂ Monitors

a. Inspection Scope (71707)

The inspectors conducted routine observations of the main control room activities and identified that the Unit 1 and 2 drywell post-accident H₂/O₂ (hydrogen/oxygen) monitors were being operated in continuous mode. This was not consistent with the methods described in the updated final safety analysis report (UFSAR). Follow-up inspection activities were performed to assess the issue.

b. Observations and Findings

On June 13, 1996, the inspectors noted that the drywell post-accident H₂/O₂ monitors in both units were being run continuously. The inspectors discussed this with a reactor operator (RO) and unit supervisor (SRO), and were informed that the H₂/O₂ monitors were being run continuously to monitor the oxygen levels in the suppression pool. This action was directed by the operating department daily orders, rather than a normal operating procedure. The existing system operating procedure (LOP-CM-02, "Startup, Operation and Shutdown of the Post LOCA Primary Containment Atmosphere Hydrogen and Oxygen Monitoring System," Revision 14) covered operating in a post-accident condition or for periodic surveillances, as this is a standby system and normally not operating. The inspectors determined that the H₂/O₂ monitors had been run in this manner for more than a year. The RO stated he had raised questions to operations management several times on whether the lens color of the monitor's containment isolation valves should be changed from open-red to open-green [red being the abnormal position and green being the normal position], but had not received a response.

The inspector interviewed the cognizant system engineer who stated that the station had a long-standing problem with unexpected changes in suppression pool O₂ concentrations. When the monitoring system was run weekly, to perform Technical Specification (TS) surveillance 4.6.6.2, the suppression chamber O₂ concentration would occasionally be found above the 4% TS limit. This would place the unit in a 24-hour shutdown statement to re-inert the suppression pool. The engineer also stated that the H₂/O₂ monitors were run continuously during a special test procedure which was used early in 1996 to validate engineering's proposed solution to the problem, which will be to install new additional monitors to run continuously and perform the TS monitoring function. The existing monitors will only perform a post-accident monitoring function. These modifications were scheduled to be completed at the next Unit 1 refueling outage (spring 1998). The engineer also stated that the special test procedure had been closed out and was not being used to run the monitors continuously, but that operations management had chosen to run the monitors continuously and directed this in the daily orders to the operating crews.

UFSAR Section 7.5.2.2.2.1, "Drywell Hydrogen and Oxygen Monitoring Subsystem," subsection Operational Considerations, Revision 5, stated, in part, "During normal operation, the system is maintained in a standby mode." Title 10 to the *Code of Federal Regulations*, Part 50.59(b)(1) requires, in part, that licensees maintain records of changes in the facility "to the extent that these changes constitute changes in the facility as described in the safety analysis report." These records must include a written safety evaluation which provides the bases that the change does not involve an unreviewed safety question. The failure to perform a safety evaluation on the method of operation of a system which was different than described in the UFSAR is a violation of 10 CFR 50.59(b)(1). (VIO 373;374/96006-01(DRP))

c. Conclusion

There was little potential safety consequence with the continuous operation of the H₂/O₂ monitors. This event was of concern because operations department management directed long-term operation of a safety-related system, in a manner outside plant procedures and contrary to the UFSAR, without performing a safety evaluation.

02 Operational Status of Facilities and Equipment

02.1 Engineered Safety Feature System Walkdowns (71707)

The inspectors used NRC Inspection Procedure 71707 and IDNS risk-based worksheets to walk down accessible portions of the Class 1E battery system.

The walkdowns included the battery rooms, the charger areas, and the divisional switchgear rooms. In the control room; the inspectors used logs, annunciators, and component status lights to verify the proper alignment of the systems and associated components. In the reactor and

auxiliary buildings, several tours were made, including walkdown of accessible portions of safety systems and verification that selected electrical components were in the correct position. No significant safety concerns were noted.

04 Operator Knowledge and Performance

04.1 Control Rod Mispositioned Due to Personnel Error (71707)

The inspectors reviewed the circumstances surrounding the control rod mispositioning event that occurred on May 28, 1996. This event resulted from a personnel error. The rod was supposed to have been withdrawn from position 6 to position 12. A Qualified Nuclear Engineer (QNE) and an operator were at the control room panel. The operator told the QNE that he would use "continuous rod withdrawal" to withdraw the rod; however, he inadvertently pushed the "continuous insert" push button and the rod inserted one notch. The QNE immediately recognized the error and all rod movements were stopped. The operator was removed from rod pulls for the remainder of the shift. The rest of the crew was briefed on the importance of self-check and peer-check. When rod pulls were resumed, they proceeded without incident. There was minimal safety significance associated with this specific event, but it was an example of a failure to self-check.

06 Operations Organization and Administration (71707)

On June 17, 1996, ComEd reduced the number of operating shift crews from six to five. Shift length for management personnel (senior reactor operators) was changed to 12 hours (6 a.m. to 6 p.m. to 6 a.m.). Shift length for union personnel (reactor operators and auxiliary operators) remained at the current 8 hours. The title of the shift supervisor position was changed from "shift engineer" to "shift manager" to more accurately reflect the roles and responsibilities expected by operations department management. The sixth shift engineer was assigned to a leadership position in the licensee's new "fix it now" program, whose objective is to work on non-complex maintenance tasks without all of the administrative burdens imposed by the normal maintenance planning and preparation process. The inspectors reviewed these changes against Technical Specifications and the UFSAR and determined that the licensee remained in compliance with established requirements.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Unit 1 Division 1 125 volt DC

a. Inspection Scope (62703)

Beginning on June 3, 1996, Unit 1 began experiencing problems with the division 1, 125 volt DC system. Battery charger discharge high alarms were received and charger amps and voltage were observed to be

oscillating. The inspector followed the licensee's investigation into the cause of the problem. This included observations of troubleshooting activities and numerous interviews of the System Engineer.

b. Observations and Findings

The System Engineer was cognizant of the problem and was pursuing a resolution. The System Engineer contacted experts on battery chargers at the station, knowledgeable personnel at the ComEd corporate office, and personnel at the vendor. All of the personnel contacted believed the charger was functioning as designed and the problem was due to a large load on the system cycling on and off. The System Engineer determined the Unit 1, division 1, 125 volt DC system was operable due to the charger functioning properly and the batteries being sufficiently charged. The System Engineer believed the problem was caused by a fire protection inverter which was fed from the battery system. The inverter was removed from service and minor problems were found. While the inverter was out of service, the problem with the 125 volt DC system returned, eliminating it as the sole cause of the problem. Chart recorders were set up to monitor various loads on the charger to find the load which was causing the problem. After the recorder was installed, the oscillations did not recur. The System Engineer believed there was still a problem with one of two remaining fire protection inverters which are powered by the battery. Preventive maintenance was in progress on these inverters to correct the problem.

c. Conclusion

The cause of the current and voltage oscillations was not positively determined. The inspectors consider this an Inspection Follow-up Item (IFI 373/96006-02(DRP)) pending review of the licensee's root cause determination.

M1.2 1A and 1B Diesel Generator Monthly Surveillance (61726)

On June 5 and June 12, 1996, respectively, an inspector observed LOS-DG-M3, Revision 31, "1B Diesel Generator Operability Test," and LOS-DG-M2, Revision 33, "1A Diesel Generator Operability Test." The inspector walked down the diesel generators during the testing. Both diesel generators ran satisfactorily with no abnormal vibrations or leaks. In both instances the non-licensed operators performing the surveillances followed the procedure and observed the diesel generator for potential problems. All procedural and acceptance requirements were met.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Premature Instantaneous Trip of GE 480 Volt Breakers (62703)

The inspector reviewed and followed licensee action on a circuit breaker problem. On May 29, 1996, the licensee found during preventive maintenance testing that the GE RMS-9 overcurrent trip devices on four 480 Volt GE breakers were not functioning properly. The

instantaneous trip function was tripping the circuit breaker prematurely. The failed breakers were used in the Control Room HVAC system and the Auxiliary Electrical Equipment Room HVAC system. The licensee promptly replaced these breakers with operable breakers.

The licensee conducted some tests on the circuit boards of two failed RMS-9 units and determined that a thin film of an unknown material on the circuit board, around the sliding contacts, was causing the failures. The licensee sent two failed RMS-9 units to the manufacturer (GE) for further evaluation. GE informed the licensee that they found a polymer film on the circuit board, but did not determine its source or composition. GE informed the licensee that a potential reportable condition exists, and that the final determination and Part 21 Notification, if required, must be made by August 12, 1996. The licensee had not yet received a final report from GE. Following receipt of the final report, a regional specialist inspector will review the report and the licensee's actions with respect to the report. This issue will be tracked as an Inspection Follow-up Item (IFI 373;374/96006-03(DRS)).

M7 Quality Assurance in Maintenance Activities

a. Inspection Scope (40500)

The inspector reviewed and evaluated Site Quality Verification (SQV) Audit 01-96-04, dated June 5, 1996, concerning LaSalle's readiness to implement the maintenance rule (10 CFR 50.65).

b. Observations and Findings

The audit appeared to be quite thorough and identified several deficiencies and potential weaknesses. The audit concluded that while the engineering department had a good understanding of its role in implementing the maintenance rule, other organizations did not. The station's overall procedure to implement the rule was issued in mid-June, 1996, but departmental procedures were yet to be written. Also, while initial, informal training had been provided to station personnel, the training department had yet to develop any formalized training on the rule.

The audit did conclude that maintenance rule structures, systems, and components were acceptably classified and categorized in accordance with the guidance of NUMARC 93-01 and the regulations of 10 CFR 50.65. The temporary procedure used to perform the initial system classifications was acceptable and risk significance ranks were used. However, SQV was concerned that the most up-to-date risk (IPE) numbers were not used.

c. Conclusion

The audit was thorough and identified several areas of weakness. The NRC will conduct its own inspections of the licensee's implementation of the maintenance rule in the near future.

M8 **Miscellaneous Maintenance Issues**

(Closed) LER (373/95001): Residual Heat Removal (RHR) system inoperable due to shut instrument isolation valve. The inspectors reviewed this LER in Inspection Report 373/95004 and concluded that the LER was technically weak and insufficient. The licensee re-reviewed the LER and concluded that the event had never been reportable under 10 CFR 50.73; consequently, the LER was withdrawn. Based on the licensee's latest actions this LER is considered closed.

III. Engineering

E2 **Engineering Support of Facilities and Equipment**

E2.1 Licensee Review of UFSAR Accuracy (37551)

In light of recent industry events in which utilities were found to be operating their facilities contrary to information contained in the updated final safety analysis report (UFSAR), the licensee has initiated a systematic review of the UFSAR. The following is a list of the issues identified by the licensee this report period. Pending NRC's resolution of how to disposition these licensee-identified issues, these issues will be tracked by an inspection follow-up item (IFI).

- PIF 96-1748: UFSAR, Rev. 11-April 1996, section 9.1.3.1.1, the water level specified in the spent fuel pool over the spent fuel storage racks is inconsistent with technical specifications and operating procedures. (IFI 373;374/96006-04a(DRP))
- PIF 96-1750: UFSAR, Rev. 7-April 1991, section 9.2.2.3, the UFSAR does not recognize the use of fire protection water as a backup to service water and is inconsistent with operating procedures. (IFI 373;374/96006-04b(DRP))
- PIF 96-1770: UFSAR, Rev. 7-April 1991, section 7.A.3.1.1.2, control power breaker in dc cabinets are not lockwired per a commitment to IEEE-279. (IFI 373;374/96006-04c(DRP))
- PIF 96-1776: UFSAR (various sections), UFSAR was not updated when a modification was made to Unit 1 but was scheduled to be updated after the modification was completed for Unit 2. The modification involved relocation of main steam tunnel thermocouples and a logic change for main steam tunnel leak detection. (IFI 373;374/96006-04d(DRP))

- Site Quality Verification (SQV) Field Monitoring Report 96006-0026 and Corrective Action Record (CAR) 01-96-032: UFSAR, Rev. 1-April 1985, Section 7.A.2.1.1, subsection titled, "Access to Means for Bypassing (IEEE 279, Par.4.14)." instrumentation valves associated with scram discharge volume level transmitters were not locked per a commitment to IEEE-279. (IFI 373;374/96006-04e(DRP))

IV. Plant Support

R1 Radiological Protection and Chemistry Controls (71750)

a. Inspection Scope

The inspectors routinely observed and evaluated radiological protection activities and results.

b. Observations and Findings

On June 6, 1996, while touring the reactor building, the inspector observed an inadequate radiation control boundary in the Unit 1, High Pressure Core Spray pump room. The boundary for a contaminated area had increased in size due to ongoing maintenance. When moving the boundary to increase the area, an approximate 18-inch opening was left between the boundary and a wall in the room. There was no evidence of anyone entering or exiting the contaminated area through the opening. The inspector reported the problem to the Radiation Protection Department and the boundary was promptly corrected.

On June 11, 1996, while touring the reactor building, inspectors observed two hoses running from inside the reactor building under the truck-bay doors to high pressure washer equipment outside the reactor building. The hoses were being used to allow high pressure washing of various pieces of plant equipment, as part of the source term reduction effort at the station. At the time of the inspectors' observations, the high pressure washer was not in operation. The hoses were located in the openings for the railroad track and did not increase the opening at the truck-bay doors. It was learned from conversations with the Operations Manager that Radiation Protection had issued a letter stating that the hoses were to be removed from under the truck-bay doors when personnel were not present. The hoses were not removed and personnel were not present to monitor the hoses. There was potential for an unmonitored release point if one of the hoses broke and released its contents, although the significance was minimal as the hydrolase was required to be connected to the clean condensate system. The inspectors' concern was the licensee's lack of oversight and lack of communication concerning the hoses.

R2 Status of Radiological Protection and Chemistry Facilities and Equipment

R2.1 Materiel Condition Problem with Radwaste Evaporator Leads to Spill of Contaminated Water and Sludge (71750)

a. Inspection Scope

On June 15, 1995, a failure of the chemical waste (WZ) evaporator resulted in a spread of contaminated water and sludge to the evaporator room and surrounding hallways. The inspectors reviewed the circumstances of the event and followed license actions to address the cause and consequences.

b. Observations and Findings

The liquids radwaste operator initially identified a potential problem when he noted the vaporbody level in the evaporator was low with unusually high feed flow. Then he observed a level increase in the sludge tank indicative of a leak in the room. A radiation protection technician (RPT) and another operator were dispatched to the WZ room. The RPT and the operator noted a small glandwater leak in the WZ evaporator pump room, and a major leak in the WZ evaporator room. The large leak was evident as a small amount of water was coming under the WZ evaporator room door into the hallway outside the room. In addition, the operator observed a major leak hitting the wall of the room. The WZ evaporator was secured to stop the leak.

An event investigation was started to determine the root cause of the leak. ComEd began to develop a plan to recover the evaporator. The dose rates in the room were very high. On the first entry, the RPT encountered a dose rate of 5 R/hr just inside the room, at which point, he turned back. High pressure washing was done from the doorway of the room to unclog the floor drain which had become plugged with insulation which had come off of the evaporator. This allowed the water in the room to drain.

c. Conclusions

Maintenance personnel had not been into the evaporator room to determine the failure mechanism of the evaporator which caused this leak. The inspectors will follow up on the root cause of the evaporator incident when ComEd enters the room to troubleshoot and repair the evaporator. This will be tracked as an Inspection Followup Item (IFI 373;374/96006-05(DRS)).

P3 Emergency Preparedness (EP) Procedures and Documentation

P3.1 Review of Exercise Objectives and Scenario (82302)

The inspectors reviewed the 1996 exercise's objectives and scenario and determined that they were acceptable. The scenario provided an adequate

framework to support demonstration of the licensee's capabilities to implement its emergency plan.

P4 Staff Knowledge and Performance in EP

P4.1 The 1996 Evaluated Biennial EP Exercise

a. Inspection Scope (82301)

Licensee performance was evaluated in the Control Room Simulator, Technical Support Center, Operational Support Center, Corporate Emergency Operations Facility, Emergency Operations Facility, and Joint Public Information Center. Inplant teams were accompanied.

b. Observations and Findings

- b.1 In the Control Room Simulator (CRS), the Shift Engineer (SE) properly made Unusual Event and Alert declarations in a timely manner. The SE did not seek offsite confirmation that the seismic event had occurred, as was suggested in supplemental event classification guidance.

Notifications to State and simulated NRC officials were completed in an adequately detailed and timely manner.

Communications between responders in the CRS and Technical Support Center (TSC) were good. Transfer of command and control from the SE to the TSC's Station Director (SD) was orderly and clear. Communications among the CRS crew were good.

- b.2 The TSC was activated in an orderly manner. The SD effectively managed activities and involved his staff in periodic update briefings, which were also audible in the Operational Support Center (OSC). The TSC's status boards were effectively used for event chronology and action items.

The SD correctly declared a Site Area Emergency following a degradation in plant conditions, and State and simulated NRC officials were properly notified. There was an orderly transfer of command and control to the Corporate Manager of Emergency Operations (CMEO) in the Corporate Emergency Operations Facility (CEOF).

A timely decision was made to assemble and account for onsite personnel; however, the subsequent decision to evacuate nonessential personnel was untimely (about 25 minutes). The untimely decision to evacuate non-essential personnel will be tracked as Inspection Followup Item (IFI 373;374/96006-06(DRS)).

Two offsite radiation survey teams were adequately briefed and dispatched following the Alert declaration. The TSC effectively controlled these teams until the EOF assumed this responsibility.

The TSC's environs staff continued to assess offsite Protective Action Recommendations (PARs), but did not always effectively communicate with EOF personnel.

- b.3 The OSC's Director and Supervisor maintained a good understanding of priorities and kept the TSC informed of inplant teams' activities. Status boards were effectively used to track available resources and team status.

OSC personnel failed to demonstrate adequate concern for simulated high radiation and contamination levels. Examples included:

- A team knowingly traversed a high radiation area without trying to identify an alternate route.
- Surveys of Turbine Building radiological conditions were not initiated until about 90 minutes after the release began.

The inadequate concern for inplant radiological conditions was an Exercise Weakness that will be tracked as Inspection Followup Item (IFI 373;374/96006-07(DRS)).

Several instances were identified where exercise controllers improperly provided scenario information. Examples included:

- While enroute to a job site, a controller informed a team that repair efforts would be unsuccessful until a specific time later in the scenario.
- After a radiation protection technician demonstrated taking a radiation level reading, a controller provided a scenario data sheet containing readings for the next several hours.
- A controller gave a technician a requested instrument readout that was beyond the scale being used.

Inadequate performance by controllers accompanying inplant teams will be tracked as an Inspection Followup Item (IFI 373;374/96006-08(DRS)).

Inplant team briefings were adequate. However, teams were not always instructed to use radios to contact the OSC. Several teams attempted to report their results either to the other facilities or used an inplant telephone instead of their radios.

- b.4 The activation of the CEOF was timely. Transfers of command and control of event response were orderly and timely. The CMEO effectively managed the CEOF's staff and provided good update briefings. Communications between CEOF staff and their TSC and EOF counterparts were good.

CEOF staff displayed knowledge of computers and equipment with one minor exception. Status boards were not effectively used to record complete event chronology information or to track all higher priority tasks.

- b.5 The EOF was activated following the Site Area Emergency. Initial and update briefings to EOF staff were good.

The Manager of Emergency Operations (MEO) promptly and correctly declared a General Emergency. Proper notifications were made to State and simulated NRC officials. The initial PAR was correctly revised following a shift in wind direction.

The EOF assumed control of radiological survey teams and acceptably used them to track the simulated release.

- b.6 Corporate public affairs staff issued two press releases prior to the staffing of the Joint Public Information Center (JPIC). Two press briefings were conducted at the JPIC. Overall performance by the licensee's briefers was good; however, there were a few cases of failing to respond to a question asked during the previous briefing.

With the exception of an event chronology press release, press releases generally contained little information beyond boilerplate text, such as definitions of the emergency classification. One news release contained inaccurate information regarding onsite damage.

c. Conclusion

The exercise was a good demonstration of the licensee's capabilities to implement its emergency plan. Event classifications, notifications and protective action recommendations were correct and timely. Transfers of command and control were appropriately coordinated. Many exercise participants were pre-staged; the timing of their arrivals at response facilities was unrealistic.

The decision to evacuate non-essential personnel was untimely after onsite personnel were accounted for. Some OSC personnel failed to demonstrate concern for radiological conditions. Several controllers of inplant teams provided information in an improper manner. The licensee's initial post-exercise critiques were good.

F8 Miscellaneous Fire Protection Issues

(Closed) LER (373/96002): Hourly compensatory fire watch not performed on door 406. The licensee identified that an hourly fire watch had not been performed for 3 hours on March 24, 1996. Door 406 is located in the reactor building and the fire watch was unable to gain access to the reactor building because a secondary containment leak rate test was in progress. However, the firewatch failed to communicate this problem to his supervisor. Technical Specification 3.3.7.9 requires that a 1 hour

compensatory fire watch be established when the fire barrier between zones 2F and 3F is impaired (door 406).

The failure to perform a compensatory fire watch for 3 hours with fire door 406 impaired is a violation of Technical Specification 3.3.7.9. However, this licensee-identified violation is being treated as a Non-Cited Violation, because it meets the criteria in Section VII.B.1 of the NRC Enforcement Policy, NUREG-1600 (NCV 373/96006-09(DRP)).

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 June 21, 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

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

* Present at exit meeting on June 21, 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 82301 Evaluation of Exercises for Power Reactors
- IP 82302 Review of Exercise objectives and Scenarios for Power Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

373;374/96006-01	VIO	Failure to perform a 10 CFR 50.59 safety evaluation for changing the method of operating the drywell H ₂ O ₂ monitors (01.2)
373/96006-02	IFI	Battery charger oscillations (M1.1)
373;374/96006-03	IFI	RMS-9 breaker trip device failure (M2.1)
373;374/96006-04	IFI	Five licensee-identified disparities between the UFSAR and the plants' configuration or operation (E2.1)
373;374/96006-05	IFI	Evaporator spill incident (R2.1)
373;374/96006-06	IFI	Decision to evacuate non-essential personnel during a drill (P4.1.b.2)
373;374/96006-07	IFI	Exercise Weakness related to inadequate concern for inplant radiological conditions (P4.1.b.3)
373;374/96006-08	IFI	Performance by controllers accompanying inplant teams (P4.1.b.3)
373/96006-09	NCV	Failure to perform hourly fire watch with an impaired fire barrier (F8)

Closed

373/95001	LER	RHR system inoperable due to shut instrument isolation valve (M8)
373/96002	LER	Failure to perform hourly fire watch with an impaired fire barrier (F8)

LIST OF ACRONYMS USED

AR	Action Request
CAR	Corrective Action Record
CEOF	Central Emergency Operations Facility
CM	Containment Monitoring
CMEO	Corporate Emergency Operations Facility
CRS	Control Room Simulator
DG	Diesel Generator
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
EOF	Emergency Operations Facility
EPRI	Electric Power Research Institute
EP	Emergency Preparedness
GE	General Electric
IDNS	Illinois Department of Nuclear Safety
IEEE	Institute of Electrical and Electronic Engineers
IP	Inspection Procedure
IPE	Individual Plant Evaluation
IFI	Inspection Follow-up Item
JPIC	Joint Public Information Center
LER	Licensee Event Report
LOP	LaSalle Operating Procedure
LOS	La Salle Operating Surveillance
MEO	Manager of Emergency Operations
NRC	Nuclear Regulatory Commission
NUMARC	Nuclear Utility and Resource Council
OSC	Operations Support Center
PAR	Protective Action Recommendations
PIF	Problem Identification Form
PDR	NRC Public Document Room
QNE	Qualified Nuclear Engineer
RO	Reactor Operator
RPT	Radiation Protection Technician
SD	Station Director
SE	Shift Engineer
SRO	Senior Reactor Operator
SQV	Site Quality Verification
TS	Technical Specification
TSC	Technical Support Center
UFSAR	Updated Final Safety Analysis Report
WZ	Chemical Waste