

Exelon Generation Company, LLC
LaSalle County Station
2601 North 21st Road
Marseilles, IL 61341-9757

www.exeloncorp.com

January 6, 2004

10 CFR 50.73

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

LaSalle County Station, Unit 1
Facility Operating License Nos. NPF-11
NRC Docket No. 50-373

Subject: Licensee Event Report

In accordance with 10 CFR 50.73 (a)(2)(i)(B) and 50.73(a)(2)(v)(D), Exelon Generation Company, (EGC), LLC, is submitting Licensee Event Report Number 03-004-00, Docket No. 050-373.

Should you have any questions concerning this letter, please contact Mr. Glen Kaegi, Regulatory Assurance Manager, at (815) 415-2800.

Respectfully,



Susan Landahl
Plant Manager
LaSalle County Station

Attachment: Licensee Event Report

cc: Regional Administrator - NRC Region III
NRC Senior Resident Inspector - LaSalle County Station

JEZZ

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U. S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and by internet e:mail to bjsl@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NOEB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME LaSalle County Station, Unit 1	2. DOCKET NUMBER 05000373	3. PAGE 1 of 3
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4. TITLE High Pressure Core Spray Inoperable Due to Improperly Seated Fuse

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
11	17	2003	2003	004	00	01	06	04	FACILITY NAME	DOCKET NUMBER

9. OPERATING MODE 1
10. POWER LEVEL 100
11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)

<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)
<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)
<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 73.71(a)(4)
<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(5)
<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> OTHER
<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	Specify in Abstract below or in NRC Form 366A
<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(D)	
<input type="checkbox"/> 20.2203(a)(2)(v)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(vii)	
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	

12. LICENSEE CONTACT FOR THIS LER

NAME Mark Venaas, Operations Analyst	TELEPHONE NUMBER (Include Area Code) (815) 415-2771
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED

YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
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16. ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines)

At 0110 on 11/17/03, during the performance of a maintenance surveillance, fuse 1B21A-F8, the power supply fuse for the High Pressure Core Spray System (HPCS) Low Level Initiation/High Level Trip, was found not fully seated in its fuse clip. Loss of fuse continuity would have prevented automatic actuation of HPCS on reactor vessel low level, and would have prevented automatic closure of the HPCS discharge valve on reactor water high level.

The fuse was pushed back fully into the fuse clip at 0143. Engineering determined that, with the fuse not fully seated, continuity might not have been retained during a seismic event.

The cause of this event could not be determined. The most probable cause was a failure to fully seat the fuse during the last clearance order restoration in March 2002. Corrective actions included a walk down of other cabinets in the Main Control Room and Auxiliary Electric Equipment Room for similar conditions.

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

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor, 3489 Megawatts Thermal Rated Core Power

A. CONDITION PRIOR TO EVENT

Unit(s): 1 Event Date: 11/17/03 Event Time: 0110
 Reactor Mode(s): 1 Power Level(s): 100
 Mode(s) Name: Run

B. DESCRIPTION OF EVENT

At 0110 on 11/17/03, during the performance of a maintenance surveillance, fuse 1B21A-F8, the power supply fuse for the High Pressure Core Spray System (HPCS) [BG] Low Level Initiation/High Level Trip was found not fully seated in its fuse clip. This fuse was not involved in the surveillance. The fuse was pushed back fully into the fuse clip at 0143.

An Engineering evaluation concluded that the fuse function might not have been retained during a seismic event, and continued operability could not be assured while in the as-found condition. Failure of this fuse would have prevented automatic actuation of HPCS on reactor vessel low level 2; and would prevent automatic closure of the HPCS discharge valve 1B21-F004 on reactor water high level 8. This might prevent the HPCS system, a single train system, from performing its design function during a loss of coolant accident subsequent to a seismic event.

Extent of condition walk downs in the Division 3 Control Panels (1H13-P625 and 2H13-P625) found no similar conditions. A subsequent expanded extent of condition review was completed in the Auxiliary Electric Equipment Room and the Main Control Room. There were two other instances where fuses were not completely seated in their carriage. In both of cases, Engineering determined that this minor misalignment would not impact the ability of these fuses to perform their design function. The fuses were reseated properly.

This condition is reportable under 10 CFR 50.72(b)(3)(v)(D), and 50.73(a)(2)(v)(D) as an event or condition that could have prevented the fulfillment of a safety function needed to mitigate the consequences of an accident". An ENS call was made at 0835 CST on 11/17/03. It is also reportable under 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by the plant's Technical Specifications.

C. CAUSE OF EVENT

A review of the Passport work management system identified that this fuse was last manipulated as part of a clearance in March 2002. The operator who participated in the clearance had no specific recollection of installing this fuse, but was aware that fuse installation is always verified by pushing both ends of the fuse to ensure that it is fully engaged.

The cause of this event could not be determined. The most probable cause was a failure to fully seat the fuse during the last clearance order restoration in March 2002.

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

D. SAFETY ANALYSIS

The safety significance of this event was minimal. Failure of the fuse would have prevented automatic actuation of HPCS on reactor vessel low level, and would have prevented automatic closure of the HPCS discharge valve on reactor water high level. However, had fuse continuity not been maintained, control room operators would have been alerted by alarm 1H13-P625 "Rosemount Card File Trouble" on the 1H13-P601 panel, and would have responded to replace the fuse.

With the fuse open, HPCS could have been manually operated if required to mitigate the consequences of an accident. Additionally, RCIC provides alternate high-pressure injection, and Automatic Depressurization System and Low Pressure Core Spray were available to provide low pressure spray to the reactor.

This event constitutes a safety system functional failure.

E. CORRECTIVE ACTIONS

1. An extent of condition review of the Division 3 Control Panels (1H13-P625 and 2H13-P625) was completed with no other improper fuse installations identified. This action is complete.
2. An extent of condition review was completed in the Auxiliary Electric Equipment Room and the Main Control Room. This action is complete.
3. This event was reviewed with all Operations and Maintenance personnel, stressing the importance of ensuring fuses are fully seated in their clips, specifically for the purpose of maintaining seismic qualification and operability of equipment. This action is complete.

F. PREVIOUS OCCURRENCES

A search of the corrective action program database identified a similar, non-reportable event (CR# 125478) that occurred in October 2002. A loose fuse clip resulted in a "Drywell Equipment Drain Pump Failure to Start" alarm, and a loss of indication for the Drywell Equipment Drain Sump pump suction valve. The corrective action was to replace the loose fuse clip. The corrective action would not have prevented this event.

G. COMPONENT FAILURE DATA

This is not applicable, as no component failures occurred.