



Commonwealth Edison
LaSalle County Nuclear Station
Rural Route #1, Box 220
Marseilles, Illinois 61341
Telephone 815/357-6761

April 26, 1991

Director of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Mail Station P1-137
Washington, D.C. 20555

Dear Sir:

Licensee Event Report #91-003-00, Docket #050-374 is being
submitted to your office in accordance with
10CFR50.73(a)(2)(iv).

W.R. Diederich

for G. J. Diederich
Station Manager
LaSalle County Station

GJD/CLA/mkl

Enclosure

cc: Nuclear Licensing Administrator
NRC Resident Inspector
NRC Region III Administrator
INPO - Records Center
IDNS Resident Inspector

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) LaSalle County Station Unit 2 Docket Number (2) 05000374 Page (3) 1 of 4
 Title (4) Reactor Building Ventilation Isolation Due To Personnel Error During Return To Service

Event Date (5)				LER Number (6)				Report Date (7)			Other Facilities Involved (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)		
03	28	91	91	003	00	04	26	91		05000374		

OPERATING MODE (9) 1

POWER LEVEL (10) 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

20.402(b)	20.405(c)	X	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)		50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)		50.73(a)(2)(vii)	Other (Specify
20.405(a)(1)(iii)	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)	in Abstract
20.405(a)(1)(iv)	50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)	below and in
20.405(a)(1)(v)	50.73(a)(2)(iii)		50.73(a)(2)(x)	Text)

LICENSEE CONTACT FOR THIS LER (12)

Name Cynthia L. Alleman, Regulatory Assurance, Extension 2925 TELEPHONE NUMBER 815 357-6761

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
A	V	A		N					

SUPPLEMENTAL REPORT EXPECTED (14)

Expected Submission Date (15) Month Day Year

Yes (If yes, complete EXPECTED SUBMISSION DATE) X NO

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On March 28, 1991, with Unit 2 in Operational Condition 1 (Run) at 100% power, and Unit 1 defueled, the Operating Department was to transfer the Reactor Protection System bus. The Nuclear Station Operator reviewed the procedure and transferred a part of it to a separate piece of paper where he wrote incorrectly the terminal points to be jumpered out by the Equipment Operator. The Equipment Operator followed the instructions on the piece of paper for jumpering out the terminal points, therefore the wrong terminal points were jumpered out. (The Unit 2 Isolation logic from Unit 1 should have been jumpered out but instead Unit 1 Isolation logic from Unit 1 was jumpered out.) When the Reactor Protection System bus was transferred to the alternate power supply, the Division 1, Unit 2 Reactor Building Ventilation Isolation dampers isolated and the Unit 1 Standby Gas Treatment System auto started.

By using LaSalle Operating Abnormal Procedure, LOA-VR-01, "Recovery from a Group IV Isolation or Spurious Trip of Reactor Building Vent", the system was un-isolated. The involved personnel were tailgated in the importance of following procedure and the use of "in-hand" procedures.

This event is being reported pursuant to the requirements of 10CFR50.73(a)(2)(iv) due to the actuation of an Engineered Safety System.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION												Form Rev. 2.0											
FACILITY NAME (1)		DOCKET NUMBER (2)				LER NUMBER (6)				Page (3)													
						Year	///	Sequential Number	///	Revision Number													
LaSalle County Station Unit 2		0	5	0	0	0	3	7	4	9	1	-	0	0	3	-	0	0	0	2	OF	0	4
TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]																							

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as [XX].

A. CONDITION PRIOR TO EVENT

Unit(s): 1 Event Date: 03/28/91 Event Time: 2104 Hours

Reactor Mode(s): 1 Mode(s) Name: Run Power Level(s): 100%

B. DESCRIPTION OF EVENT

On March 28, 1991 at 2104 hours with Unit 2 in Mode 1 (Run) at 100% power and Unit 1 defueled, a Reactor Protection System (RPS) [JC] bus transfer was in progress in accordance with LaSalle Operating Procedure, LOP-RP-03 "RPS Bus A Transfer". Unit 2 Isolation logic from Unit 1 should have been jumpered out per the procedure (terminal points CC-73 to CC-74 on drawing 1E-2-4083AG). Instead Unit 1 Isolation logic from Unit 1 was mistakenly jumpered out (terminal points CC-61 to CC-62 on drawing 1E-1-4083AG). The incorrectly placed jumper was installed for approximately 15 minutes and had no other impact on Unit 2 Isolation instrumentation with respect to Technical Specifications.

A Control Room Nuclear Station Operator (NSO, licensed Reactor Operator) was assigned the task of making the RPS bus transfer and was therefore responsible for co-ordinating the paperwork. Prior to this the outage Shift Control Room Engineer (SCRE, Licensed Senior Reactor Operator) had researched the procedure and marked up the checklists appropriately. When the NSO made preparations to perform the transfer per the annotated checklists, he transcribed the information that the Equipment Operators (EOs, Non-Licensed Operator) would require to install the two jumpers in the Auxiliary Equipment Room on a separate piece of paper. During the transcription of the required information from the procedure to another piece of paper, the NSO inadvertently wrote down the wrong terminal points. The NSO gave the EOs this piece of paper to perform the jumper installation instead of the actual procedure. The EOs installed the jumpers per the instructions on this piece of paper and the RPS bus transfers were made. When the A RPS bus was transferred to the alternate power supply, the Division 1, Unit 2 Reactor Building Ventilation (VR) [VA] Isolation Dampers 2VR04YA and 2VR05YB isolated and the Unit 1 Standby Gas Treatment (SBGT) [BH] System auto started (Unit 2 SBGT System was in Pull-To-Lock in accordance with LOP-RP-03). The crew then recovered from the isolation in accordance with LaSalle Operating Abnormal Procedure, LOA-VR-01, "Recovery from a Group IV Isolation or Spurious Trip of Reactor Building Vent."

This event is reportable pursuant to the requirements of 10CFR50.73(a)(2)(iv) due to an actuation of an Engineered Safety Feature System.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION												Form Rev 2.0	
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						Page (3)					
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LaSalle County Station Unit 2	0 5 0 0 0 3 7 4	9 1	-	0 0 3	-	0 0	3	OF	0 4				
TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]													

C. APPARENT CAUSE OF EVENT

The NSO and EOs did not comply with the requirements for procedural adherence. By not complying, the second verification process was not used by the NSO to authorize a change to a safety-related system (this would not have been required had an actual copy of the procedure been used to perform the transfer). Also the NSO indirectly authorized the performance of a temporary system change without the use of a procedure by incorrectly transcribing the information to be used by the EOs for installation of the jumpers. This allowed the EOs to perform a temporary system change to a safety-related plant system without the use of a procedure or electrical drawings.

D. SAFETY ANALYSIS OF EVENT

The safety consequences of this event were minimal due to the system responding as designed, by placing the reactor building ventilation system in a safe condition. The incorrectly placed jumper was installed for approximately 15 minutes and had no other impact on Unit 2 Isolation Instrumentation. Any other valid isolation signals would still have performed their design functions.

E. CORRECTIVE ACTIONS

Station management has placed documentation of this event in the files of the personnel who were involved. This documentation notes the seriousness of this event and the failure of the individual to comply with procedural adherence requirements.

The Operators involved in this event have tailgated the Operating crews on the importance of procedural adherence, including the use of "in-hand" procedures when required.

This event will also be tailgated by other departments affiliated with the use of jumpers stressing the importance of procedural adherence. Action Item Record 374-200-91-01201 will track these tailgates.

F. PREVIOUS EVENTS

LER Number	Title
373/86-005-00	An ESF Actuation From Loss Of Division I DC Caused By Personnel Error.
373/86-011-00	Personnel Error Primary Containment Isolation.
373/86-013-00	Loss Of Bus 141Y And Auto Start Of Diesel ODG01K Due To Personnel Error.
373/86-022-02	Shut Down Cooling Isolation Due To Operator Error (Inattention To Detail).
373/86-023-00	Secondary Containment Damper Isolation During RPS Bus Transfer Procedure Preparation.
373/87-030-00	Reactor Scram While Shutdown During Surveillance Due To Communication Error.

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		Year	///	Sequential Number	///	Revision Number							
LaSalle County Station Unit 2	0 5 0 0 0 3 7 4	9 1	-	0 0 3	-	0 0	0 4	OF 0 4					
TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]													

F. PREVIOUS EVENTS CONTINUED

LER Number	Title
374/89-002-00	Engineered Safety Feature Actuation Due To Instrument Valving Error During Surveillance Testing.
374/89-014-00	Primary Containment Isolation System Group IV Isolation During Ground Isolation.
374/90-013-00	Main Steam Isolation Valve Initiation Signal During Surveillance Test Due To Personnel Error.

G. COMPONENT FAILURE DATA

None