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February 27, 1997

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

Subject: LaSalle County Station Units 1 and 2
Response to NRC Notice of Violation
Inspection Report Nos. 373/374-96013
NRC Docket Numbers 50-373 and 50-374

Reference: J. L. Caldwell letter to W. T. Subalusky,
Dated, January 29, 1997, Transmitting
NRC Inspection Report 50-373/96013 and
50-374/96013

The enclosed attachment contains LaSalle County Station's response to the Notice of Violation that was transmitted in the reference letter.

In general, the cited violation examples deal with procedural adherence and/or procedure quality. Fundamental to good operation is for workers to follow well written procedures. Our current performance continues not to meet our expectations in this area. Therefore, our near term focus is on improved human performance. At a recent "all hands" briefing, management clearly communicated their expectation for LaSalle's improvement and the necessary elements of each individual's contribution to this effort: Strict procedural adherence, strong use of the self-checking program, a questioning attitude and a demand for resolution of issues. We expect all workers at LaSalle County Station to follow procedures or, if necessary, get the procedure corrected.

The attachment to this letter contains the immediate corrective actions taken as well as long term corrective actions to preclude recurrence of the violations.

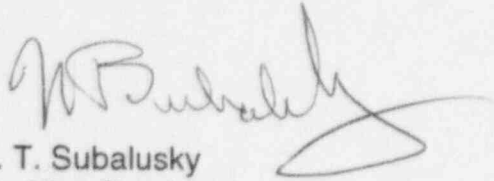
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If there are any questions or comments concerning this letter, please refer them to me at (815) 357-6761, extension 3600.

Respectfully,

A handwritten signature in dark ink, appearing to read 'W. T. Subalusky', with a large, stylized flourish at the end.

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
F. Niziolek, Office of Nuclear Facility Safety - IDNS

**ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
373/374-96013**

VIOLATION: 373/374-96013-02

Technical Specification 6.2.A.a requires that applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, be established, implemented, and maintained.

Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, specifies procedures for plant shutdown, procedure adherence and temporary change methods, and maintenance that can affect the performance of safety-related equipment.

LaSalle General Procedure LGP-2-1, "Normal Unit Shutdown," Revision 48, Step 7, requires operators to downshift the reactor recirculation (RR) pumps to slow speed per LaSalle Operating Procedure LOP-RR-08, "Changing Recirculation Pump Speed from Fast to Slow Speed."

LaSalle Administrative Procedure LAP-100-40, "Procedure Use and Adherence Expectations," Revision 6, requires that a temporary procedure change be completed and the procedure revised when the change is more than an editorial change and the procedure cannot be performed as written.

LaSalle Maintenance Procedure LMP-GM-25, "Emergency Core Cooling System Service Water Strainer Maintenance," Revision 4, Step F.4.25, requires that workers ensure that the exposed faces of the shear key collar and the drive shaft which contact the inner and outer thrust bearing faces of the strainer backwash valve, are flush with each other. If these faces are not flush, the procedure directs the worker to install a spacer.

Contrary to the above, applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, were not correctly implemented in the following instances:

- a. On September 22, 1996, operators did not downshift the Unit 2 RR pumps to slow speed per LOP-RR-08 as required by LGP-2-1. Instead, operators downshifted the RR pumps per LaSalle Instrument Surveillance procedure LIS-RR-205A, "Unit Recirculation Pump Trip System A Breaker Arc Suppression Response Time Test," Revision 2, without first completing a temporary procedure change to LGP-2-1 as required by LAP-100-40.
- b. On October 2, 1996, during work on the 0 emergency diesel generator (EDG) cooling water strainer, workers did not ensure that the exposed faces of the shear key collar and the drive shaft which contact the inner and outer thrust bearing faces of the strainer backwash valve, were flush with each other, and did not install a spacer as required by LMP-GM-25.

This is a Severity Level IV violation (Supplement I) (50-373/96013-02; 50-374/96013-02).

REASON FOR VIOLATION: 373/374-96013-02

- a. The downshifting of Unit 2 reactor recirculation pumps was actually done on September 19, 1996 and was performed in accordance with an approved surveillance procedure, LIS-RR-205B. This surveillance fulfills the requirements of Technical Specification 4.3.4.2.3 to verify the time allotted for breaker arc suppression and is performed once every 60 months. The surveillance was scheduled during unit shutdown when it could be performed safely and substituted for the step where the pumps' speed is downshifted. Although the pump downshift was accomplished using an approved procedure, neither the personnel scheduling the activity nor the operating shift conducting the infrequent evolution briefing recognized that a temporary procedure change was required to resolve a procedural conflict with the normal shutdown procedure, LGP-2-1.

When the conflict was pointed out by the NRC inspector, the operators incorrectly concluded that step 7 of the LGP could be marked as 'not applicable' since the pump downshift, as accomplished using LIS-RR-205B, was similar to the method used in the normal procedure, LOP-RR-08, and the activity had been scheduled in place of this step. Although, under certain conditions, procedure steps may be marked N/A, use of this provision is limited by procedure LAP-100-40 to steps that are not performed in a partial surveillance or when so stated in another governing procedure.

Neither of these provisions applied in this case. The causes of the violation were (1) human performance errors in applying and understanding when the designator, N/A, may be used in lieu of a temporary procedure change, (2) conducting an inadequate briefing in that the use of the LIS to substitute for a step in the LGP was not discussed and (3) incomplete planning of the task when the procedure substitution was not addressed. More thorough review and action in any of these activities could have identified the need for a temporary change to the LGP and prevented the error.

- b. Our investigation has identified that this event occurred due to poor procedure quality rather than a failure to adhere to procedures. The procedure steps had been followed and a flush condition, as described in step F.4.25, existed. Per the procedure, if the exposed faces are flush, no spacer is required.

However, we acknowledge that procedure LMP-GM-25 did not provide adequate direction necessary to properly perform the disassembly and reassembly work. Pertinent direction, specifically documentation of spacer removal and detailed direction for the performance of the drive shaft gasket compression activity, were not specified in the procedure.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

- a. Subsequent to this event, on October 14, 1996, the Station held a work stand down. During this time, management communicated the expectation for procedural awareness and strict adherence to procedure steps including the requirement to initiate a temporary procedure change (TPC) when the procedure cannot be followed as written.

LaSalle procedure LAP-820-4, "Temporary Procedure Changes", has been revised to provide additional guidance to aid the operators in determining the need and proper use of a TPC. It also provides the approved alternative methods available to the operator in the event that a TPC is not the appropriate method to implement the desired change. These alternative methods include processing an accelerated procedure change, developing a Special Procedure or a Special Operational Test but do not include marking steps as not applicable.

- b. Following the identification of the leak, supplemental instructions to the work package for troubleshooting the leak were developed. The workers identified that the drive shaft gasket needed to be properly seated before reassembly and verification that the exposed faces were flush. Following this check, the workers determined that a spacer was required and it was installed. Reassembly was completed, and the strainer was tested. No leakage was observed. Procedure LMP-GM-25 was revised on November 12, 1996, to provide steps necessary to assure proper performance of the disassembly and reassembly work.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

- a. A general information notice (GIN) has been issued to Operating department personnel to inform them of the changes to LAP-820-4 and the guidance provided on when to use a TPC and the approved alternatives to using a TPC. The GIN will also be communicated to other departments as part of their routine human performance meetings. The review of this GIN will be completed by May 15, 1997.
- b. No additional corrective actions are required.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

- a. Full compliance was achieved when management reinforced procedural adherence expectations with regard to issuing temporary procedure changes during the October 14, 1996 stand down.
- b. Full compliance was achieved when procedure LMP-GM-25, Revision 5, was issued on November 12, 1996.

VIOLATION: 373/374-96013-03

10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," requires that activities affecting quality be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and be accomplished in accordance with these instructions, procedures, or drawings.

Out-of-service (OOS) 960012473 special instructions dated October 11, 1996, specified that the Unit 2, Division 2 battery charger be shut down in accordance with LOP-DC-01, "Energizing, Startup, and Shutdown of a Battery Charger," Revision 8, Step F.3.

Work request (WR) 940061754-01, "Install/Remove 2B Reactor Recirculation Loop Jet Pump Plugs to Support 67B Work," instructions specified that jet pump plugs be installed in jet pumps 11 through 20.

Contrary to the above, activities affecting quality were not accomplished in accordance with instructions in the following instances:

- a. On October 12, 1996, equipment operators shut down the Unit 1, Division 2 battery charger instead of the Unit 2, Division 2 battery charger as specified in OOS 960012473 special instructions.
- b. On October 9, 1996, fuel handlers installed two jet pump plugs in jet pumps 1 and 2 instead of installing plugs in jet pumps 11 through 20 as specified in WR 940061754-01 instructions.

This is a Severity Level IV violation (Supplement I) (50-373/96013-03; 50-374/96013-03).

REASON FOR VIOLATION: 373/374-96013-03

- a. After correctly completing the preliminary work involved with this out of service, the operators were in the Unit 1 Division 2 switchgear area. The next task involved removing the Unit 2 Division 2 battery charger from service; the charger that was associated with the breaker being taken out of service. However, the operators went to the nearby Unit 1 charger, removed it from service and then noticed that the breaker listed on the out of service was not the breaker associated with that charger. This human performance error occurred because of inattention to detail on the part of both operators, lack of a questioning attitude and inadequate work practices in independently verifying that the correct component had been taken out of service.

- b. The reason for this violation in which Jet Pump Plugs (JPP) were installed in the incorrect jet pump nozzles is that a "sketch" was missing from a work request. The Fuel Handling Supervisor (FHS), upon questioning the missing jet pump location diagram was verbally given incorrect jet pump locations from the Refuel Floor Coordinator and GE Floor Supervisor. This information was incorrect. Upon receipt and review of a requested drawing of jet pump locations, the FHS noted that the JPPs were in the wrong location, stopped JPP installation and notified work control. Due to being a critical path activity, a poor decision was made to install the JPPs based on verbal communications of the jet pump locations and not verifying the locations with the appropriate drawings.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

- a. The operators were counseled by senior department management regarding the need for attention to detail and thorough use of self-check prior to implementing out of services. Additionally, disciplinary action has been taken.

Procedure LOP-DC-01, Energizing, Startup and Shutdown of a Battery Charger, has been revised to clarify the instructions and provide specific identification of the AC and DC electrical breakers associated with each battery charger.

Additional training has been provided to operators who implement out of service checklists as part of the 1997 License Continuing Training program during Module 97-1. This training focused on use of special instructions, methods for locating and verifying the components and component position, and documenting the work performed.

- b. The Outage Manager briefed Fuel Handlers on the event. The FHS initiated a Work Request to remove incorrectly placed JPPs. The work analyst upgraded the work package to include the proper drawings. The Maintenance Superintendent and Consolidated Facilities Maintenance (CFM) Supervisor held expectation meetings with the personnel involved. The FHS created approved Operator Aids on JPP and reactor recirculation suction locations and added these documents to the refuel bridge Operator Aid Book. The CFM supervisor met with the fuel handling department personnel to emphasize the importance of pre-job briefings and questioning attitudes. The FHS held discussions with the fuel handling department personnel on the requirement to ensure that work packages are complete prior to starting work and the requirement to stop work when information is discovered to be missing from the work package. Management took appropriate disciplinary action with the FHS.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

No additional corrective steps were taken other than those corrective steps listed above.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

- a. Full compliance was achieved when the Unit 1 battery charger was restored to service on October 12, 1996 and the correct Unit 2 battery charger was removed from service as listed on the out of service checklist.
- b. Full compliance was achieved on October 12, 1996, with the removal of the JPPs from the incorrect jet pumps.

VIOLATION: 373/374-96013-05

10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," requires in part, that activities affecting quality be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances.

Contrary to the above, procedures affecting quality were not appropriate to the circumstances in the following instances:

- a. On October 10, 1996, LMP-GM-14, "Use of Freeze Jackets," Revision 4, dated July 1, 1992, did not provide workers with information on the lower temperature limit when establishing a freeze seal.
- b. Prior to October 24, 1996, LAP-1300-16, "Engineering Request," Revision 1, and LAP-1300-18, "Roadmap to Plant Design Changes," Revision 1, failed to provide sufficient controls to ensure timely completion of engineering work.

This is a Severity Level IV Violation (Supplement I) (50-373/96013-05; 50-374/96013-05).

REASON FOR VIOLATION: 373/374-96013-05

- a. Procedure LMP-GM-14 does provide information to the worker on the lower temperature limit for maintaining a freeze seal. Step F.3.1 states the "When warmest thermocouple temperature reaches -30 degrees F, open bottle stop inlet valve until both chambers are overflowing with LN-2, or until lowest temperature is -50 degrees F, then shut bottle stop valve." However, there is no lower temperature limit information provided for establishing the freeze seal. This appears to have been an oversight in the development of the procedure.
- b. It was recognized late in 1995, that the ER backlog was increasing and there was an inadequate review, control, and approval process in place. To address the lack of ER prioritization, a process was developed by Design Engineering representatives from each ComEd site. At LaSalle, the process was implemented in February 1996, and by June 1, 1996, the entire backlog of ERs was reviewed and prioritized. Shortly after accomplishing this task, several interruptions affected the ability of the Prioritization Group to meet as a quorum. This resulted in an increase in the number of unprioritized ERs. Therefore, implementation of the process was inconsistent and ineffective in ensuring scheduling of engineering work. The apparent cause for not implementing the prioritization process was lack of appropriate engineering management attention.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

- a. Work was stopped. Specific guidance on lower temperature limits was added to the Nuclear Work Request (NWR) being used for the freeze seal work. This guidance was also added to other pending NWRs that required freeze seal work.

- b. LaSalle has implemented a new Engineering management team made up of personnel with successful engineering leadership and experience. In addition, coaching or mentoring of engineering personnel has been implemented to make substantive improvements in engineering capability in all areas.

The ER administrative procedure LAP-1300-16 has been revised to include improvements such as the use of the site's work prioritization codes, explanation of different ER types, sequencing of responsibilities, and periodic reviews of ERs in "Initiation" status to ensure that ERs are submitted for review in a timely manner.

To ensure uniform communication of site priorities, management has placed increased emphasis on ER prioritization. The ER Prioritization Group now meets on a regular schedule to ensure that work is properly prioritized for implementation.

The role of System Engineering, having responsibilities for plant systems, has been strengthened by the System Engineering Supervisor's participation in the Prioritization Group meetings.

The updated process was scheduled to be discussed in detail, including prioritization process and cognizant design and system engineer expectations at Engineering Communications Meetings. The first was completed on February 24, 1997, and the second to be completed on March 3, 1997.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

- a. ComEd procedure NSWP, SMP-M-07 "Pipe Freeze Seals" provides specific temperature guidance during the performance of freeze seals, such that piping integrity will be protected. This procedure is now in use at LaSalle County Station. Procedure LMP-GM-14 was deleted by February 28, 1997.
- b. We believe that the steps taken above will adequately address the identified deficiencies in the ER process implementation.

The problem of not providing sufficient management attention to ensure timely completion of engineering work may not be limited to ERs. Other engineering processes will be evaluated to ensure adequate review, control, and approval. This review will be completed by May 1, 1997.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

- a. Full compliance was achieved on October 10, 1996, when appropriate guidance was added to freeze seal NWRs.
- b. Full compliance was achieved with the issuance of the revised LAP-1300-16 on February 26, 1997.

VIOLATION: 373/374-96013-06

Technical Specification 6.2.A.g requires that written procedures be established, implemented, and maintained for the fire protection program.

LaSalle Administrative Procedure LAP-900-10, "Fire Protection Procedure for Welding and Cutting," Revision 16, dated June 27, 1996, Step F.1.c, requires, in part, that areas where cutting and welding are in progress be kept clean and that all accumulation of trash, rags, etc., be removed.

Contrary to the above, on September 29, 1996, workers welding on the 0 EDG cooling water strainer did not keep the area clean, and the area contained several cloth rags, electrical cords, and plastic bags.

This is a Severity Level IV violation (Supplement I) (50-373/96013-06; 50-374/96013-06).

REASON FOR VIOLATION: 373/374-96013-06

The Contractor Supervisor verified the work area clean prior to the start of welding activities. Rags used during the work were allowed to accumulate because the workers and supervisor involved exhibited inattention to detail during the work. The workers had become focused on performing their task to the extent that their attention to maintaining the detailed requirements of the procedure was reduced.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

Welding was stopped. The workers cleared the area of combustibles to bring the area into compliance with the procedural requirements of LAP-900-10, "Fire Protection Procedure for Welding and Cutting".

The Fire Marshal counseled the workers and Contractor Supervisor at the work area. Specific emphasis was placed on LAP-900-10, "Fire Protection Procedure for Welding and Cutting" and the Site expectation for procedural adherence.

Increased Fire Marshal oversight was implemented when welding resumed. Conditions in the area were found to be acceptable.

Following the event, the Fire Marshal made area inspections prior to approving and issuing the next 12 welding, cutting, grinding, open flame permits. All areas were found to comply with procedure requirements, and the permits were issued.

Procedural compliance expectations and the importance of implementing the requirements of LAP-900-10, "Fire Protection Procedure for Welding and Cutting", were stressed during the routine contractor tailgate sessions conducted in the days following event. Construction Management again reinforced this during contractor weekly safety meeting held on October 28, 1996.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

Random inspections of work sites will continue to be performed by the Fire Protection group to verify safe working conditions.

Station management's procedural adherence expectations, supervisory roles and responsibilities, along with the requirements of LAP-900-10, "Fire Protection Procedure for Welding and Cutting", were discussed during the contractor weekly safety meeting held on all shifts January 20, 1997. Printed material outlining the contractor management's expectations and guidelines for fire protection was distributed to the workers.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Adherence to the procedural requirements of LAP-900-10, "Fire Protection Procedure for Welding and Cutting" were brought into full compliance immediately following the observed event. The expectation for adherence to all procedure requirements, and adherence to the requirements of LAP-900-10, "Fire Protection Procedure for Welding and Cutting" in particular, has been communicated to the individuals involved and other contractor personnel.

VIOLATION: 373/374-96013-09

Technical Specification 6.2.B. requires that radiation control procedures be maintained, available to all station personnel, and adhered to.

LaSalle Radiation Procedure LRP-1490-1, "Construction of Radiologically Posted Areas and Step Off Pad Areas," Revision 13, dated January 12, 1996, Step F.2.d, requires that hoses, electrical cords, etc., which breach a contaminated area boundary, be taped or tied securely, or otherwise be secured where they exit the area.

LaSalle Radiation Procedure LRP-1410-2, "Minimal Protective Clothing," Revision 7, dated June 23, 1994, Step F.2, requires that minimal protective clothing requirements include cloth and rubber shoe covers and cloth and rubber gloves.

Contrary to the above, radiation control procedures were not adhered to in the following instances:

- a. On October 7 and 11, 1996, hoses that breached a contaminated area boundary in the vicinity of the 2D heater drain (HD) pump room and the 2A HD pump room, respectively, were not taped or secured as required by LRP-1490-1.
- b. On October 10, 1996, a maintenance worker did not wear the proper minimal protective clothing specified in LRP-1410-2. The worker wore rubber gloves and rubber shoe covers but did not have on cloth gloves or cloth shoe covers.

This is a Severity Level IV violation (Supplement I) (50-373/96013-09; 50-374/96013-09).

REASON FOR VIOLATION: 373/374-96013-09

Station management has tolerated a low standard for plant radiological housekeeping. Management has not held workers and first line supervisors accountable for radiological procedural adherence.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED:

The hoses were secured on October 11, 1996. Additional walkdowns of all areas of the plant were walked down on February 21, 1997 and all hoses, cords, etc. were verified to be properly secured where they cross contamination boundaries.

Senior management has communicated their expectations to site personnel for adherence to procedures including adherence to good radiation protection (RP) practices. Strong corrective measures will be taken when any individual violates RP procedures or good practices. This includes such measures as having the involved individual and their supervisor's access to the RPA removed pending direct counseling by RP Supervision. Escalated corrective action up to and including termination will be taken with individuals involved in repeat occurrences.

Expectations for Zone Technicians were again communicated on February 24, 1997, with the emphasis on finding and correcting radiological deficiencies and documenting these occurrences via the PIF process.

CORRECTIVE ACTIONS TO BE TAKEN TO PREVENT FURTHER VIOLATIONS:

New expectations have been set and incorporated into LAP-2200-2, "Radiation Protection Memorandum", on February 28, 1997, for Radiation Protection Technicians and Radiation Protection Management on ensuring workers are following radiological procedures. If a technician and/or Radiation Protection management person is in the field and fails to correct a poor radworker practice, they will have their RPA access denied and will need to meet with the Radiation Protection Manager or designee for coaching and RPA access reinstatement. Repeated failure to correct deficiencies will result in individual escalated corrective action up to and including termination of employment.

Radiation Protection (RP) has assigned ownership of various areas of the plant to RP personnel. Expectations have been established for routine tours and inspections of these areas. The frequency of tours and continuing need for inspections will be reviewed every six months.

Visual aids showing the proper clothing for minimum and a full set of protective clothing have been posted in conspicuous locations around the plant including near the bins where radiation workers pick up protective clothing.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Full compliance was achieved on October 11, 1996, when the hoses were properly secured as required by LRP-1490-1.