

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Q 1 | L | L | S | C | 1 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 0 | 0 | 10 | 4 | 5

LICENSE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 31 CAT 58 59

CONT
0 1 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 7 | 3 | 7 | 0 | 7 | 1 | 1 | 8 | 8 | 3 | 8 | 0 | 8 | 1 | 2 | 8 | 3 | 9

DOCKET NUMBER 58 59 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

0 2 | On July 18, 1983 at 1137 hours a cooldown rate in excess of 100°F/hr was observed when

0 3 | a Full Core SCRAM occurred as a result of a bypass valve transient during EHC

0 4 | troubleshooting. T.S. 3.4.6.1.a was violated. Engr. evaluation was performed by

0 5 | G.E. San Jose and CECO Engr. They concluded that no structural effects on the vessel

0 6 | had occurred.

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7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

SYSTEM CODE 9 10 CAUSE CODE 11 CAUSE SUBCODE 12 COMPONENT CODE 13 COMP. SUBCODE 15 VALVE SUBCODE 16

R A 11 A 12 C 13 Z Z Z Z Z Z Z 14 Z 15 Z 16

SEQUENTIAL REPORT NO. 24 25 OCCURRENCE CODE 28 29 REPORT TYPE 30 REVISION NO. 32

0 8 5 0 3 L 0

17 LER/RO REPORT NUMBER 21 22 EVENT YEAR 23 24

8 3 0 8 5 0 3 L 0

ACTION TAKEN 33 FUTURE ACTION 34 EFFECT ON PLANT 35 SHUTDOWN METHOD 36 HOURS 37 ATTACHMENT SUBMITTED 40 NPRO-4 FORM SUB. 42 PRIME COMP. SUPPLIER 43 COMPONENT MANUFACTURER 44

X 18 H 19 Z 20 Z 21 0 0 0 0 0 Y 23 N 24 Z 25 Z 9 9 9 9 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

1 0 | Excessive cooldown was a result of rapid depressurization, full core SCRAM and HPCS

1 1 | & RCIC injection. Operations recovered from the transient and restored Unit para-

1 2 | meters to normal. Corrective actions to the transient are addressed in DVR 1-1-83-270

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1 4 |

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FACILITY STATUS 7 8 9 % POWER 10 11 OTHER STATUS 12 13 METHOD OF DISCOVERY 14 15 DISCOVERY DESCRIPTION 16 17

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Z 33 Z 34 NA 35 NA 36

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Z 42 NA 43

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N 44 NA 45

2 0 N 44 NA 45

NAME OF PREPAREP

D. R. Winterhoff

8308220240 830812
PDR ADOCK 05000373
S PDR

PHONE:

815/357-6761

NRC USE ONLY

I. LER NUMBER: 83-085/03L-0

II. LASALLE COUNTY STATION: Unit 1

III. DOCKET NUMBER: 050-373

IV. EVENT DESCRIPTION:

Technical Specifications 3.4.6.1.a states that the Reactor Coolant temperature shall not exceed a maximum cooldown rate of less than or equal to 100°F per hour. On July 18, 1983 at 1137 hours a cooldown rate in excess of 100°F/hr (113°F/hr) was observed when a full core scram occurred as a result of a bypass valve transient during EHC troubleshooting.

V. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

To satisfy the action statement of Technical Specification 3.4.6.1, an engineering evaluation was conducted by CECO engineering and General Electric in San Jose. They were informed of the occurrence and supplied with the following data:

1. Cooldown rate as calculated from steam space pressure and temperature of approximately 113°F/hour.
2. Maximum metal temperature change of 10°F during transient.
3. Rx vessel level remained below shell flange.

It was concluded by the engineering evaluation that no structural effects on the reactor vessel had occurred, and that no nil ductility limits had been approached. These conclusions were reached based on the following facts:

1. Rx pressure vessel flange bolts were the limiting component.
2. Based on events, this occurrence was less severe than a normal shutdown during which water quenching of the flange occurs due to flooding.
3. Total fatigue usage for the limiting component was not affected as determined by the General Electric analysis.

VI. CAUSE:

LaSalle Unit 1 scrambled on low reactor water level, +12.5", as a result of a bypass valve transient during EHC troubleshooting. The excessive vessel cooldown addressed in this report was a consequence of rapid vessel depressurization, full core SCRAM and HPCS & RCIC injection. A detailed description of those events are discussed in DVR 1-1-83-270.

VII. CORRECTIVE ACTION:

Immediate response by the Operations Department was to return unit parameters to normal and to recover from the transient. An engineering evaluation was

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VII. CORRECTIVE ACTION (Cont'd):

performed as outlined in Section V of this report to determine the impact of the event.

Corrective actions to the cause of the transient and the resultant SCRAM are addressed in DVR 1-1-83-270.

Prepared by: D. R. Winterhoff



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

August 12, 1983

James G. Keppler
Regional Administrator
Region III
U.S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Dear Sir:

Reportable Occurrence Report #83-085/03L-0 Docket #050-373 is being submitted to your office in accordance with LaSalle County Nuclear Power Station Technical Specification 6.6.B.2.(b), conditions leading to operation in a degraded mode permitted by a limiting condition for operation or plant shutdown required by a limiting condition for operation.

CE Sargent

for G. J. Diederich
Superintendent
LaSalle County Station

GJD/GW/rg

Enclosure

cc: Director of Inspection & Enforcement
Director of Management Information & Program Control
U.S. NRC Document Management Branch
INPO-Records Center
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AUG 17 1983

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