

June 12, 2001

Mr. Oliver D. Kingsley, President
Exelon Nuclear
Exelon Generation Company, LLC
1400 Opus Place, Suite 500
Downers Grove, IL 60515

SUBJECT: LASALLE COUNTY STATION
NRC INSPECTION REPORT 50-373/01-07(DRP); 50-374/01-07(DRP)

Dear Mr. Kingsley:

On May 19, 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 May 18, 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 (No Color) 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 U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001, with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at LaSalle County Station.

O. Kingsley

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Sincerely,

/RA/

Kenneth Riemer, Acting Chief
Branch 2
Division of Reactor Projects

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

Enclosure: Inspection Report 50-373/01-07(DRP);
50-374/01-07(DRP)

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

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

Report No: 50-373/01-07(DRP); 50-374/01-07(DRP)

Licensee: Exelon Generation Company

Facility: LaSalle County Station, Units 1 and 2

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

Dates: April 1 through May 19, 2001

Inspectors: E. Duncan, Senior Resident Inspector
G. Wilson, Resident Inspector
W. Slawinski, Senior Radiation Specialist
J. Yesinowski, Illinois Department of Nuclear Safety

Observer: R. Alexander, Radiation Specialist

Approved by: Kenneth Riemer, Acting Chief
Branch 2
Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000373-01-07, IR 05000374-01-07, on 04/01-05/18/2001, Exelon, LaSalle County Station, Units 1 & 2, Operability Evaluations.

This report covers a routine resident inspection and a baseline radioactive effluent inspection. The inspections were conducted by resident and specialist inspectors. One "No Color" finding was identified which was the subject of a Non-Cited Violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using 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

No Color. The inspectors identified a Non-Cited Violation for the failure of operators to recognize that the Unit 1 and Unit 2 containment air particulate and gaseous radiation monitors, 1(2)PL15J and 1(2)PL75J, were inoperable when they were isolated from containment and therefore unable to sample the containment atmosphere.

The finding was of very low safety significance since the periods during which the monitors were inoperable was of a relatively short duration and other diverse means were available to identify an increase in reactor coolant system leakage (Section 1R15).

B. Licensee Identified Violations

Violations of very low significance which were identified by the licensee have been reviewed by the inspector. Corrective actions taken or planned by the licensee appear reasonable. These violations are listed in Section 4OA7 of this report.

Report Details

Summary of Plant Status: Both units operated at or near full power until April 6, 2001, when Unit 2 experienced an automatic shutdown due to a blown fuse associated with the feedwater control system. The issue was resolved and the unit was restarted and synchronized to the grid on April 8. Both units operated at power for the remainder of the inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R01 Adverse Weather Protection (71111.01)

a. Inspection Scope

The inspectors verified that the design features and licensee procedures protecting systems from the effects of hot weather and high winds were adequate. The inspectors reviewed the Updated Final Safety Analysis Report (UFSAR) and other documentation and verified that the plant was adequately protected from the effects of hot weather and high winds. The inspectors reviewed LaSalle Abnormal Operating Procedures (LOA) TORN-001, "High Winds/Tornado," Revision 2, and LOA-DIKE-001, "Lake Dike Damage/Failure," Revision 1, and verified that prescribed operator actions were appropriate to maintain readiness of essential systems to the maximum extent practicable.

The inspectors reviewed the LaSalle Summer 2001 Readiness Plan and verified that the plan assessed potential items that could affect unit operation during the summer. The inspectors verified that scheduled critical maintenance associated with the switchyard was completed and that non-critical maintenance which was not completed was accurately identified. The inspectors reviewed the licensee's root cause analysis and corrective actions to address elevated switchyard temperatures identified during the Summer 2000 period. The associated Trend Investigation Report documented the root cause for elevated switchyard disconnect temperatures as the failure to perform adequate parts replacement during switchyard breaker overhaul. Corrective actions to address this issue included a complete refurbishment of all LaSalle disconnects, including critical component replacement, as well as a review of the LaSalle switchyard structural and electrical design.

The inspectors reviewed LaSalle Operating Surveillance (LOS) ZZ-A2, "Preparation for Summer Operations," completed May 8, 2001, and independently verified that dampers associated with the Emergency Diesel Generator Ventilation (VD), Main Control Room Ventilation (VC), and Auxiliary Electric Equipment Room (AEER) Ventilation (VE) systems were properly positioned for hot weather conditions.

The inspectors conducted walkdowns outside the plant and verified that the configuration of the ultimate heat sink was consistent with plant drawings and the description contained in the UFSAR. The inspectors also reviewed calculation

L-002457, “LaSalle County Station Ultimate Heat Sink Analysis,” and verified that the methodology and acceptance criteria were adequate to ensure that in the event of worst historical hot weather, that the design of the ultimate heat sink was adequate to ensure that the units could be taken to cold shutdown and maintained in a cold shutdown condition for 30 days, consistent with design requirements.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment (71111.04)

.1 Partial Walkdown

a. Inspection Scope

The inspectors performed a walkdown of accessible portions of the Unit 2 High Pressure Core Spray (HPCS) system to verify system operability during maintenance activities associated with the Unit 2 Reactor Core Isolation Cooling (RCIC) system; as well as the Unit 2 Residual Heat Removal (RHR) system during maintenance activities associated with the Unit 2 Low Pressure Core Spray (LPCS) system. 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.

.2 Complete Walkdown

a. Inspection Scope

The inspectors performed a complete walkdown of accessible portions of the Unit 1 and Unit 2 Residual Heat Removal Service Water (RHRSW) system to verify system operability. The inspectors verified the correct valve position of all valves in the primary system flowpath using the system piping and instrumentation drawings (P&IDs) and the RHRSW system mechanical checklists and verified breaker alignment using the RHRSW system electrical checklists. Instrumentation valve configurations and appropriate meter indications were also observed. Lubrication and cooling of major components were verified by direct observation. Proper installation of hangars and supports was periodically observed during the walkdown, and operational status of support systems was directly verified by observation of various parameters. The inspectors also evaluated other conditions such as adequacy of housekeeping, the absence of ignition sources, and proper component labeling.

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 looking for any fire protection degradations:

- Fire Zone 10A1: Off-Gas Building Ventilation Room - Elevation 710'
- Fire Zone 10A2: Off-Gas Building Filter Access Room - Elevation 710'
- Fire Zone 10B1: Off-Gas Building General Floor Area - Elevation 690'
- Fire Zone 10B2: Off-Gas Building After Filter Cubicle - Elevation 690'
- Fire Zone 2I2: Unit 1 High Pressure Core Spray (HPCS) Cubicle - Elevation 673'
- Fire Zone 2I3: Unit 1 RHR Pump B and C Cubicle - Elevation 673'
- Fire Zone 2I5: Unit 1 RHR Pump A Cubicle - Elevation 673'
- Fire Zone 2D: Unit 1 General Area - Elevation 786'

Emphasis was placed on the 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 also observed and verified to be 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.

1R06 Flood Protection Measures (71111.06)

a. Inspection Scope

The inspectors reviewed the UFSAR and related flood analysis documentation to identify those areas susceptible to internal and external flooding.

With regard to external flooding, design basis documentation indicated that LaSalle was a “dry” site since external flooding was not a threat to the plant. The inspectors reviewed calculation L-002536, “PMP [Probable Maximum Precipitation] Basin Area B1 Water Level Evaluation,” Revision 1, dated March 20, 2000, which concluded that the maximum PMP water level was below the lowest exterior entrances of safety-related buildings and therefore the PMP had no adverse impact on the safety-related function of the plant. The inspectors also reviewed calculation WR-LS-PF-9, “Probable Maximum Flood in Illinois River,” Revision 0, dated January 6, 1976, which concluded that LaSalle was a “dry” site with regard to flooding in the Illinois River. The inspectors reviewed calculation WR-LS-PF-7, “Wind Wave Analysis,” Revision 0, dated August 13, 1975, which concluded that the plant site was unaffected by wave runup due to high winds at maximum flood lake level.

With regard to internal flooding, the inspectors reviewed design basis documentation that identified the design internal flood levels for areas which contained safety-related equipment. The inspectors walked down accessible portions of the Unit 1 and Unit 2 suppression pool raceways, Emergency Core Cooling System (ECCS) corner rooms, and Core Standby Cooling System (CSCS) pump rooms to verify that the licensee’s flooding mitigation plans and equipment were consistent with design requirements and risk analysis assumptions. The inspectors reviewed Work Request (WR) 980131367-01 for Unit 1 and WR 990023863-01 for Unit 2 which accomplished LaSalle Technical Surveillance (LTS) 1000-29, “Watertight Door and Penetration Inspection,” on November 6, 1999, and November 13, 2000, respectively. The inspectors independently verified that the watertight doors and selected penetrations reviewed in the surveillance were intact. In particular, the inspectors observed the sealing of equipment below the floodline, such as electrical conduits, the presence of holes or unsealed penetrations in floors and walls between flood areas, the adequacy of watertight doors between flood areas, and determined whether sources of potential internal flooding that had not been previously analyzed existed.

The inspectors also reviewed LaSalle Abnormal Operating Procedure (LOA) FLD-001, “Flooding,” Revision 3, dated August 16, 2000, and verified that actions prescribed in the procedure could reasonably be used to achieve the desired actions. The inspectors verified that problems related to flooding, including past flooding events, were included in the licensee’s corrective action program and were properly identified and prioritized for resolution.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification (71111.11)

a. Inspection Scope

On May 14, 2001, the inspectors observed licensed operator requalification training scenarios ESG39, “Increased SW [Service Water] Pressure/Leak in the Main Generator/Increased Main Turbine Vibration/Scram/ATWS [Anticipated Transient Without Scram]/1B EDG [Emergency Diesel Generator] Failure/1WR179 Fails to

Isolate,” and ESG40, “Reactor Startup/Stuck Rod/Loss of MDRFP [Motor-Driven Reactor Feedwater Pump]/Scram-ATWS/Small Break LOCA [Loss-of-Coolant-Accident].”

The inspectors verified crew performance in terms of clarity and formality of communication; the ability to take timely action in the safe direction; the prioritizing, interpreting, and verifying of alarms; the correct use and implementation of procedures, including alarm response procedures; timely control board operation and manipulation, including high-risk operator actions; the oversight and direction by the shift manager, including the ability to identify and implement appropriate Technical Specification (TS) actions such as reporting and emergency plan actions and notifications; and the group dynamics.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

a. Inspection Scope

The inspectors reviewed the licensee 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 following systems were evaluated:

- Instrument Nitrogen
- Computer Room Heating, Ventilation, and Air-Conditioning (HVAC)
- Condenser
- Main Turbine

The Instrument Nitrogen and Computer Room HVAC systems were selected based upon performance problems and maintenance rule (a)(1) classification. The Condenser and Main Turbine systems were selected based upon their contribution to Core Damage Frequency (CDF). 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, and 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 specific activities were reviewed:

- The inspectors reviewed the maintenance risk assessment for work planned for the week of April 15, 2001. This included work associated with the Unit 1, Division 1, 4160 Volts Alternating Current (VAC) unit cross-tie breaker 1412, the Unit 2 Motor-Driven Reactor Feedwater Pump (MDRFP) discharge stop valve, and the 1B Condensate Booster Pump. Planned surveillance activities were also reviewed to ensure that they did not adversely impact the availability of the respective systems.
- The inspectors reviewed the maintenance risk assessment for work planned for the week of April 29, 2001. This included work associated with the 1B Condensate Booster Pump, Oil Circuit Breaker 2-3, Unit 1 cross-tie breaker 1512, and the 1A Station Air Compressor. Planned surveillance activities were also reviewed to ensure that they did not adversely impact the availability of the respective systems.
- The inspectors reviewed the maintenance risk assessment for work planned for the week of May 13, 2001. This included work associated with the Unit 2 Low Pressure Core Spray (LPCS) system and the 2B Control Rod Drive (CRD) pump. Planned surveillance activities were also reviewed to ensure that they did not adversely impact the availability of the respective systems.

b. Findings

No findings of significance were identified.

1R14 Personnel Performance During Nonroutine Plant Evolutions (71111.14)

.1 Unit 2 Startup From Forced Outage L2F31

a. Inspection Scope

On April 6, 2001, Unit 2 automatically shutdown as a result of a blown fuse in the feedwater control system. The inspectors observed portions of the Unit 2 restart activities, including the approach to criticality, synchronization of the main generator to the grid, startup and operation of the feedwater system, and power ascension.

b. Findings

No findings of significance were identified.

.2 (Closed) Licensee Event Report 50-373/01-01: Reactor Scram Due to Electrical Fault on Transformer Yard 345 Kilovolt (KV) Line "C" Phase Insulator.

On January 31, 2001, current from the "C" phase of the 345 KV power line between the Unit 1 main power transformer and the switchyard flashed to ground across a support insulator. The phase-to-ground fault activated the transformer protective relays, resulting in a turbine trip and reactor scram. The licensee entered this issue into their corrective action program and conducted a root cause investigation which determined that the fault was due to an excess of bird excrement that had built up on the support insulators. Corrective actions included replacement of the damaged insulator, and inspection and cleaning of other insulators.

The inspectors responded to the reactor scram as documented in Section 4OA3 of NRC Inspection Report 50-373/2001002(DRP); 50-374/2001002(DRP). Based on the inspectors' observations and a review of this LER, the inspectors verified that the scram was uncomplicated, all essential systems responded as expected, and no emergency core cooling systems were challenged. The inspectors communicated details of the event to the region-based risk analysts who determined that the event was of low risk-significance. This LER is closed.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed selected condition reports (CRs) concerning 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 CRs were reviewed:

- Condition Report L2001-02043

This condition report identified that the containment air particulate and gaseous radiation monitors, 1(2)PL15J and 1(2)PL75J, installed to meet the requirements of TS 3.4.3.1,

“Leakage Detection System,” were inappropriately considered to be operable during maintenance and surveillance activities which prevented the monitors from sampling the containment atmosphere.

- Condition Report L2001-01982

This condition report identified that engineering personnel were unable to locate design basis documents to support measuring a single temperature point at the inlet of the operating drywell cooler, as described in TS Surveillance Requirement 4.6.1.7. The condition report also documented that following a review of available historical data and based on the ductwork configuration, the current practice for measuring average drywell temperature was acceptable and that the system was operable.

- Condition Report L2001-02663

This condition report identified that incorrect Local Power Range Monitor (LPRM) currents were input into the Unit 1 “B” Average Power Range Monitor (APRM). The incorrect currents were input during the cleaning and inspection of components in the “B” APRM during the performance of LaSalle Instrument Surveillance (LIS) NR-111B, “Flux Amplifier Gain Adjustments.” Seven LPRM cards were adjusted outside of the 10 microampere tolerance. The inspectors verified that there were no APRM operability concerns based on the gain adjustment factor for the seven LPRM cards.

b. Findings

One No Color finding and an associated Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Actions,” was identified due to a failure to recognize that the containment air particulate and gaseous radiation monitors were inoperable when they were isolated from containment and therefore unable to sample the containment atmosphere.

One Unresolved Item was identified concerning the lack of design basis documentation to justify the selection of a single point in the drywell as representative of average drywell temperature to satisfy TS Surveillance Requirement 4.6.1.7.

Condition Report L2001-02043

On March 29, 2001, during a routine review of operator logs prior to shift turnover, the inspectors identified a Unit 1 log entry which indicated that the containment air particulate and gaseous radiation monitors, 1(2)PL15J and 1(2)PL75J, were considered operable during a “B” Reactor Protection System (RPS) bus transfer. The inspectors questioned this operability evaluation, since the sample pumps were shut down and primary containment isolation valves 1CM027, 1CM029, and 1CM034 associated with 1(2)PL15J and 1(2)PL75J were closed during the RPS bus transfer evolution. In response to the inspectors’ concerns, operators referenced LaSalle Operating Surveillance (LOS) PC-Q1, “Primary Containment Isolation Valves Operability and Inservice Inspection Test For Conditions 1, 2, and 3,” Revision 30, which in Step 9.0 stated, “. . .Shutting off 1PL15J and 1PL75J pumps for cycling valves does not make systems inoperable since systems are still available for operation and do not require

automatic initiation. The short duration of shutting off sample pumps will not significantly reduce monitoring.” The inspectors reviewed this statement and questioned whether the monitors were operable during the performance of the portion of LOS-PC-Q1 which affected the radiation monitors during the RPS bus transfer evolution as well as when closing the primary containment isolation valves. Following additional discussions, licensee management concluded that the 1(2)PL15J and 1(2)PL75J radiation monitors were, in fact, inoperable since they were incapable of sampling the containment atmosphere.

Following additional review, the inspectors determined that LOS-PC-Q1, Revision 14, dated November 1, 1990, added the note discussed above. The inspectors reviewed the safety evaluation screening associated with this revision and identified that the screening erroneously stated that equipment operation was not affected by the revision and that the revision helped clarify a TS concern.

The inspectors reviewed recent plant operating history as well as TS 3.4.3.1, “Leakage Detection Systems,” and identified two occasions in which a requirement to be in hot shutdown within 12 hours was not recognized by operators to have been entered. In the first case, on March 29, 2001, with the Unit 1 primary containment air cooler condensate flow rate monitoring system inoperable, the 1PL15J and 1PL75J primary containment particulate and gaseous radiation monitors were rendered inoperable from 7:39 p.m. until 8:23 p.m. during an RPS bus transfer evolution. In addition, between March 29 at 6:00 p.m. until March 30 at 6:05 a.m., LOS-PC-Q1 was performed for the Unit 1 primary containment isolation valves associated with the 1PL15J and 1PL75J, which also rendered the radiation monitors inoperable for a short period during the surveillance with the drywell air cooler condensate flow rate monitoring system inoperable.

Significance Evaluation

The inspectors reviewed this issue against the guidance contained in Appendix B, “Thresholds for Documentation,” of Inspection Manual Chapter (IMC) 0610*, “Power Reactor Inspection Reports.” The inspectors determined that since the period during which the 1PL15J and 1PL75J radiation monitors were inoperable during the performance of LOS-PC-Q1 and RPS bus transfer evolutions was relatively brief, that the response to the Group 1 questions in Manual Chapter 0610* indicated that a finding did not exist. However, in accordance with the Group 3 questions, the inspectors determined that the issue had the potential for impacting the NRC’s ability to perform its regulatory function since the issue involved the 10 CFR 50.59 process. In determining the significance of the violation, and in accordance with NUREG-1600, “General Statement of Policy and Procedure for NRC Enforcement Actions,” the inspectors considered the following factors: 1) the significance of the underlying issue, 2) whether the failure actually impeded or influenced regulatory action, 3) the level of the individuals involved with the failure and the reasonableness of the failure given their position and training, and 4) whether the failures invalidated the licensing basis.

The inspectors concluded that since the underlying issue concerned the operability of a system required to meet TSs; that an entry into a 12-hour shutdown condition was not recognized on at least two occasions; that the condition had existed since November 1, 1990, a period of over 10 years; and that the level of individuals involved included senior

licensed operators, the issue was more than minor. In accordance with the guidance related to the Group 3 questions contained in Manual Chapter 0610*, the issue was categorized as a “No Color” finding.

Additionally, the inspectors noted two other examples during the same general time period where licensed operators failed to recognize that an entry into a TS action statement was required. On April 6, 2001, following the Unit 2 automatic reactor scram, the inspectors identified that TS 3.4.3.2, “Operational Leakage,” had not been entered when required (reference NRC Special Inspection Report 50-374/01-09(DRP)). Subsequent to the end of the inspection period, licensee personnel identified another example of the operators’ failure to recognize TS entry condition requirements. Specifically, on May 29, 2001, a work planning coordinator identified that operators failed to verify the performance of the hi setdown function of the APRM channel checks, as required by Surveillance Requirement 3.3.1.1.4. The surveillance was subsequently performed satisfactorily. The licensee documented the issue and entered the item into the station corrective action program via Condition Report L2001-03162.

Enforcement Actions

10 CFR 50, Appendix B, Criterion XVI, “Corrective Actions,” requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and non-conformances are promptly identified and corrected. The failure to identify that the 1(2)PL15J and 1(2)PL75J particulate and gaseous radiation monitors were inoperable during periods in which the containment atmosphere was not being sampled was an example where the requirements of 10 CFR 50, Appendix B, Criterion XVI, 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 the corrective action program (Condition Report L2001-02043), this corrective action violation is being treated as a Non-Cited Violation (NCV 50-373/01007-01).

Condition Report L2001-01982

Background

Technical Specification 4.6.1.7, “Drywell Average Air Temperature,” required that the drywell average air temperature shall not exceed 135 degrees fahrenheit (°F) in Operational Conditions 1, 2, and 3. This ensured that the peak containment air temperature following a design basis accident did not exceed the design temperature limit of 340°F. The associated surveillance requirement prescribed by TS 4.6.1.7 identified that the drywell average air temperature shall be the average temperature of the operating return air plenum upstream of the primary containment ventilation heat exchanger coil and cabinet. This temperature was measured by recording the temperature reading from the operating air return plenum fan at drywell elevation 740' azimuth 248° (“A” train) and drywell elevation 740' azimuth 76° (“B” train) utilizing temperature instruments 1(2) TE-VP033 and 1(2)TE-VP034, respectively. Because only one primary containment ventilation fan unit is operated at a time, only one temperature measurement was required to be recorded.

Inspector Review

During a routine review of the Unit 1 operator logs and during discussions with operators regarding recent problems which had been experienced with the Unit 1 primary containment chillers, the inspectors identified that in accordance with TS 4.6.1.7, a single temperature point was relied upon to be representative of average drywell temperature to meet the requirements of TS 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 TS 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. The inspectors reviewed the condition report, which documented that after reviewing historical data, and based on the ductwork configuration to provide adequate drywell mixing, the current practice of measuring average drywell temperature at the inlet of the operating drywell cooler was acceptable. The inspectors discussed this conclusion with cognizant engineering personnel and determined that although the historical data reviewed verified that historical drywell cooler inlet temperatures had not exceeded the TS limits, no additional effort to determine whether the current methodology was acceptable was planned since TSs prescribed the method currently in use.

This is an Unresolved Item (URI) 50-373/01007-02(DRP);50-374/01007-02(DRP) 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 TS 4.6.1.7 for bulk average drywell temperature was required.

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 306: A/B Offgas Ventilation System Problems

This operator challenge identified that offgas ventilation system problems had challenged operators by requiring operators to provide manual assistance in the operation of the suction ventilation dampers, due to inadequate damper operator size. The damper positions provided an interlock for fan operation. The inspectors verified that the function of accident mitigating systems and the ability to implement procedures to respond to the events had not been adversely impacted.

OC 320: Reset Band For Tank Level Alarms

This operator challenge identified that the reset band for the Emergency Diesel Generator (EDG) storage tank level alarms was not adequate to prevent nuisance alarms when tank level was near the alarm setpoint. The inspectors verified that the presence of these nuisance alarms had no direct impact on the function of the EDGs or

support systems, and had no direct impact on the ability to implement event response procedures.

OC 308/309: Turbine-Driven Reactor Feedwater Pump (TDRFP) Turning Gear

This operator challenge identified that operators must manually engage the TDRFP turning gear before and after TDRFP runs and that operators must take the TDRFP turning gear oil supply out-of-service whenever the turning gear was not in use. The inspectors discussed this issue with LaSalle personnel and determined that the TDRFPs will not incur damage if they are not placed on the turning gear following shutdown. As a result, this operator challenge did not adversely impact event response.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors observed post-maintenance testing activities involving risk significant equipment. 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.

The following work requests (WRs) involving risk significant equipment were reviewed:

- WR 980114091 Gamma Traversing Incore Probe (TIP) Installation

The inspectors compared the measured data against the acceptance criteria following the performance of Powerplex updates after the completion of Gamma TIP installation on Unit 2. The review evaluated the TIP symmetry test, symmetric TIP pair test, gamma and neutron TIP comparison, and microburn data calculations.

- WR 99028107801 Unit 2 HPCS Minimum Flow Bypass Switch Replacement

The inspectors observed the performance and reviewed the data from LIS-HP-205, the Unit 2 HPCS minimum flow bypass calibration associated with the 2E22-N006 switch replacement. The review evaluated the surveillance acceptance criteria and the adequacy of the post-maintenance testing.

- WR 99026131901 Unit 1 LPCS Discharge Pressure Permissive Switch Replacement

The inspectors observed the performance and reviewed the data from LIS-LP-104, the Unit 1 LPCS discharge pressure permissive calibration associated with the 1E21-N009 switch replacement. The review evaluated the surveillance acceptance criteria and the adequacy of the post-maintenance testing.

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 TSs, the 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 activities were observed:

- LIP-GM-964 Eberline Ping-3B (SA-9) Radiation Monitor Functional Test

On April 10, 2001, the inspectors observed the performance of LIP-GM-964. The inspectors verified through observation of the maintenance activity that the alarm actuation, and associated relay actuation were obtained within surveillance acceptance criteria and TSs.

- LIS-NB-318A Unit 1 Reactor Vessel Low Pressure and Injection Line Low Pressure LPCS [Low Pressure Core Spray]/RHR [Residual Heat Removal] "A" Injection Valve Open Permissive Functional Test

On April 20, 2001, the inspectors observed the performance of LIS-NB-318A. The inspectors verified through observation of the maintenance activity that the pressure switch actuation, the alarm actuation, and associated relay actuation were obtained within the pressure bands specified in the surveillance acceptance criteria and TSs.

- LOS-DG-Q3 Unit 2, 2B EDG Cooling Water Pump Inservice Test

On May 3, 2001, the inspectors observed the performance of LOS-DG-Q3. The inspectors verified through a review and observation of the operations activity that the EDG cooling water pump flow and vibration readings were within surveillance and inservice testing acceptance criteria.

- LOS-LP-Q1 LPCS [Low Pressure Core Spray] Pump Inservice Test

On May 15, 2001, the inspectors observed the performance of LOS-LP-Q1. The inspectors verified through a review and observation of the operations activity that the LPCS pump flow and vibration readings were within surveillance and inservice testing acceptance criteria.

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors reviewed Temporary Modification 9900440 which installed a jumper around cell #9 of the Unit 2, Division 2, safety-related 125 Volts Direct Current (VDC) battery and replaced it with a spare cell. The inspectors reviewed the associated 10 CFR 50.59 safety evaluation against the system design basis documentation, including the Updated Final Safety Analysis Report and TSs. The inspectors also conducted a walkdown of the temporary modification and compared the installed configuration against the configuration prescribed in design drawings.

b. Findings

No findings of significance were identified.

1EP6 Drill Evaluation (71114.06)

a. Inspection Scope

The inspectors evaluated the adequacy of the licensee's conduct of drills and critique of performance through the observation of simulator training scenario SEG 01C3-04, "Loss of Condenser Vacuum/Loss of SAT [Station Auxiliary Transformer]/UAT [Unit Auxiliary Transformer]/Drywell Leak/Station Blackout," on May 8, 2001. The inspectors reviewed the scenario to identify the timing and location of classification, notification, and protective action measure activities, and for licensee expectations and response. The inspectors verified that these actions were accomplished in a timely manner.

During the Unit 1 simulator scenario, a loss of condenser vacuum in conjunction with a failure of the SAT/UAT was properly classified by Operations personnel as an Unusual Event and then upgraded to an Alert following the identification of a leak in the Unit 1

drywell. Following further degradation which resulted in a Station Blackout, General Site Emergency Plan (GSEP) personnel properly classified the event as a Site Area Emergency on Unit 1 and an Unusual Event on Unit 2.

b. Findings

No findings of significance were identified.

2. RADIATION SAFETY

Cornerstone: Public Radiation Safety (PS)

2PS1 Radioactive Gaseous and Liquid Effluent Treatment and Monitoring Systems (71122.01)

.1 Liquid and Gaseous Release Systems Walkdowns

a. Inspection Scope

The inspector performed walkdowns of the major components of the liquid and gaseous release systems (e.g., radiation and flow monitors) to verify that the current system configuration was as described in the Updated Final Safety Analysis Report (UFSAR) and the Offsite Dose Calculation Manual (ODCM), and to observe equipment material condition. In particular, the inspector reviewed and observed the station's use of a System Particulate Iodine Noble Gas (SPING) Unit (Model SPING-3B) Wide Range Gas Monitor (WRGM) as a pre-planned alternate for the Standby Gas Treatment System (SBGT) Stack WRGM to verify that ODCM and TS monitoring requirements were met while the SBGT WRGM was under repair and tagged out-of-service.

The inspector also observed ongoing activities, including observations of plant chemistry personnel performing a weekly surveillance on the station Main Stack WRGM, to verify adherence to licensee procedures for collecting samples and the use of proper chemistry practices. This activity included noble gas sampling and the change-outs of the iodine collection cartridge and particulate filter for the monitoring system.

b. Findings

No findings of significance were identified.

.2 Radioactive Effluent Release Data, Dose Calculations, and Changes to the Offsite Dose Calculation Manual (ODCM)

a. Inspection Scope

The inspector reviewed the 1999 and 2000 Annual Radioactive Effluent Release Reports, the 2000 Radiological Environmental Operating Report, and radioactive effluent release data for January 2000 through December 2000, to verify that the radioactive effluent program was implemented as described in the UFSAR and ODCM and to ensure that any anomalies in the release data were adequately understood by

the licensee. The inspector reviewed the licensee's offsite dose calculations to ensure that the licensee had properly calculated the offsite dose from radiological effluent releases and to determine if any annual TS or ODCM limits (i.e., Appendix I to 10 CFR Part 50 values) were exceeded. In addition, the inspector reviewed Revision 3 of the ODCM and the licensee's technical justifications for changes to the document to verify that changes were made in accordance with the requirements of the TS.

b. Findings

No findings of significance were identified.

.3 Liquid and Gaseous Effluent Releases

a. Inspection Scope

As there were no liquid batch releases performed during the inspection period, the inspector reviewed the release packages for three liquid effluent batch releases completed in December 2000, to verify that the licensee's processing and release procedures, including dose projections to members of the public, were conducted in accordance with ODCM and TS requirements. Additionally, the inspector selectively reviewed grab sample results and licensee calculations for containment purge radioactive gaseous releases completed in calendar year 2000, including the projected doses to members of the public, to verify that appropriate treatment equipment was used and that the radioactive gaseous effluents were processed and released in accordance with ODCM requirements.

b. Findings

No findings of significance were identified.

.4 Liquid and Gaseous Effluent Monitor Calibrations

a. Inspection Scope

The inspector reviewed records of instrument calibrations performed since the last inspection for selected point of discharge effluent radiation monitors, to verify that they had been calibrated consistent with industry standards and in accordance with station procedures. Specifically, the inspector reviewed the calibration records for:

- Station Main Stack WRGM (including its flow rate monitor)
- SBGT System Stack WRGM (including its flow rate monitor)
- SPING-3B (pre-planned alternate for the stack WRGMs)
- Unit 1 Offgas Treatment System (Post Treatment) Effluent Monitors (A & B)
- Unit 2 Offgas Treatment System (Post Treatment) Effluent Monitors (A & B)
- Unit 2 Reactor Building Vent Exhaust Plenum Radiation Monitor
- Unit 2 "A" Residual Heat Removal System Service Water Process Radiation Monitor
- Radwaste Liquid Effluent Radiation Monitor

Additionally, the inspector reviewed recent modifications to effluent monitoring systems and the current effluent radiation monitor alarm setpoint values for these monitors to assess compliance with ODCM requirements. The inspector also examined the licensee's data for calendar years 1998 - 2001 for trending and tracking the reliability and maintenance of selected point of discharge effluent radiation monitors, to assess the adequacy of the licensee's efforts to improve the overall health of the effluent and process radiation monitoring system.

b. Findings

No findings of significance were identified.

.5 Analytical Instrumentation Quality Control and Interlaboratory Comparison Program

a. Inspection Scope

The inspector reviewed the Chemistry Department's quality control (QC) data and charts for the five gamma spectroscopy instrument systems used to quantify effluent release and environmental samples, to verify the equipment was properly maintained consistent with station procedures and to ensure that effluent concentrations were accurately calculated.

The inspector also reviewed the results of the 2000 interlaboratory comparison program, as reported in the 2000 Radiological Environmental Operating Report, to verify the quality of radioactive effluent sample analyses performed by the licensee. The inspector reviewed the licensee's quality control evaluation of the interlaboratory comparison for any associated corrective actions.

b. Findings

No findings of significance were identified.

.6 Identification and Resolution of Problems

a. Inspection Scope

The inspector reviewed self-assessments, Nuclear Oversight field observations, and licensee condition reports (CRs) completed since January 2000, which focused on the ODCM and liquid and gaseous effluent release programs. The inspector reviewed these documents to assess the licensee's ability to identify repetitive problems, contributing causes, the extent of conditions, and implement corrective actions to achieve lasting results.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification

Cornerstone: Initiating Events, Mitigating Systems

.1 Operational Performance

a. Inspection Scope

The inspectors reviewed the following 1st quarter 2001 performance indicators for Unit 1 and Unit 2 utilizing the performance indicator definitions and guidance contained in Nuclear Energy Institute (NEI) 99-02, "Regulatory Assessment Indicator Guideline," Revision 0:

- Unplanned Scrams Per 7,000 Critical Hours
- Scrams With a Loss of Normal Heat Removal

The inspectors reviewed Licensee Event Reports (LERs) and operator log entries to determine the number of scrams that occurred during the previous four quarters and compared that number to the number in the performance indicator. The inspectors also reviewed licensee Monthly Operating Reports and operator logs to verify the accuracy of the number of critical hours reported. The inspectors also reviewed the licensee's basis for crediting normal heat removal capability for each of the reported reactor scrams.

- Unplanned Power Changes Greater Than 20 Percent Per 7,000 Critical Hours

The inspectors reviewed Monthly Operating Report power history data, control room logs, and Performance Indicator data sheets to verify that the licensee had adequately identified the number of unplanned power changes greater than 20 percent that had occurred during the previous four quarters. The inspectors verified performance indicator results through independent calculations.

- RCIC System Unavailability

The inspectors verified the Unit 1 and Unit 2 RCIC system unavailability Performance Indicator data reported by the licensee for April 2000 through March 2001. In particular, the inspectors reviewed Performance Indicator data sheets which formed the basis for the reported RCIC system unavailability and compared that data to control room operating logs and Monthly Operating Reports to determine if the RCIC system was unavailable for time periods which had not been previously identified and reported. The inspectors verified performance indicator results through independent calculations.

b. Findings

No findings of significance were identified.

.2 Radiological Effluent TS (RETS)/Offsite Dose Calculation Manual (ODCM) Radiological Effluent Occurrence Performance Indicator

b. Inspection Scope

The inspector reviewed the licensee's CRs for calendar years 2000 - 2001 to the date of the inspection and offsite dose calculations (September 2000 through April 2001) to identify any occurrences that were not identified by the licensee and to verify the performance indicator for the public radiation safety cornerstone. The inspector also reviewed performance indicator verification records generated by the RP staff since September 2000, and discussed the RETS/ODCM performance indicator data collection and analysis process with the data steward for this indicator, to verify that the program was implemented consistent with industry guidelines provided in NEI 99-02 and licensee procedures.

b. Findings

No findings of significance were identified.

.3 Reactor Coolant System Specific Activity Performance Indicator

a. Inspection Scope

The inspector observed a chemistry technician obtain and prepare for analysis a reactor coolant sample. Following the analysis, the gamma analysis data and the dose equivalent iodine (DEI) calculations were reviewed to verify adherence with licensee procedures and the guidance contained in NEI 99-02. Additionally, the inspector reviewed all DEI analyses from October 2000 to April 2001, to verify the licensee reported values for the reactor coolant system specific activity performance indicator for the barrier integrity cornerstone.

b. Findings

No findings of significance were identified.

4OA3 Event Followup (71153)

a. Inspection Scope

On April 6, 2001, the Unit 2 reactor automatically shutdown after experiencing high reactor water level. The high water level initiated trips of the main generator and the 2A and 2B turbine-driven reactor feedwater pumps, resulting in the Unit 2 reactor scram. In response to the event, the inspectors observed plant parameters and status, including mitigating systems and fission product barriers; evaluated the performance of mitigating systems and licensee actions; and confirmed that the licensee properly reported the event as required by 10 CFR 50.72. During the event, a number of anomalies occurred. These included performance problems associated with the Motor-Driven Reactor Feedwater pump which required operators to take action outside the control room to make that system available for injection, and unexpected oscillations in the Reactor

Core Isolation Cooling system, which resulted in the operation of the system in manual. Based on the risk and deterministic criteria specified in Management Directive 8.3, "NRC Incident Investigation Program," and Inspection Procedure 71153, "Event Followup," and due to the equipment performance problems which occurred, a special inspection was initiated in accordance with Inspection Procedure 93812, "Special Inspection," to evaluate the facts and circumstances surrounding the event as well as the actions taken by licensee personnel in response to the unexpected system performance issues encountered. The results of that review is documented in NRC Inspection Report 50-374/01-09.

b. Findings

No findings of significance were identified.

4OA6 Meetings

Exit Meeting Summary

The Region-based inspectors presented their inspection results to Mr. C. Pardee and other members of licensee management on May 15, 2001. The resident inspectors presented their inspection results to Mr. C. Pardee and other members of licensee management on May 18, 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.

4OA7 Licensee Identified Violations

The following finding of very low significance was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Policy, NUREG 1600 for being dispositioned as a Non-Cited Violation (NCV).

NCV Tracking Number

Requirement Licensee Failed to Meet

NCV 50-373/374/2001007-03

10 CFR 50, Appendix B, Criterion III, requires that the design basis is correctly translated into specifications, drawings, and procedures. Back draft dampers in the Unit 1 and Unit 2 Division 1 Essential Switchgear Rooms were locked open without a High Energy Line Break impact review. This issue was entered into the licensee's corrective action program as CR L2001-01932.

NCV 50-374/2001007-04

10 CFR 50, Appendix B, Criterion III, requires that design changes be subject to design control measures commensurate with those applied to the original design and that measures be established for the selection and review of suitability of application of equipment essential to the safety-related functions of structures, systems, and components. Unit 2 utilized a revised Powerplex deck which did not contain all the gamma traversing incore probe (TIP) data constants necessary to monitor core thermal limits to the correct accuracy. This issue was entered into the licensee's corrective action program as CR L2001-02269.

KEY POINTS OF CONTACT

Exelon

D. Bost, Site Engineering Manager
D. Enright, Operations Manager
F. Gogliotti, Design Engineering Supervisor
C. Pardee, Site Vice President
J. Pollock, System Engineering Manager
W. Riffer, Regulatory Assurance Manager
M. Schiavoni, Station Manager
C. Wilson, Station Security Manager

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-373/2001007-01;50-374/2001007-01	NCV	Inoperable Containment Radiation Monitors
50-373/2001007-02;50-374/2001007-02	URI	Containment Temperature Monitoring
50-373/2001007-03;50-374/2001007-03	NCV	Dampers Open Without HELB Review
50-374/2001007-04	NCV	Inadequate Gamma TIP Modification

Closed

50-373/2001007-01;50-374/2001007-01	NCV	Inoperable Containment Radiation Monitors
50-373/2001007-03;50-374/2001007-03	NCV	Dampers Open Without HELB Review
50-374/2001007-04	NCV	Inadequate Gamma TIP Modification
50-373/01-01	LER	Reactor Scram Due to Electrical Fault

Discussed

None

LIST OF ACRONYMS USED

APRM	Average Power Range Monitor
CR	Condition Report
DRP	Division of Reactor Projects
DRP	Division of Reactor Safety
EDG	Emergency Diesel Generator
HVAC	Heating, Ventilation, and Air-Conditioning
LER	Licensee Event Report
LPCS	Low Pressure Core Spray
LPRM	Local Power Range Monitor
MDRFP	Motor-Driven Reactor Feedwater Pump
NCV	Non-Cited Violation
NEI	Nuclear Energy Institute
OC	Operator Challenge
ODCM	Offsite Dose Calculation Manual
OE	Operability Evaluation
OWA	Operator Workaround
PCIS	Primary Containment Isolation System
RCIC	Reactor Core Isolation Cooling
REMP	Radiological Environmental Monitoring Program
RHR	Residual Heat Removal
RHRSW	Residual Heat Removal Service Water
RPS	Reactor Protection System
SGBT	Standby Gas Treatment
SDP	Significance Determination Process
SPING	System Particulate Iodine Noble Gas
SSC	System, Structure, and/or Component
TDRFP	Turbine-Driven Reactor Feedwater Pump
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report
URI	Unresolved Item
WPS	Welding Procedure Standard
WRGM	Wide Range Gas Monitor
WR	Work Request

LIST OF DOCUMENTS REVIEWED

2PS1 Radioactive Gaseous and Liquid Effluent Treatment and Monitoring Systems

	1999 Annual Radioactive Effluent Report	April 28, 2000
	2000 Annual Radioactive Effluent Report and Triannual Chlorine Survey Report	April 30, 2001
	2000 Annual Radiological Environmental Operating Report	April 30, 2001
	Focus Area Self-Assessment Report: Radiological Environmental Monitoring and Offsite Dose Calculation Program (ODCM/REMP)	April 9-10, 2001
	LaSalle Station Offsite Dose Calculation Manual (ODCM)	May 2001, Revision 3
ATM# 41486-09	N. O. Field Observation: Technical Specification Sampling and License Compliance	February 2 & 6, 2001
ATM# 41486-15	N. O. Field Observation: Technical Specification Sampling and License Compliance	March 19, 2001
ATM# 41486-16	N. O. Field Observation: Material Condition and Calibration of Analytical Eq., Organization & Administration	March 19, 2001
ATM# 41486-19	N. O. Field Observation: Technical Specification Sampling and License Compliance	March 16 & 22, 2001
CR# L2001-02528	RP Focus Self-Assessment Results: ODCM/REMP	April 10, 2001
CR# L2001-02547	Annual Effluent Report & REMP Report Submitted with Little Time for Management Review	April 25, 2001
CR# L2001-02709	SBGT WRGM Not Functioning Following Corrective Maintenance	May 4, 2001
CR# L2001-02741	VG WRGM Trips During Low Range Pump Start	May 6, 2001
CR# L2001-02744	SBGT WRGM INOP per TRM 3.3.d Condition D	May 7, 2001
LIS-OG-104A	Unit 1 Post Treatment Radiation Monitor Channel A Calibration	Revision 2
LIS-OG-104B	Unit 1 Post Treatment Radiation Monitor Channel B Calibration	Revision 2

LIS-OG-204A	Unit 2 Post Treatment Radiation Monitor Channel A Calibration	Revision 0
LIS-OG-204B	Unit 2 Post Treatment Radiation Monitor Channel B Calibration	Revision 0
LIS-PR-001	Radwaste Liquid Effluent Radiation Monitor Calibration	Revision 10
LIS-PR-002	Station Vent Main Stack Effluent and Sampler Flow Rate Monitor Calibration	Revision 9
LIS-PR-003	Standby Gas Treatment System Sampler Flow Rate Monitor Calibration	Revision 8
LIS-PR-004	Station Vent Main Stack Wide Range Gas Monitor Calibration	Revision 10
LIS-PR-005	Standby Gas Treatment System Wide Range Gas Monitor Calibration	Revision 10
LIS-VR-201	Unit 2 Reactor Building Vent Exhaust Plenum Radiation Monitor Calibration	Revision 4
NO-AA-200-001-1001	Master Oversight Plan, Plant Support	April 23, 2001
RW 00-01	Liquid Effluent Release Package	December 2000
RW 00-02	Liquid Effluent Release Package	December 2000
RW 00-03	Liquid Effluent Release Package	December 2000

40A1 Performance Indicator Verification

LCP-310-02	Sampling of Plant Process Water	Revision 13
LCP-830-14	Dose Equivalent I-131	Revision 7
RS-AA-122-112	Performance Indicator - Reactor Coolant System Specific Activity	Revision 1
RS-AA-122-116	Performance Indicator - RETS/ODCM Radiological Effluent Occurrence	Revision 1