

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK: [][][][](1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0][1] [L][L][S][C][][](2)[0][0]-[0][0][0][0][0][0]-[0][0](3)[4][1][0][0][0](4)[][](5)
7 8 9 13 14 15 25 26 30 31 32 CAT 33

LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT

CONT

CONT
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REPORT SOURCE L 6 0 5 0 0 0 3 7 3 7 1 1 2 8 8 3 8 1 2 2 3 8 3 9
60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES	
0	2 LIS-NR-02 Functional test required for operating conditions 2, 3, 4 & 5 due 11/25/83

0131 was not performed until 11/28/83.

When it was performed, no problems were noted and safe operation of the plant was

maintained at all times.

1	2	3	4	5	6	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	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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U.S. DEPARTMENT OF JUSTICE OFFICE OF THE ATTORNEY GENERAL OFFICE OF INSPECTION AND EVALUATION

7	8	9	SYSTEM	CAUSE	CAUSE	COMP.	VALVE
0	8						

0 9 | 1 | A | 11 | A | 12 | C | 13 | Z | Z | Z | Z | Z | 14 | Z | 15 | Z | 16

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	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
										SEQUENCIAL REPORT NO.										OCCURRENCE CODE										REPORT TYPE										REVISION NO.																																																					

(17) REPORT NUMBER

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	FORM SUB.	SUPPLIER	MANUFACTURER
1	2	3	4	5	6	7	8	9

33 34 35 36 37 38 39 40 41 42 43 44

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1	0	Personnel error was the cause as the LIS was overlooked during a hectic period
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 , preceding a weekend.

Administrative changes were made within the instrument department to make

_____ : stronger emphasis on the surveillance program and it's timely deployment.

1	3	
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7 8 9 (20) METHOD OF (22)

STATUS		% POWER	OTHER STATUS		DISCOVERY	OBSERVATION
1	5	B	(28)	0 0 0	(29) NA	A (31)

[illegible]

1 6 7 33 7 34 NA 44 45 NA

PERSONNEL EXPOSURES			DESCRIPTION (39)
NUMBER	TYPE		
1	37	3	28

NA

PERSONNEL INJURIES

NUMBER		DESCRIPTION
1	2	0 0 0 (40) NA

[illegible]

1 9 Z 42 NA
7 8 9 10 0101130341 031323 NRC USE ONLY

ISSUED	DESCRIPTION	(45)
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7 8 9 10

David H. Welsh

PHONE: 357-6761 x 278

NAME OF PREPARER

David J. Welsh

PHONE: 357-6761 x 278

NRC USE ONLY

8401130341 831223
PDR ADLOCK 05000373
S PDR

I. LER NUMBER: 83-151/03L-0

II. LASALLE COUNTY STATION: Unit 1

III. DOCKET NUMBER: 50-373

IV. EVENT DESCRIPTION:

On November 28, at 0888 it was identified that LIS-NR-02 Functional Test was not performed within the weekly channel functional test requirements of Table 4.3.1.1-1, item 1. The critical due date for the surveillance was November 25. The surveillance is required in conditions 2, 3, 4 and 5. The plant was placed in condition 4 the first week of November.

V. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

LIS-NR-02 Functional Test was performed on November 28, and no problems were identified. Safe operation of the plant was maintained at all times.

VI. CAUSE:

On 11/23/83 an Instrument Department Foreman was verbally informed by the Work Analyst and the Surveillance Coordinator that Surveillance LIS-NR-02 was due with a critical date of 11/25/83. The Computer Surveillance Schedule printout was also received at approximately 4:00 P.M. on 11/23/83 and a copy was distributed to the Foreman. The schedule reflected the critical date of 11/25/83. All other Control System Technician required surveillances for the cold shutdown mode had been completed, and no Control System Technicians had been scheduled to work during the Thanksgiving holiday or weekend period. On the afternoon of 11/23/83, an immediate response was requested by the operations personnel of the Instrument Department to verify the accuracy and operability of the RHR "B" Loop flow indication. This request occurred at approximately the same time period as the notification to the foreman of the surveillance requirement for LIS-NR-02. The foreman followed the work activities on the RHR System and failed to follow up on the surveillance required activity. When returning to work on 11/25/83 no review was made of the surveillance requirements for the Control System Technicians since no CST's were scheduled to work that day. The activities immediately prior to the end of the work day on 11/28/83 and the assumption that all CST surveillances were up to date since none were scheduled to work on 11/25/83 contributed to missing the required surveillance. The missed surveillance was discovered by the surveillance coordinator immediately upon return to work on 11/28/83.

VII. CORRECTIVE ACTION:

Functional test LIS-NR-02 was immediately performed on 11/28/83 and no problems were found. In order to prevent the reoccurrence of a missed surveillance of this nature again, administrative changes were initiated within the Instrument Department. The surveillance coordinator will identify to the scheduler which surveillances will have a critical date at least one day prior to the critical date. The scheduler will then require the mandatory completion, if practical, of the surveillance, as plant conditions permit, for the day prior to the critical date. The scheduler will provide followup to assure the surveillance is completed.

Prepared by: G. L. Cooper



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

AMB

December 23, 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 #83-151/03L-0 Docket #050-373 is being submitted to your office in accordance with LaSalle County Nuclear Power Station Technical Specification 6.6.B.2.(c), observed inadequacies in the implementation of administrative or procedural controls which threaten to cause reduction of degree of redundancy provided in reactor protection systems or engineered safety feature systems.

CE Sargent

for G. J. Diederich
Superintendent
LaSalle County Station

GJD/GW/sjc

Enclosure

cc: Director of Inspection & Enforcement
Director of Management Information & Program Control
U. S. NRC Document Management Branch
Info-Records Center
File/NRC

DEC 30 1983

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