Commonwealth Edison
One First National Plaza, Chicago, Illinois
Address Reply to: Post Office Box 767
Chicago, Illinois 60690 - 0767

LCO

January 8, 1988

Mr. A. Bert Davis
Regional Administrator
U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

Subject: LaSalle County Station Units 1 and 2
Response to Inspection Report Nos.
50-373/87-033 and 50-374/87-032
NRC Docket Nos. 50-373 and 50-374

Reference (a):

Dear Mr. Davis:

This letter is in response to the inspection conducted by Messrs. M. Jordan and R. Koprivo on November 3 through 30, 1987, of certain activities at LaSalle County Station. Reference (a) indicated that certain activities appeared to be in noncompliance with NRC requirements. The Commonwealth Edison Company response to the Notice of Violation is provided in the Attachment.

If you have any further questions on this matter, please direct them to this office.

Very truly yours,

L. D. Butterfield
Nuclear Licensing Manager

cs

Attachment

cc: NRC Resident Inspector - LSCS

IE01
1/1

4083K

JAN 12 1988

ATTACHMENT

VIOLATION: IR 373/87-033-01
IR 374/87-032-01

Technical Specification 6.2.A states, in part, "Detailed written procedures including applicable checkoff lists covering items listed below shall be prepared, approved, and adhered to:

The applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978."

Appendix A of Regulatory Guide 1.33 includes administrative procedures for equipment control.

LAP-900-4, "Equipment Out Of Service (OOS) Procedure," step F.1.g states, in part, "The 'Supervisor in Charge of the Work' has the responsibility to assure that an inspection has been made to see that out of service cards have been placed correctly and that the equipment is safe to work on."

LAP-900-4, "Equipment Out of Service Procedure," step F.2.a states, in part, "To clear an outage the 'Supervisor in Charge of the Work' for whom the out of service cards were placed, shall be responsible for having an inspection made to assure that the equipment is cleared of his personnel, obstructions, and all personnel protection cards."

LAP-900-12, "Caution Card Procedure," step F.4.a states, in part, "When the person requesting the caution card determines the card is no longer required, the requestor or his/her designate shall remove the card and deliver it to the shift engineer or the appropriate shift foreman..."

Contrary to the above, on October 6, 1987, procedure LAP-900-4, "Equipment Out of Service," and LAP-900-12, "Caution Card Procedure," were not adhered to by personnel performing work in the spent resin tank room such that:

1. The contractor foreman (supervisor in charge) did not perform an inspection to see if out of service cards had been placed correctly and that equipment was ready to work on, resulting in personnel working on a spent resin pump which was not out of service.

2. The radwaste foreman (supervisor in charge) temporarily lifted (cleared) out of service cards without having performed an inspection of the work site to assure that the suction and discharge valve on the spent resin pump were cleared of personnel and obstructions to prevent proper operation. If the foreman had performed the inspection, he would have noticed that the piping system was open and not connected to the pump such that starting the spent resin pump would cause a spill.

3. The person requesting the caution card or his/her designee did not remove the caution card on the manually operated valve upstream of the air operated valves for the spent resin pump. Because the caution card was in place, the station construction engineer and radwaste foreman both believed the manual valve was closed, therefore, assuring themselves that no resins would be spilled. The valve which had been closed on August 24, 1987, was not open, allowing spent resin beads to flow to the pump and onto the spent resin tank room floor.

   The results of these failures to adhere to procedures resulted in approximately 100 cubic feet of spent resin beads being pumped onto the floor of the spent resin tank room.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED FOR ITEM #1

1. An investigative meeting was held with all personnel involved with the event on October 7, 1987.

2. The spent resin pump room was cleared of spent resins and brought back to the status prior to the event on October 9, 1987.

CORRECTIVE ACTION TAKEN TO AVOID FURTHER VIOLATION FOR ITEM #1

1. On October 12, 1987, a new out of service board was installed in the contractors' office to track all existing OOS cards that have been temporarily lifted.

2. All LaSalle Projects and Construction Services Department (P&CSD) Field Engineers and contractor supervisory personnel were trained on proper communication and repeat backs on October 9, 1987.

3. All LaSalle P&CSD Field Engineers and contractor supervisors personnel were retrained on LAP-900-4 (Equipment Out of Service) procedure on October 22, 1987.

4. All contractor supervision were instructed to always check the Master OOS board prior to sending crews to work on a system that is OOS to verify no temporary lifts are in effect. This was completed on October 9, 1987.

DATE OF FULL COMPLIANCE

Full compliance has been achieved.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED FOR ITEM #2

1. On October 7, 1987, an investigative meeting was held with the operating personnel involved with the event.

2. A Potentially Significant Event (PSE) Report was written on the event and distributed to the shift on October 9, 1987. This material was covered in preshift briefings.

CORRECTIVE ACTION TAKEN TO AVOID FURTHER VIOLATION FOR ITEM #2

1. On December 29, 1987, the PSE report was sent to the shift for documented review sessions. All operating shift personnel, with the exception of one crew, held a tailgate training meeting on the proper way to take an air-operated valve out of service. The one remaining crew is away at the Production Training Center and is scheduled for the review upon their return to the station on January 13, 1988.

2. LAP-900-4, the out of service procedure, is being revised to add the requirements for taking air-operated valves OOS, and giving direction on how it should be done. The procedure is in the review chain at this time and is expected to be in the books by February 15, 1988. We are also considering changing the procedure to more clearly define the operator's responsibility on clearing or temporarily lifting an OOS. This will go into the procedure that is now in the review chain. On January 6, 1988, a clarification of the requirements in LAP-900-4 for clearing or "temporary lifting" an outage was put into the Daily Orders as an interim measure.

DATE OF FULL COMPLIANCE

Full compliance has been achieved. Operating Department will complete the tailgate training on temporary lifting and clearing of an out of service by January 13, 1988. The out of service procedure, LAP-900-4 will be in the books by February 15, 1988.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED FOR ITEM #3

1. On October 7, 1987, an investigative meeting was held with the operating personnel involved with the event.

2. The incorrect caution card has been removed.

3. A Potentially Significant Event Report was written on the event and distributed to the shift on October 9, 1987. This material was covered in preshift briefings.

CORRECTIVE ACTION TAKEN TO AVOID FURTHER VIOLATION FOR ITEM #3

1. Efforts have been in progress since November 1987 to check caution cards in the plant and to audit the Caution Card Log for accuracy. The daily Orders on November 5, 1987 instructed the operators on how to maintain accurate caution card logs. The necessity for insuring that caution cards are cleared in a reasonable time was reemphasized. Spot checks have been made by the operating engineer since then and have identified no major problems in this area.

DATE OF FULL COMPLIANCE

Full compliance has been achieved.