January 11, 2002

Mr. Oliver D. Kingsley, President
Exelon Nuclear
Exelon Generation Company, LLC
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: LASALLE COUNTY STATION
NRC INSPECTION REPORT 50-373/01-13(DRP); 50-374/01-13(DRP)

Dear Mr. Kingsley:

On December 29, 2001, the NRC completed an inspection at your LaSalle County Station. The enclosed report presents the results of that inspection. The results of this inspection were discussed on December 31, 2001, with Mr. C. Pardee and other members of your staff.

The inspection was an examination by the resident inspectors of activities conducted under your license as they relate to reactor safety and to compliance with the Commission's rules and regulations and with the conditions of your license. Within these areas, the inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of this inspection, the inspectors identified one issue of very low safety significance (Green) that was determined to involve a violation of NRC requirements. However, because of its very low safety significance and because it was entered into your corrective action program, the NRC is treating this issue as a Non-Cited Violation in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this Non-Cited Violation, you should provide a response with a basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at LaSalle County Station.

The inspectors also identified one finding of very low safety significance (Green) which did not involve a violation of NRC requirements.

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Sincerely,

/RA/

Bruce L. Burgess, Chief
Branch 2
Division of Reactor Projects

Docket Nos. 50-373; 50-374
License Nos. NPF-11; NPF-18

Enclosure: Inspection Report 50-373/01-13(DRP);
50-374/01-13(DRP)

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REGION III

Docket Nos:	50-373, 50-374
License Nos:	NPF-11, NPF-18
Report Nos:	50-373/01-13(DRP); 50-374/01-13(DRP)
Licensee:	Exelon Generation Company
Facility:	LaSalle County Station, Units 1 and 2
Location:	2601 N. 21st Road Marseilles, IL 61341
Dates:	November 18 through December 29, 2001
Inspectors:	E. Duncan, Senior Resident Inspector G. Wilson, Resident Inspector H. Peterson, Senior Operations Engineer J. Yesinowski, Illinois Department of Nuclear Safety
Approved by:	Bruce L. Burgess, Chief Branch 2 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000373-01-13(DRP), IR 05000374-01-13(DRP), on 11/18-12/29/2001; Exelon, LaSalle County Station, Units 1 & 2; Licensed Operator Requalification; Identification and Resolution of Problems.

This report covers a 6-week routine resident inspection. The inspection was conducted by the resident inspectors. Two Green findings were identified. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609 "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html. Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation.

A. Inspector Identified Findings

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

- Green. The inspectors identified that two of nine crews examined during the licensee's calender year 2001 licensed operator re-qualification operating test had failed.

  The finding was of very low safety significance because both crews that had failed received remedial training prior to being returned to shift and the results of the licensee's operator licensing re-qualification operating test given in calender year 2000 indicated that only one crew, out of a total of eight crews tested, had failed. (Section 1R11)

- Green. Licensee personnel failed to adequately control a high radiation area door which provided access into a high-high radiation area with radiation levels greater than 1000 mrem per hour. One Non-Cited Violation of Technical Specification 5.7.4 was identified.

  The finding was of very low safety significance since there was not an actual overexposure or substantial potential for an overexposure, and the ability to assess dose was not compromised. (Section 4OA2.1)

B. Licensee Identified Violations

No violations of significance were identified.

Report Details

Summary of Plant Status: Both units operated at or near full power for the entire inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R04 Equipment Alignment (71111.04)

a. Inspection Scope

On November 21, 2001, the inspectors performed a walkdown of accessible portions of the Unit 2 Reactor Core Isolation Cooling (RCIC) system to verify system operability during maintenance activities associated with the Unit 2 High Pressure Core Spray (HPCS) system.

On December 3, 2001, the inspectors performed a walkdown of accessible portions of the Unit 1 HPCS system and 1B Emergency Diesel Generator (EDG) to verify system operability during maintenance activities associated with the Unit 1 RCIC system.

On December 3, 2001, the inspectors performed a walkdown of accessible portions of the Unit 0 and 1A EDGs to verify system operability during maintenance activities associated with the 2A EDG Ventilation system which rendered the 2A EDG inoperable and unavailable.

The inspectors reviewed documentation to determine correct system lineup. These documents included plant procedures, such as abnormal and emergency operating procedures, as well as plant drawings. The inspectors verified critical portions of the redundant or backup system and identified any discrepancies between the existing equipment lineup and the correct lineup.

b. Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05)

a. Inspection Scope

The inspectors walked down the following risk significant areas to identify any fire protection degradations:

- Fire Zone 8C2 - Unit 2 Division 2 Diesel Fuel Tank Room
- Fire Zone 8C3 - Unit 2 HPCS Diesel Pump Room

- Fire Zone 8C4 - Unit 2 Division 2 Residual Heat Removal Service Water (RHRSW) Pump Room
- Fire Zone 8C5 - Unit 2 Division 1 RHRSW Pump Room

Emphasis was placed on control of transient combustibles and ignition sources; the material condition, operational lineup, and operational effectiveness of the fire protection systems, equipment, and features; and the material condition and operational status of fire barriers used to prevent fire damage or fire propagation.

In particular, the inspectors verified that all observed transient combustibles were being controlled in accordance with the licensee's administrative control procedures. In addition, the inspectors observed the physical condition of fire detection devices, such as overhead sprinklers, and verified that any observed deficiencies did not impact the operational effectiveness of the system. The physical condition of portable fire fighting equipment, such as portable fire extinguishers, was observed. The inspectors also observed that extinguishers were located appropriately and that access to the extinguishers was unobstructed. Fire hoses were verified to be installed at their designated locations and the physical condition of the hoses was verified to be satisfactory and access unobstructed. The physical condition of passive fire protection features such as fire doors, ventilation system fire dampers, fire barriers, fire zone penetration seals, and fire retardant structural steel coatings was inspected and verified to be properly installed and in good physical condition.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification (71111.11)

.7 Written Examination and Operating Test Results

a. Inspection Scope

The inspectors reviewed the results of individual written tests, operating tests, and simulator operating tests (required to be given per 10 CFR 55.59(a)(2)) administered by the licensee during calender year 2001.

b. Findings

Green. Licensee evaluators had determined that the performance of two crews on the simulator operating test was unsatisfactory. The failure of two crews out of a total of nine crews tested during the annual simulator operating test was determined to be of "Green" safety significance.

The inspectors determined that the licensed operator performance (as demonstrated by a 22 percent crew failure rate on the simulator operating test) was more than minor, in that it had a credible impact on safety. Specifically, operator performance errors could negatively impact the initiating events, mitigating systems, and barrier integrity cornerstones of Reactor Safety. The inspectors performed a Phase 2 Significance

Determination Process analysis, in accordance with NRC Inspection Manual Chapter (IMC) 0609, Appendix I, "Operator Requalification Human Performance Significance Determination Process (SDP)," and classified the finding as "Green" and of very low safety significance. Factors and assumptions which primarily contributed to this classification included:

- Both crews that had failed received remedial training prior to being returned to shift; and

- The inspectors reviewed the results of the licensee's operator licensing re-qualification operating test given in calender year 2000 and determined that only one crew, out of a total of eight crews tested, had failed.

The licensee documented the 2001 crew failures and corrective actions taken in Condition Report (CR) 00086362.

1R12 Maintenance Rule Implementation (71111.12)

a. Inspection Scope

The inspectors reviewed the licensee's implementation of the maintenance rule requirements, including a review of scoping, goal-setting, and performance monitoring, short-term and long-term corrective actions, and current equipment performance status. The systems selected for inspection were all classified as risk significant by the licensee's maintenance rule program. The systems evaluated were:

- Process Radiation Monitoring
- Station Air

The inspectors independently verified the licensee's implementation of maintenance rule requirements for these systems by verifying that these systems were properly scoped within the maintenance rule; that all failed structures, systems, or components (SSCs) were properly categorized and classified as (a)(1) or (a)(2); that performance criteria for SSCs classified as (a)(2) were appropriate; and that the goals and corrective actions for SSCs classified as (a)(1) were appropriate. The inspectors also verified that issues were identified at an appropriate threshold and entered in the corrective action program.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation (71111.13)

a. Inspection Scope

The inspectors reviewed the licensee's evaluation of plant risk, scheduling, configuration control, and performance of maintenance associated with planned and emergent work activities and verified that scheduled and emergent work activities were adequately managed. In particular, the inspectors reviewed the licensee's program for conducting

maintenance risk safety assessments and verified that the licensee's planning, risk management tools, and the assessment and management of online risk was adequate. The inspectors also verified that licensee actions to address increased online risk during these periods, such as establishing compensatory actions, minimizing the duration of the activity, obtaining appropriate management approval, and informing appropriate plant staff, were accomplished when online risk was increased due to maintenance on risk-significant SSCs. The following work was reviewed:

- The inspectors reviewed the maintenance risk assessment for work performed during the week of November 19, 2001.
- The inspectors reviewed the maintenance risk assessment for work performed during the week of November 26, 2001.
- The inspectors reviewed the maintenance risk assessment for work performed during the week of December 2, 2001.

b. Findings

No findings of significance were identified.

1R14 Non-Routine Evolutions (71111.14)

(Closed) Unresolved Item (URI) 50-373/01007-02(DRP);50-374/01007-02(DRP)

As discussed in NRC Inspection Report 50-373/01-07;50-374/01-07, the inspectors identified that in accordance with Technical Specification 4.6.1.7, a single temperature point was relied upon to be representative of average drywell temperature to meet the requirements of Technical Specification 3.6.1.7. The inspectors requested design basis documents to justify measuring a single temperature point at the inlet of the operating drywell cooler as described in Technical Specification 4.6.1.7 for bulk average drywell temperature. Licensee personnel were unable to locate the requested documentation and, as a result, Condition Report L2001-01982 was generated to identify this issue.

Unresolved Item 50-373/01007-02(DRP);50-374/01007-02(DRP) was generated pending a determination of whether design basis documents to justify measuring a single temperature point at the inlet of the operating drywell cooler as described in Technical Specification 4.6.1.7 for bulk average drywell temperature was required.

The inspectors were unable to identify a legal requirement to have design basis documents to justify the methodology employed. This Unresolved Item is closed.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed selected Operability Evaluations (OEs) of degraded and non-conforming conditions affecting mitigating systems and barrier integrity to ensure that operability was properly justified and the component or system remained available,

such that no unrecognized increase in risk had occurred. The following evaluations were reviewed:

- OE 01-16: Unit 1 "A" Master Trip Solenoid Valve
- OE 01-17: HPCS Static-O-Ring Switches

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds (71111.16)

a. Inspection Scope

The inspectors reviewed operator challenges (OCs) to identify any potentially adverse impact on the function of mitigating systems or the ability to implement an abnormal or emergency operating procedure. The following items were reviewed:

- OC 328/329: Spent Fuel Pool Cleanup Air-Operated Valve Sticking
- OC 330/331: Reheater Drain Tank Level Switch Failure
- OC 333: Standby Gas Treatment System Wide Range Gas Monitor Voltage Regulator Transformer Trips

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors reviewed and observed the following post-maintenance testing activity work order (WO) involving risk significant equipment:

- WO 00361644-03 2A Turbine-Driven Reactor Feedwater Pump Servo

During post-maintenance testing observations, the inspectors verified that the test was adequate for the scope of the maintenance work which had been performed, and that the testing acceptance criteria was clear and demonstrated operational readiness consistent with the design and licensing basis documents. The inspectors also verified that the impact of the testing had been properly characterized during the pre-job briefing; the test was performed as written and all testing prerequisites were satisfied; and that the test data was complete, appropriately verified, and met the requirements of the testing procedure. Following the completion of the test, the inspectors verified that the test equipment was removed, and that the equipment was returned to a condition in which it could perform its safety function.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed surveillance testing on risk-significant equipment and verified that the SSCs selected were capable of performing their intended safety function and that the surveillance tests satisfied the requirements contained in Technical Specifications, the Updated Final Safety Analysis Report (UFSAR), and licensee procedures. During surveillance testing observations, the inspectors verified that the test was adequate to demonstrate operational readiness consistent with design and licensing basis documents, and that the testing acceptance criteria was clear. The inspectors also verified that the impact of the testing had been properly characterized during the pre-job briefing; the test was performed as written and all testing prerequisites were satisfied; the test data was complete, appropriately verified, and met the requirements of the testing procedure; and that the test equipment range and accuracy was consistent with the application, and the calibration was current. Following the completion of the test, the inspectors verified that the test equipment was removed, and that the equipment was returned to a condition in which it could perform its safety function.

The following surveillance testing activity was observed:

- LaSalle Operating Surveillance (LOS) SC-Q1, Attachment 2A, "SBLC [Standby Liquid Control] Pump and Motor-Operated Valve Operability/Inservice Test and Explosive Valve Continuity Check"

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors reviewed Temporary Modification 333593 which replaced the existing Static O-Ring (SOR) double pole double throw (DPDT) switch used in 1E22-N006, the Unit 1 High Pressure Core Spray (HPCS) pump flow switch, with an SOR single pole double throw (SPDT) switch. This temporary modification was installed since the dead band history of the DPDT switch required a weekly calibration. The dead band history of the SPDT switch allowed a calibration frequency of 2 months. The primary contacts of the existing switch controlled the minimum flow bypass to the HPCS suppression pool minimum flow valve 1E22-F012. The secondary contacts of the existing switch provided an alarm function in the main control room to alert the operator to a high flow condition expected during operation of the system. Utilizing the SPDT switch required disabling the alarm function.

The inspectors reviewed the associated 10 CFR 50.59 safety evaluation against the system design basis documentation, including the UFSAR and Technical Specifications. In particular, the inspectors verified that the alarm function, which was disabled as part of the temporary modification activity, was not required by the plant licensing or design basis. The inspectors also conducted a walkdown of the temporary modification which was installed in accordance with WO 00373568, and compared the installed configuration against the configuration prescribed in design drawings.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA2 Identification and Resolution of Problems

.1 Inadequate Corrective Actions To Address Locked High Radiation Area Door Concern

a. Inspection Scope

The inspectors reviewed the circumstances surrounding the identification that high radiation area door #208, which provided an entrance to a high-high radiation area associated with the Unit 1 High Pressure Turbine area, was unlocked and ajar without positive controls established for individual access as required.

b. Findings

One Green finding and an associated Non-Cited Violation of Technical Specification 5.7.4 was identified due to the failure to adequately control high radiation area door #208 which provided an entrance to a high-high radiation area.

Description of Issue

On November 1, 2001, an Instrument Maintenance Department technician noticed that high radiation area door #208, which provided an entrance to a high-high radiation area associated with the Unit 1 High Pressure Turbine area, was slightly open. Radiation levels in accessible areas of the high pressure turbine at the time exceeded 1000 mrem per hour. Radiation Protection personnel verified that the door was ajar, immediately closed the door, and verified that it was locked and secured. A review of key logs, shift logs, and electronic dosimetry reports since the door was last verified to be properly secured by radiation protection staff on October 31, 2001, did not identify any indications of an entry into the area. The licensee reviewed the circumstances surrounding this issue and identified that the most likely cause was a spurious door strike signal since no other reasonable potential cause could be identified. The licensee determined that although the primary power supply to the card reader had been previously removed, disabling the reader's function, other power inputs into the card reader still existed, which allowed a spurious door strike signal to unlock the door.

Inspector Review

The inspectors reviewed previous instances in which a high radiation area door which was required to be locked was found open and identified that CR L2000-03555 described a similar event in which high radiation area door #562, which provided an entrance into the Unit 2 Offgas Charcoal Bed Vault, was identified as unlocked due to a spurious door strike signal. The inspectors reviewed the corrective actions for this issue which included the installation of a separate lock and chain on all potentially affected doors. The doors considered to be within the scope of this corrective action were only those doors with a similar type of card reader, and had discounted door #208 since the primary power input had been removed. The inspectors concluded that since door #208 was not identified as potentially impacted because the card reader function had been disabled, that the licensee's corrective actions for this previous event were inadequate since it did not also ensure that all power to all door strike mechanisms, including door #208, had been completely removed.

Significance Evaluation

The inspectors reviewed this issue against the guidance contained in Appendix B, "Thresholds of Documentation," of IMC 0610*, "Power Reactor Inspection Reports." In accordance with the Group 1 questions, the inspectors determined that the issue could be reasonably viewed as a precursor to a significant event since the potential existed for unauthorized access to an unsecured high radiation area with radiation levels up to 1400 mrem per hour (a high-high radiation area). As a result, the inspectors reviewed this issue against the Group 2 questions and determined that since the issue involved the potential for an unplanned, unintended dose resulting from conditions which were contrary to Technical Specification 5.7.4, which required that high-high radiation areas not equipped with computerized card readers be locked, that the issue warranted further review in accordance with Appendix C, "Occupational Radiation Safety Significance Determination Process," of IMC 0609, "Significance Determination Process" (SDP). The inspectors determined that since no unauthorized entry into the inadequately secured high radiation area occurred, a substantial potential for an overexposure did not exist based on area radiological conditions, and that the ability to assess dose was not compromised, that the finding screened out as Green.

The licensee concluded that the event represented a high radiation area occurrence under the occupational exposure control effectiveness performance indicator. The licensee planned to report the occurrence in its fourth quarter 2001 performance indicator submittal to the NRC.

Enforcement Actions

Technical Specification 5.7.4 requires that high-high radiation areas not equipped with computerized card readers shall be locked except when access to the area is required with positive control over each individual entry. The failure to adequately control high radiation area door #208 which provided an entrance to a high-high radiation area associated with the Unit 1 High Pressure Turbine area was an example where the requirements of Technical Specification 5.7.4 were not met and was a violation. However, because of the very low safety-significance of the item and

because the licensee has included this item in their corrective action program (Condition Report L2001-06182), this violation is being treated as a Non-Cited Violation (50-373/2001013-01;50-374/2001013-01).

4OA6 Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. C. Pardee and other members of licensee management on December 31, 2001. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

KEY POINTS OF CONTACT

Exelon

D. Czufin, Site Engineering Manager
D. Enright, Operations Manager
C. Pardee, Site Vice President
J. Henry, System Engineering Manager
W. Riffer, Regulatory Assurance Manager
C. Wilson, Station Security Manager

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-373/374/2001013-01	NCV	Unlocked High-High Radiation Area Door

Closed

50-373/374/2001013-01	NCV	Unlocked High-High Radiation Area Door
50-373/01007-02;50-374/01007-02	URI	Containment Temperature Monitoring

Discussed

None

LIST OF ACRONYMS USED

CR	Condition Report
DPDT	Double Pole Double Throw
DRP	Division of Reactor Projects
EDG	Emergency Diesel Generator
HPCS	High Pressure Core Spray
IMC	Inspection Manual Chapter
LOS	LaSalle Operating Surveillance
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
OC	Operator Challenge
OE	Operability Evaluation
RCIC	Reactor Core Isolation Cooling
RHRSW	Residual Heat Removal Service Water
SBLC	Standby Liquid Control
SDP	Significance Determination Process
SPDT	Single Pole Double Throw
SSC	Structure, System, or Component
UFSAR	Updated Final Safety Analysis Report
URI	Unresolved Item
WO	Work Order

LIST OF DOCUMENTS REVIEWED

1R05: Fire Protection

Appendix H LaSalle Updated Final Safety Analysis Report

1R11: Licensed Operator Requalification

CR 00086362 2001 Licensed Operator NRC Exam Results

1R12: Maintenance Rule

Radiation Monitoring and Station Air Systems Functional Failure and Availability Data Sheets

1R13: Maintenance Risk Assessment and Emergent Work Evaluation

LaSalle 7-Day Look-Ahead Schedules (Various)

1R15: Operability Evaluations (OEs)

OE 01-16 Unit 1 "A" Master Trip Solenoid Valve
OE 01-17 HPCS Static-O-Ring Switches

1R16: Operator Workarounds

OC 333 Description Document - Standby Gas Treatment System Wide Range Gas Monitor Voltage Regulator Transformer Trips

OC 328/329 Description Document - Spent Fuel Pool Cleanup Air-Operated Valve Sticking

OC 330/331 Description Document - Reheater Drain Tank Level Switch Failure

1R19: Post-Maintenance Testing

WO 00361644-03 2A Turbine-Driven Reactor Feedwater Pump Servo

1R22: Surveillance Testing

LOS-SC-Q1, Attachment 2A SBLC Pump and Motor-Operated Valve Operability/Inservice Test and Explosive Valve Continuity Check

1R23: Temporary Plant Modifications

Temporary Modification 333593 Replace Existing Static O-Ring Double Pole Double Throw Switch Used In HPCS Flow Switch 1E22-N006 With A Single Pole Double Throw Switch.

LIST OF DOCUMENTS REVIEWED (con't)

1R23: Temporary Plant Modifications (con't)

Work Order 00373568	Install Single Pole Double Throw HPCS Flow Switch

4OA2: Identification and Resolution of Problems

CR L2000-03555	Locked High Radiation Area Door Opening From Spurious Strikes From Abandoned Card Reader; June 30, 2000.
CR L2001-06182	Locked High Radiation Area Door #208 Found Open; November 1, 2001