NRC FORM 366 (6-1998) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-
EXPIRES 06/30/2001

LICENSEE EVENT REPORT (LER)

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. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), 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. If an 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.

FACILITY NAME (1): LaSalle County Station, Unit 1

DOCKET NUMBER (2): 05000373

TITLE (4): Missed Technical Specification Rod Operability Surveillance 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	DOCKET NUMBER
06	23	99	99	002	00	07	23	99	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9): 1

POWER LEVEL (10): 096

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

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

LICENSEE CONTACT FOR THIS LER (12)

NAME: Charles Maney, Operations Staff

TELEPHONE NUMBER (Include Area Code): (815) 357-6761 Extension 2929

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

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

SUPPLEMENTAL REPORT EXPECTED (14)

☐ YES (If yes, complete EXPECTED SUBMISSION DATE) ☒ NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

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

On June 23, 1999, the Unit Supervisor for Unit 1 discovered that only a portion of the Rod Operability Check had been performed. The Rod Operability Check had last been performed in its entirety on June 13, 1999. Therefore, the surveillance interval on the remaining control rods had exceeded Technical Specification 4.4.1.3.1.1.b. requirements.

The cause of the missed surveillance was a personnel error on the part of the Unit Supervisor on June 19, 1999, who made an erroneous assumption that a portion of the control rods had been checked previously. The surveillance was immediately performed on the remaining control rods, and all were found to be operable. Corrective actions included counseling for the responsible individual and a lessons learned briefing using the General Information Notice process for all departments performing Technical Specification surveillances.

The significance of the event was minimal, since all rods were found to be operable. This event is reportable under 10 CFR 50.73(a)(2)(i)(B) as an event or condition prohibited by the plant's Technical Specifications.

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LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
LaSalle County Station, Unit 1	05000373	99	002	00	2 of 3

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

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor, 3323 Megawatts Thermal Rated Core Power

Energy Industry Identification System (EIIS) codes are identified in the text as [XX].

A. CONDITION PRIOR TO EVENT

Unit(s): 1 Event Date: 06/23/99 Event Time: 1800 Hours

Reactor Mode(s): 1 Power Level(s): 096
Mode(s) Name: Run

B. DESCRIPTION OF EVENT

On June 23, 1999, while completing documentation associated with the June 19, 1999, performance of LOS-AA-W1, "Technical Specification Weekly Surveillances," the Unit Supervisor for Unit 1 discovered that only a portion of the Rod Operability Check had been performed. The Rod Operability Check had last been performed in its entirety on June 13, 1999, which meant that the surveillance interval on the remaining control rods had, on June 22, 1999, exceeded the seven days allowed by Technical Specification 4.4.1.3.1.1.b. plus the 25 per cent additional period permitted by Technical Specification 4.0.2.

A review determined that the Unit Supervisor on June 19, 1999, had assumed but failed to verify that a portion of the control rods (RD)[AA] had been checked on Thursday, June 17, 1999, when power was reduced to make an entry into the Main Condenser waterbox to remove zebra mussels. This assumption was based on the practice of including the Rod Operability Check as part of the control rod maneuver for a downpower on Unit 1, since the control rods in the vicinity of an existing fuel element leak could only be exercised at a lower power. The Rod Operability Check Surveillance was scheduled and communicated for its regular time and day on Sunday and not as part of the downpower control rod maneuver.

Having made the assumption that the other control rods had been checked, the Unit Supervisor directed that the surveillance only be conducted on the rods in the vicinity of the fuel element leak. He then signed for acceptable completion of the surveillance, noting which rods were exercised, with a comment that the other rods had been exercised previously.

Subsequent review of the surveillance documentation on June 23, 1999, identified the incomplete surveillance. The Rod Operability Check was immediately performed satisfactorily on the remaining rods.

This event is reportable under 10 CFR 50.73(a)(2)(i)(B) as an event or condition prohibited by the plant's Technical Specifications.

C. CAUSE OF EVENT

It was determined that the root cause of this event was a lack of attention to detail on the part of the Unit Supervisor on June 19, 1999, by his failure to meet management's expectations to verify and validate assumptions before proceeding.

Both the schedule and the surveillance paperwork were clear and unambiguous and, if followed, would have prevented this event.

D. SAFETY ANALYSIS

The safety significance of the event is minimal. Once discovered, the remaining control rods were tested immediately and were found to be operable. All prior performances of the Rod Operability Check had found the rods operable.

E. CORRECTIVE ACTIONS

Immediate Actions:

1. The remaining control rods were checked and verified to be operable. COMPLETE.

2. To determine extent of condition, all Rod Operability Check surveillances since the surveillance was moved to the weekend were reviewed to determine if there were any additional incidents. None were found. COMPLETE.

3. Available Senior Reactor Operators and training personnel were called in to discuss the incident and its impact, and to reinforce management standards and expectations. COMPLETE.

Corrective Actions to Prevent Recurrence:

4. The responsible individual was counseled in accordance with management policy. COMPLETE.

5. A General Information Notice (GIN) describing this event and its cause will be distributed to all departments performing Tech Spec surveillances (ATM# 12850-16).

F. PREVIOUS OCCURRENCES

A review of Licensee Event Reports over the previous two years found no previous occurrences of a failure to complete a Technical Specification surveillance due to a personnel error on the part of a licensed operator.

G. COMPONENT FAILURE DATA

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