

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

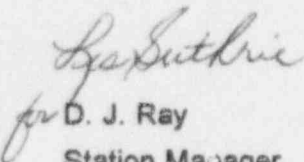


August 9, 1995

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

Licensee Event Report #95-012-00, Docket #050-373 is being submitted to your office in accordance with 10CFR50.73(a)(2)(i).

Sincerely,


for D. J. Ray
Station Manager
LaSalle County Station

DJR/pav

Enclosure

cc: H. J. Miller, NRC Region III Administrator
P. G. Brochman, NRC Senior Resident Inspector
R. J. Zuffa, IDNS Resident Inspector
F. Niziolek, IDNS Senior Reactor Analyst
INPO - Records Center
D. L. Farrar, Nuclear Regulatory Services Manager

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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.

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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 None	DOCKET NUMBER
07	10	95	95	-- 012 --	00	08	09	95	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
POWER LEVEL (10)	000	20.2201(b)	20.2203(a)(3)(i)	50.73(a)(2)(iii)	73.71(b)
		20.2203(a)(1)	20.2203(a)(3)(ii)	50.73(a)(2)(iv)	73.71(c)
		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)	x 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)	

NAME	TELEPHONE NUMBER (Include Area Code)
	(815) 357-6761

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

YES (If yes, complete EXPECTED SUBMISSION DATE).	NO	EXPECTED SUBMISSION DATE (15)			
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On July 10, 1995, Operations personnel identified that two fire protection valves, 1FP141 on Unit 1 and 2FP141 on Unit 2, had not been verified to be in the correct position within the last 31 days as required by Technical Specifications. These valves, 1FP141 and 2FP141, are fire water suppression header stop valves for the Auxiliary Building for Units 1 and 2, respectively. The cause of this event was personnel error in that a procedure revision, made in March of 1983, improperly removed the subject valves from a surveillance.

The 1FP141 and 2FP141 valves were immediately verified to be in their proper open positions. GSRV revisions have been made to ensure these valves are verified to be in the correct position during all plant conditions.

NRC FORM 366A (5-92)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95	
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 Units 1 & 2		05000373	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
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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: 07/10/95 Event Time: 0500 Hours

Reactor Mode(s): 1 / 1 Modes(s) Name: Run / Run Power Level(s): 81% / 100%

B. DESCRIPTION OF EVENT

On July 10, 1995, Operations Department personnel identified that Technical Specification related surveillances on two fire protection valves, 1FP141 on Unit 1 and 2FP141 on Unit 2, that were due on June 23, 1995 had not been performed before their critical date of June 26, 1995. This is contrary to Technical Specification 4.7.5.1.1.a which states that the fire suppression water system shall be demonstrated operable at least once per 31 days by verifying that each valve in the flow path is in its correct position.

A review of the surveillance history of the subject valves and the revision change history of the associated surveillance procedure revealed that a procedure revision, made in March 1983, improperly removed the subject valves from a surveillance that was to be conducted in all operating conditions (LaSalle Operating Surveillance LOS-FP-M3, Fire Protection Flow Path Valve Position Check) and put them into a surveillance that was performed only in operating conditions 3, 4, and 5 (LOS-FP-M5, Fire Protection Sprinkler and Deluge System Valve Lineup and Alarm Check for Conditions 3, 4, and 5). The purpose of the procedure changes for Operating Surveillances LOS-FP-M3 and LOS-FP-M5 in March 1983 was to exempt 1FP141 and 2FP141 from being performed in all modes due to the difficulty in establishing the required plant conditions to perform the surveillances. However, Technical Specification requirements were not reviewed prior to making the procedure change. The procedure review that was performed was not adequate in that the procedure change did allow an operation or condition prohibited by the Technical Specifications.

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

B. DESCRIPTION OF EVENT (Continued)

On February 16, 1995, an LER investigation was initiated to determine how a battery surveillance was missed (LER 373/95-007). The cause was determined to be inappropriate changes to the GSRV program involving the data cleanup during the migration of GSRV data to the Electronic Work Control System (EWCS). A line-by-line Surveillance Program Validation was performed to ensure each Technical Specification surveillance requirement was covered by a procedure and that GSRV reflected that a procedure existed. This validation failed to detect that LOS-FP-M5 Att 1B(2B) should be performed in all conditions, not just 3, 4, and 5. The content of the procedures and GSRV entries were not verified in the validation. Clearly, this corrective action did not adequately address the problem.

Because of the original mistake in 1983, the surveillance on 1FP141 was not performed monthly as required approximately 48 times and the surveillance on 2FP141 was not performed approximately 52 times.

C. CAUSE OF EVENT

This event is being reported pursuant to the requirements of 10CFR50.73(a)(2)(i) due to a deviation from the plant Technical Specifications.

The root cause of this event was personnel error in that inappropriate procedure changes were made to Operating Surveillance Procedures LOS-FP-M3 and LOS-FP-M5 in March of 1983. A contributing cause was a lack of accountability and ownership for implementation of Fire Protection Surveillances by Operations and Fire Protection personnel.

There were opportunities to discover that the surveillance was not being scheduled appropriately. There was a insufficient management oversight in regards to Technical Specification surveillance requirements and implementation of the GSRV program.

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D. SAFETY ANALYSIS

The 1FP141 and 2FP141 valves are a set of parallel valves that supply water to a fire protection water suppression loop header. The other valves that supply the loop (1FP140 and 2FP140) were on the correct surveillance procedure (LOS-FP-M3) and had been checked every month. Even if valves 1FP141 or 2FP141 had been inadvertently closed, water suppression would still have been available through the other valves. Since these valves are locked open and since these valves have never been found out of the correct position during any previous surveillance, assurance that the valves were always open is maintained. Additionally, Operating would have known if someone had entered the room where the valves are located because the VR Fans would have tripped upon opening the door. Therefore, at no time was the Auxiliary Building deprived of a fire suppression water supply. The safety consequences of this event are minimal.

E. CORRECTIVE ACTIONS

Valves 1FP141 and 2FP141 were verified to be in the correct open position immediately after the problem was identified on July 10, 1995.

Video cameras were installed inside the Unit 1 and Unit 2 Reactor Building Ventilation exhaust fan rooms such that the surveillance can be performed on the 1FP141 and 2FP141 valves without having to shut down the Reactor Building Ventilation System and physically enter the rooms.

The GSRV program was verified to insure that the surveillances on valves 1FP141 and 2FP141 are performed monthly in all operating modes.

Procedures LOS-FP-M3 and LOS-FP-M5 will be revised by August 25, 1995, to place valves 1FP141 and 2FP141 into the LOS-FP-M3 surveillance procedure.

All valves that are required to be checked by Technical Specification 4.7.5.1.1.a were verified to insure they are included on the surveillance procedure that is performed at the correct frequency and Operating Condition.

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E. CORRECTIVE ACTIONS (Continued)

Repeated problems with the Fire Protection Program implementation has resulted in the formation of a fire protection group led by an experienced Fire Protection Engineer within System Engineering. This group leader has oversight responsibility for all aspects of the LaSalle County Station Fire Protection Program. Also the scope of the surveillance issue investigation has been significantly expanded to review the LaSalle LCO Surveillance Program in order to prevent future failure to comply with Technical Specifications. The Operations Manager is the senior manager for this project. This will be a rigorous effort that will result in a high quality surveillance program and will include provisions for maintaining the quality of the surveillance program.

F. PREVIOUS OCCURRENCES

<u>LER Number</u>	<u>Title</u>
373/89-015-00	Missed Fire Protection Valve Position Verifications Due to Procedural Error.
373/90-008-00	Missed Technical Specification Hourly Fire Watch Due to Miscommunication
373/92-012-00	Missed Fire Watch Due to Personnel Error
374/95-002-00	Fire Watch Not Started Per Technical Specifications
374/95-004-00	Fire Watch Not Established Within Hourly Limit
373/95-007-00	Technical Specification Surveillances Were Not Performed on Unit 1 and Unit 2 Division III 125 VDC Batteries Due to Management Deficiency.
373/95-011-00	Missed Technical Specification Hourly Fire Watch

G. COMPONENT FAILURE DATA

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