

Commonwealth Edison Company  
LaSalle Generating Station  
2601 North 21st Road  
Marseilles, IL 61341-9757  
Tel 815-357-6761



May 15, 1995

U.S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, D.C. 20555

Licensee Event Report #95-010-00, Docket #050-373 is being submitted to your office in accordance with 10CFR50.73 (a)(2)(iv).

Sincerely,

A handwritten signature in dark ink, appearing to read "D. J. Ray".

D. J. Ray  
Station Manager  
LaSalle County Station

DJR/JG/lja

Enclosure

cc: NRC Region III Administrator  
NRC Senior Resident Inspector  
INPO - Records Center  
IDNS Resident Inspector  
IDNS Senior Reactor Analyst  
Nuclear Licensing Administrator  
Nuclear Safety Review

9505230083 950515  
PDR ADDCK 05000373  
S PDR

A Unicom Company

Handwritten initials or a signature in the bottom right corner, possibly reading "JE221".

NRC FORM 366 (5-92)		U.S. NUCLEAR REGULATORY COMMISSION			APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95					
<b>LICENSEE EVENT REPORT (LER)</b>										
FACILITY NAME (1) LaSalle County Station Unit 1					DOCKET NUMBER (2) 05000373			PAGE (3) 1 OF 4		
TITLE (4)      Auto Start of Standby Gas Treatment, Unit 1 and 2 Division 2 Reactor Building Ventilation Isolation, and Other Isolation Signals Received Due to the Wrong Fuse Being Pulled Due to Personnel Error										
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 NAME LaSalle Unit 2	DOCKET NUMBER 05000374
04	15	95	95	-- 010 --	00	05	15	95	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
N		20.2201(b)			20.2203(a)(3)(i)			50.73(a)(2)(iii)		73.71(b)
POWER LEVEL (10)		20.2203(a)(1)			20.2203(a)(3)(ii)			X 50.73(a)(2)(iv)		73.71(c)
000		20.2203(a)(2)(i)			20.2203(a)(4)			50.73(a)(2)(v)		OTHER
		20.2203(a)(2)(ii)			50.36(c)(1)			50.73(a)(2)(vii)		(Specify in Abstract below and in Text, NRC Form 366A)
		20.2203(a)(2)(iii)			50.36(c)(2)			50.73(a)(2)(viii)(A)		
		20.2203(a)(2)(iv)			50.73(a)(2)(i)			50.73(a)(2)(viii)(B)		
		20.2203(a)(2)(v)			50.73(a)(2)(ii)			50.73(a)(2)(x)		
LICENSEE CONTACT FOR THIS LER (12)										
NAME  Joe Giuffre, Master Mechanic, Extension 2222								TELEPHONE NUMBER (Include Area Code)  (815) 357-6761		
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	
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 15 single-spaced typewritten lines) (16)

On April 15, 1995, LaSalle Unit 1 was in Operational Condition 1 (Run) at 100% power, and Unit 2 was in Operational Condition 5 (Refuel). While performing a functional surveillance test on Primary Containment Cooling Water and Reactor Building Closed Cooling Water, the wrong fuse was pulled, resulting in multiple Engineered Safety Feature (ESF) actuations, including auto-start of the Standby Gas Treatment System, and isolation of Unit 1 and Unit 2 Division 2 Reactor Building Ventilation. Isolation signals were also received on Unit 2 Division 2 Containment Monitoring, Reactor Recirculation Hydraulic Power Unit, and Traversing Incore Probe (TIP) Purge.

The root cause of the event was personnel error. Electrical Maintenance personnel did not properly identify the correct terminal block prior to pulling the fuse. Corrective actions will include re-training of maintenance personnel in the performance of independent verification requirements, and management verification of each independent verification performed by maintenance personnel, until the re-training is complete.

This event is reportable pursuant to 10CFR50.73(a)(2)(iv) as an automatic actuation of an Engineered Safety Feature.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
LaSalle County Station, Unit 1	05000373	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 4
		95	-- 010 --	00	

TEXT (if more space is required, use additional copies of NRC Form 366A) (17)

## 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): 1/2 Event Date: 4/15/95 Event Time: 0108 Hours  
Reactor Mode(s): 1/5 Modes(s) Name: Run/Refuel Power Level(s): 100%/0

## B. DESCRIPTION OF EVENT

On April 15, 1995, LaSalle Unit 1 was in Operational Condition 1 (Run) at 100% power and Unit 2 was in Operational Condition 5 (Refuel Outage L2R06). A LaSalle Electrical Surveillance LES-PC-209, "Unit 2 PCCW and RBCCW Group 2 Isolation Logic System Functional Test", was being performed on Unit 2 Group 2 Isolation Logic for the Primary Containment Chilled Water (PCCW) System and Reactor Building Closed Cooling Water (RBCCW, WR)[CC] System. At 0108 hours, an Engineered Safety Feature (ESF) actuation occurred when an Electrical Maintenance (EM) Technician pulled a fuse from Terminal Point BB-13 in the Main Control Room Panel 2H13-P611, rather than the correct fuse at Terminal EE-13 in the same panel.

This action resulted in Unit 2 Division 2 Containment Monitoring (CM)[IK], Reactor Recirculation Hydraulic Power Unit (RR) [AD], and Traversing Incore Probe (TIP) Purge isolations, which are reportable ESF actuations. In addition, the Standby Gas Treatment System (SBGT, VG)[BH] auto-started, and Unit 1 and Unit 2 Division 2 Reactor Building Ventilation (VR)[VA] isolated.

The fuse was reinstalled by EM Technicians after concurrence was given by the Unit Shift Supervisor (USS) and Nuclear Station Operator (NSO). The Primary Containment Isolation Signals (PCIS, PC)[NH] were reset, and Unit 1 and 2 isolated systems were restored in accordance with Station procedures.

This event is reportable pursuant to 10CFR50.73(a)(2)(iv) as an automatic actuation of an Engineered Safety Feature.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

## C. CAUSE OF EVENT

Personnel error was the root cause of this event based on Electrical Maintenance (EM) Personnel incorrectly identifying terminal block BB as terminal block EE.

A contributing cause was a proper independent verification not being performed in accordance with LaSalle Administrative Procedure LAP-100-30, "Independent Verification". The first electrician located the terminal block, mistaking BB for EE in the 2H13-P611 panel and counted down the correct number of fuse positions. He then installed a fuse puller for means of identification of the fuse. The second individual, while watching the first individual, only counted fuse positions as his second or Independent Verification rather than satisfying the procedure by verifying the correct terminal block.

Both individuals involved are experienced Electrical Maintenance Technicians, trained and qualified on the independent verification process. This is documented on the Electrical Maintenance Job Assignment Matrix. During interviews with both individuals involved, it was determined that the pre-job briefing was thorough and fatigue was not a contributing factor.

## D. SAFETY ANALYSIS

The safety significance of this event is minimal. The isolation was generated as the result of an invalid signal caused by a loss of electrical power to the Primary Containment Isolation System (PCIS, PC) [NH] circuitry due to the personnel error. The Unit 2 Instrument Nitrogen TIP Indexer Purge, Containment Monitoring and the Reactor Recirculation Hydraulic Pressure Units were isolated but were not required to be operable during the event.

The Unit 1 and 2 Reactor Building Ventilation was also isolated and the Unit 1 and 2 Standby Gas Treatment Systems were initiated by the invalid signal.

The PCIS System operated as designed on the receipt of the isolation signal. All automatic isolation signals were received by the affected inservice equipment, and the equipment responded as designed. Isolated systems on both Unit 1 and Unit 2 were restored in accordance with station procedures.

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				REVISION NUMBER 00	PAGE (3) 4 OF 4

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

#### E. CORRECTIVE ACTIONS

Immediate corrective actions included the fuse being replaced upon recognition of the mistake and after concurrence of the USS and NSO. PCISs were reset, and the isolated systems were restored in accordance with Station procedures. Unit 1 and Unit 2 SEGT were then placed on standby operation.

The EM Supervisor and the EM Department Head counselled the involved EM Technicians on the importance of performing self-check, and to heighten their awareness of independent verification.

Maintenance Management Personnel will perform independent verification Apart-In-Time Prior to the Action (Apart-in-Action) of all Maintenance Bargaining Unit independent verification actions. Training will be given to station employees who perform or observe any independent verification actions. Training will consist of knowledge training and a performance demonstration exercise. Maintenance Management overview will continue until employees have been trained for independent verification and had a Task Performance Evaluation (TPE) performed and documented.

#### F. PREVIOUS OCCURRENCES

A previous events search (1993 to current) was performed for ESF actuations caused by personnel error.

LER Number	Title
373/93-001	Instrument Spike with Resulting Division II Low Pressure Coolant Injection Pump Start and 1A Diesel Generator Start Due to a Personnel Error
374/94-001	Scram when in Shell Warming on the Main Turbine Due to Personnel Error and Equipment Failure
374/95-001	Division 1 Emergency Core Cooling System/Reactor Core Isolation cooling Initiation Due to Personnel Error

#### G. COMPONENT FAILURE DATA

Since no component failure occurred, this section is not applicable.