Commonwealth Edison Company
LaSalle Generating Station
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ComEd

October 24, 1996

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D.C. 20555

Licensee Event Report #96-008-00, Docket #050-374 is being submitted to your office in accordance with 10 CFR 50.73(a)(2)(i).

Respectfully,

D. J. Ray
Station Manager
LaSalle County Station

Enclosure

cc: A. B. Beach, NRC Region III Administrator
M. P. Huber, NRC Senior Resident Inspector - LaSalle
C. H. Mathews, IDNS Resident Inspector - LaSalle
F. Niziolek, IDNS Senior Reactor Analyst
INPO - Records Center

IE22/1

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 05/31/95

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.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1):	DOCKET NUMBER (2)	PAGE (3)
LaSalle County Station Unit Two	05000374	1 of 4

TITLE (4)
Inadequate Review of Out of Service Checklist Results in Technical Specification Violation.

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	DOCKET NUMBER
									LaSalle County Station Unit One	05000373
09	28	96	96	008	00	10	28	96	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	5
POWER LEVEL (10)	000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

☐ 20.2201(b)	☐ 20.2203(a)(3)(i)	☐ 50.73(a)(2)(iii)	☐ 73.71(b)
☐ 20.2203(a)(1)	☐ 20.2003(a)(3)(ii)	☐ 50.73(a)(2)(iv)	☐ 73.71(c)
☐ 20.2203(a)(2)(i)	☐ 20.2003(a)(4)	☐ 50.73(a)(2)(v)	☐ OTHER
☐ 20.2203(a)(2)(ii)	☐ 50.36(c)(1)	☐ 50.73(a)(2)(vii)	
☐ 20.2203(a)(2)(iii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)
☐ 20.2203(a)(2)(iv)	☒ 50.73(a)(2)(i)	☐ 50.73(a)(2)(viii)(B)	
☐ 20.2003(a)(2)(v)	☐ 50.73(a)(2)(ii)	☐ 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Jack Leider, Operating	(815) 357-6761 Extension 3026

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

SUPPLEMENTAL REPORT EXPECTED (14)

				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
☐	YES (If yes, complete EXPECTED SUBMISSION DATE)	☒	NO				

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

On September 26, 1996, the Common Emergency Diesel Generator (EDG) was taken out of service for repairs. With this power source unavailable, the Primary Containment Vent and Purge Downstream Isolation dampers to the purge air filters were deactivated to comply with a technical specification. On September 28, 1996 the OOS was cleared for planned maintenance activities. Although the EDG remained inoperable, the dampers were also inadvertently cleared and electrical power was reinstated to the dampers. Approximately two hours later, the Shift Supervisor identified that the OOS had been incorrectly cleared, and an administrative OOS was prepared. During this period the isolation dampers remained closed and fuel movement and core alterations continued on Unit 2. Requirements of the technical specifications were not met and the handling of irradiated fuel in the secondary containment should have been suspended. The cause of this human performance error was inadequate review of the information on the checklist regarding the components being cleared. Corrective actions included review of the OOS to ensure that other OOSs had not been inadvertently cleared, counseling and training to Operating department supervisors on review of OOS checklists, and revision to equipment OOS procedure.

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: 09/28/96 Event Time: 0015 Hours
Reactor Mode(s): 4/5 Mode(s) Name: Cold Shutdown/Refuel Power Level(s): 0%/0%

B. DESCRIPTION OF EVENT

On September 26, 1996, the Common or 'O' Emergency Diesel Generator was taken out of service (OOS) to replace an underfrequency relay. With the Diesel Generator inoperable, emergency power is unavailable to the Primary Containment Vent and Purge Downstream Isolation [VB] dampers (1VQ038 and 2VQ038) to the purge air filters for both units. To comply with Technical Specification 3.6.5.2, the Upstream Isolation dampers, 1VQ037 and 2VQ037, were deactivated. This required taking the dampers out of service in the closed position, by opening the electrical power supply breakers, as part of out of service Number 960007844 for the Diesel Generator. During this period, Unit 1 was in cold shutdown with maintenance activities in progress and Unit 2 was in a refueling outage with fuel movements and core alterations in progress.

At 0015 hours on September 28th, the out of service was cleared for planned maintenance activities on the Common Diesel Generator, however, the Diesel Generator remained inoperable. In performing this final clear of the diesel's out of service tags, the 1VQ037 and 2VQ037 dampers were also inadvertently cleared and electrical power was reinstated to the dampers. When the OOS tag was being removed from the damper control switch, the Unit 1 control room operator questioned clearing the out of service with the Common Diesel Generator inoperable. The shift supervisors reviewed Technical Specification 3.6.5.2.a and determined that the out of service on the isolation dampers had been incorrectly cleared. The Shift Manager requested that an administrative out of service be written for 1VQ037 and 2VQ037 dampers. Based on their review of the Technical Specifications, the Shift Manager also considered that the Action statement for this section allowed 8 hours to return the dampers to the out of service, deactivated condition. The dampers were out of service again at approximately 0215 hours. During this period, the isolation dampers remained closed and fuel movement and core alterations continued on Unit 2.

During a review of the event later that morning, Operating department senior managers determined that when the isolation dampers were no longer deactivated, the requirements of Technical Specification 3.6.5.2.a were not met and that the handling of irradiated fuel in the secondary containment should have been suspended in accordance with Technical Specification 3.6.5.2.c. The event was then reported per 10 CFR 50.73(a)(2) due to a limiting condition for operation not being met.

C. CAUSE OF EVENT

The Senior Reactor Operator reviewed the checklist prepared to clear the Diesel Generator out of service for maintenance testing. The Senior Reactor Operator did not recognize that the 1VQ037 and 2VQ037 isolation dampers were inadvertently included and that the dampers needed to remain out of service, deactivated to comply with Technical Specification 3.6.5.2. This was a result of inappropriate human performance in not thoroughly reviewing the information on the checklist regarding the components being cleared and the referenced Technical Specifications which applied to the isolation dampers.

A contributing cause was that the components taken out of service for administrative control, such as the 1VQ037 and 2VQ037 dampers, were included on an out of service that was held only under the control of the working department, rather than under the control of the Operating department. As a result, when the Maintenance department requested the OOS be cleared, there was no corresponding Operating department holder to identify that the isolation dampers should be excluded from the request. This was a deficiency in the out of service program in that the necessary requirement to maintain the control of administrative out of services with a licensed operating supervisor was omitted.

D. ASSESSMENT OF SAFETY CONSEQUENCES

The event is of minimal safety significance. The Primary Containment Vent and Purge upstream and downstream dampers remained closed during the several hours that the upstream isolation dampers were not out of service. In the event of a fuel drop accident on Unit 2, the dampers were already closed thus ensuring that secondary containment boundary integrity was maintained. When power was reinstated to the isolation dampers' electrical breakers, the upstream and downstream dampers could have been opened by operator action. However, the dampers are only opened per procedure to vent primary containment or perform surveillance tests. In addition, the instrumentation which provides the isolation signal to close the dampers remained available and would have performed its function in the event of a fuel handling accident with the dampers open.

E. CORRECTIVE ACTIONS

1. Out of services in effect at the time of this event were reviewed to ensure that other components under administrative out of services had not been inadvertently cleared. No additional events were identified by this review. Where administrative out of services were included with other out of services, the components were verified to be held under the control of the operating department or they were removed and a separate out of service was written to obtain this control.

2. A second, additional Senior Reactor Operator review and approval of out of service checklists has been put into effect. This is an interim corrective action which will be instituted for six months to assure that the OOS review by the first SRO is correct.

3. Components being taken out of service administratively in order to meet Technical Specification requirements are now being held under the control of the Shift Manager or Operating Engineer. An operating department memo will be issued to incorporate this administrative control into the out of service process.

4. Counseling was provided by the Senior Operating Manager to operators and supervisors who review out of service checklists on the need for attention to detail.

5. Counseling and training were provided to Operating department supervisors on proper application of Technical Specification Limiting Conditions for Operation.

F. PREVIOUS OCCURRENCES

LER NUMBER.	TITLE
LER 373-94-014	High Pressure Core Spray Pump Made Inoperable in Unplanned/not Clearly Understood Manner due to Management Deficiency. The corrective actions from this event were to train operating personnel to include the Technical Specifications references on the out of service checklist. This corrective action was completed satisfactorily and would not have prevented the above event.

G. COMPONENT FAILURE DATA

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