January 27, 2006

EA-06-022

Mr. Christopher M. Crane
President and Chief Nuclear Officer
Exelon Nuclear
Exelon Generation Company, LLC
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: LASALLE COUNTY STATION, UNIT 2 - NRC INTEGRATED INSPECTION REPORT NO. 05000374/2005002 AND NRC OFFICE OF INVESTIGATIONS REPORT NO. 3-2005-007

Dear Mr. Crane:

This refers to a U.S. Nuclear Regulatory Commission (NRC) occupational radiation safety inspection conducted in February 2005 and an NRC Office of Investigations (OI) investigation of an event involving an apparent violation of the Technical Specifications on February 13, 2005, at LaSalle County Station, Unit 2. The purpose of the OI investigation was to determine if a contractor pipefitter foreman and two contractor pipefitters willfully entered a posted high radiation area (HRA) without receiving the required HRA briefing. The OI investigation was completed on October 27, 2005, and based on the information developed during the investigation, the OI substantiated the issue. The enclosed Summary of Investigation summarizes the results of the investigation. Additionally, we consider the foreman as a licensee official in accordance with Section IV.A.4 of the Enforcement Policy.

Based on the results of the inspection and investigation, one apparent violation was identified and is being considered for escalated enforcement action in accordance with the Enforcement Policy. The current Enforcement Policy is included on the NRC's Web site at www.nrc.gov; select **What We Do**, **Enforcement**, then **Enforcement Policy**.

On February 13, 2005, a contractor pipefitter foreman and two contractor pipefitters entered a posted HRA in the Unit 2 condenser pit to conduct repairs to a sprinkler head and did not sign the required HRA radiation work permit (RWP) or receive the radiation protection technician (RPT)-provided HRA briefing required for work in a HRA. The HRA was properly posted and barricaded with a fence gate and with a swing gate to preclude inadvertent entry. A licensee contractor RPT identified the contractor pipefitter foreman and pipefitters inappropriate entry into the HRA. The contractor pipefitter foreman and pipefitters actions were an apparent violation of Technical Specification 5.4.1.a and Exelon Procedure RP-AA-460, Revision 4.

The NRC became aware of the event during the occupational radiation safety inspection. The circumstances surrounding this apparent violation, the significance of the issues, and the need for lasting and effective corrective actions were discussed with members of your staff at the preliminary exit meeting on February 18, 2005. Additionally, your root cause investigation report, associated corrective actions, and other pertinent documents were obtained during the OI investigation. As a result, we have concluded that neither a written response nor a pre-decisional enforcement conference are necessary to enable the NRC to make an enforcement decision.

In addition, because you identified the violation and based on our understanding of your corrective actions, a civil penalty may not be warranted in accordance with Section VI.C.2 of the Enforcement Policy. However, before the NRC makes its enforcement decision, we are providing you an opportunity to either: (1) respond to the apparent violation within 30 days of the date of this letter or (2) request a pre-decisional enforcement conference. If a conference is held, it will be transcribed and closed to public observation because it involves the findings of an NRC OI report which has not been publicly disclosed. Please contact Steven Orth, Health Physics Program Manager, at (630)829-9827, within 7 days of the date of this letter to notify us of your decision.

If you choose to provide a written response, it should be clearly marked as a "Response to an Apparent Violation, EA-06-022" and should include: (1) the reason for the apparent violation or, if contested, the basis for disputing the apparent violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken to avoid further violations; and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response.

In addition, please be advised that the number and characterization of the apparent violation described may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

As an alternative to a written response or pre-decisional enforcement conference, the NRC would normally offer you the opportunity to request alternate dispute resolution (ADR) with the NRC as a part of our pilot program for resolving issues involving apparent willful violations. However, the topic of unauthorized HRA entries was recently the subject of a successful ADR mediation between the NRC and Exelon Nuclear for a previous violation (reference LaSalle EA-04-170). *(NOTE: This ADR mediation took place after the occurrence of the current violation (EA-06-022)).* Therefore, after consultation with the Director, Office of Enforcement, the NRC believes we have each had ample opportunity to share our views and interests on this issue and that further use of ADR is unnecessary. If you have any additional information or views contrary to the above, we would consider your request for ADR.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if you choose to provide one) will be made available electronically for public inspection in the NRC Public Document Room or from the

NRC's document system (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

Sincerely,

/RA by Anne T. Boland Acting for/

Cynthia D. Pederson, Director
Division of Reactor Safety

Docket No. 50-374
License No. NPF-18

Enclosure: Investigation Summary

cc w/encl: Site Vice President - LaSalle County Station
LaSalle County Station Plant Manager
Regulatory Assurance Manager - LaSalle County Station
Chief Operating Officer
Senior Vice President - Nuclear Services
Senior Vice President - Mid-West Regional Operating Group
Vice President - Mid-West Operations Support
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Summary of Investigation

The investigation was initiated by the U.S. Nuclear Regulatory Commission, Office of Investigations (OI), Region III, on March 8, 2005, to determine if a contractor pipefitter foreman and two pipefitters at the LaSalle County Station Unit 2 willfully entered a posted high radiation area (HRA) without the required HRA briefing. Through interviews and reviews of procedures, radiation work permits (RWP), training records, and other licensee documentation of the circumstances surrounding the event, the investigation revealed the following.

On February 13, 2005, a contractor pipefitter foreman and two contractor pipefitters entered a posted HRA in the Unit 2 condenser pit to conduct repairs to a sprinkler head and did not sign the required HRA RWP or receive the required briefing by radiation protection technicians (RPT) for work in a HRA. The HRA was properly posted and barricaded with a fence gate and with a swing gate to preclude inadvertent entry. A licensee contractor RPT identified the apparent inappropriate actions by the contractor pipefitter foreman and contractor pipefitters. The inappropriate entries into the HRA were an apparent violation of Technical Specification 5.4.1.a and Exelon Procedure RP-AA-460, Revision 4.

The pipefitters were signed onto RWP 1004122 which does not allow entry into HRAs. The licensee's root cause investigation report identified two root causes for the event: (1) communications between the work group and access control point personnel were unclear and led to a misunderstanding of the work location, and (2) contrary to known rules, the individuals believed permission had been granted to proceed to the work area regardless of radiological postings.

The licensee provided training at the beginning of the outage which included radiological access issues. All three individuals were noted as having attended the training and OI obtained copies of the sign-in registers which documented their attendance. During their interviews, all three individuals acknowledged being in attendance at the training. The training included a scenario similar to what happened in this event.

The preparation and documentation of the work order package was relevant to the event. The radiological condition of the Unit 2 condenser pit changed because a valve in the system did not operate as expected and water went to the condenser without being routed through filters. As this area was expected to be a low radiological area, a low radiation RWP had been assigned to the work order package. The change in radiological conditions was noted by the contractor superintendent during his walkdown of the area. He communicated the need for an HRA RWP to the night superintendent. The night superintendent communicated the need for the workers to receive a HRA briefing through a note on the work order package. None of these individuals identified the package as having an inappropriate RWP.

During the brief of the pipefitters at the first radiation protection control desk, the RPT advised that he was not familiar with the work area where the pipefitters were going. The RPT disavowed any responsibility to assign RWPs to work orders, provided a briefing for the RWP that was assigned to the work order, and referred the workers to a control desk closer to the work area. The pipefitter foreman asserted that he voiced the need for a high radiation briefing at this control desk.

At the second control desk, the pipefitters encountered two RPTs. All involved parties agreed that the workers did not receive an HRA briefing. The disconnect between the involved parties occurred because of a misunderstanding as to where the pipefitters were going to work. The RPTs did not review the most current survey maps to ensure a clear understanding of the location and radiological conditions of the proposed work area. The pipefitters left with the understanding they were authorized to do the work. Based on the facts developed, it would appear that all parties involved in this briefing were, in part, responsible for the misunderstanding.

The pipefitters entered the work area past high radiation postings. The pipefitter foreman was the first to pass through the barriers and denied that there were any postings present. The second pipefitter to pass through the barriers stated that he observed the high radiation posting on the swing gate. The third pipefitter to pass through the barriers stated that he did not observe any postings. The contractor superintendent and radiation protection contractor field supervisor both asserted that they were in the work area within several hours of the event and observed the high radiation postings. The licensee's root cause investigation noted that the postings were placed on February 8, 2005 – a few days before the event on February 13, 2005.

There were a series of events prior to the entry into the work area that contributed to the pipefitters being at the entry point of the work area and at risk of violating known radiation protection protocol. However, it was not until the three pipefitters passed through the barriers that a violation occurred. As the pipefitters passed through the barriers, only they were responsible for that act. The photographs of the barriers and postings and testimony of individuals confirm that the postings were present.

Based on the evidence developed, the investigation substantiated that a contractor pipefitter foreman and two pipefitters at the LaSalle County Station, Unit 2 willfully entered an HRA without the required HRA briefing.