Commonwealth Edison
Braidwood Nuclear Power Station
Route #1, Box 84
Braceville, Illinois 60407
Telephone 815/458-2801

January 2, 1990
BW/89-3224

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

Dear Sir:

The enclosed Licensee Event Report from Braidwood Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(iv) which requires a 30-day written report.

This report is number 89-018-00; Docket No. 50-456.

Very truly yours,

for R. E. Querio
Station Manager
Braidwood Nuclear Station

REQ/JDW/jfe
(7126z)

Enclosure: Licensee Event Report No. 89-018-00

cc: NRC Region III Administrator
NRC Resident Inspector
INPO Record Center
CECo Distribution List

IE22
1/1

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Braidwood 1	0 5 0 0 0 4 5 6	1 of 0 3

Title (4)

Containment Ventilation Isolation Signal Due to Surveillance Procedure Deficiency

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 Names	Docket Number(s)
1 2	1 5	8 9	8 9	---	0 1 1 8	0 0	0 1	0 2	9 0	NONE	0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)			
		___ 20.402(b)	___ 20.405(c)	X 50.73(a)(2)(iv)	___ 73.71(b)
POWER LEVEL (10)	0 1 8	___ 20.405(a)(1)(i)	___ 50.36(c)(1)	___ 50.73(a)(2)(v)	___ 73.71(c)
		___ 20.405(a)(1)(ii)	___ 50.36(c)(2)	___ 50.73(a)(2)(vii)	___ Other (Specify in Abstract below and in Text)
		___ 20.405(a)(1)(iii)	___ 50.73(a)(2)(i)	___ 50.73(a)(2)(viii)(A)	
		___ 20.405(a)(1)(iv)	___ 50.73(a)(2)(ii)	___ 50.73(a)(2)(viii)(B)	
		___ 20.405(a)(1)(v)	___ 50.73(a)(2)(iii)	___ 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name	TELEPHONE NUMBER
	AREA CODE
P. G. Holland, Regulatory Assurance Ext. 2364	8 1 5 4 5 8 - 2 8 0 1

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)	X NO				

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

Surveillance 1BwVS 3.3.1-2, Monthly Digital Channel Operational Test of Area Radiation Monitors 1RT-AR011 and 1RT-AR012 was in progress. The procedure required a lead to be lifted, contacts verified open or closed several times using a Volt-Ohm Meter (VOM), and the lead landed. At 1318 on December 15, 1989, as the lead was being landed, the Containment Building Fuel Handling Incident Area Radiation Monitor 1Rt-AR011 (AR)(IL) went into alert alarm and interlock actuation. The interlock function of monitor 1RT-AR011 initiated a Train A Containment Ventilation Isolation Signal. No components were repositioned as the associated containment isolation valves were already closed. The root cause of this event was a deficient procedure. The procedure failed to direct removal of the VOM prior to landing the lead. This allowed a spike to occur as the lead was landed. The containment isolation signal was reset following verification that it was due to the performance of the surveillance. 1BwVS 3.3.1-2 will be revised to include a step for removal of the VOM prior to landing the lead. The other Technical Staff radiation monitor surveillance procedures that have a potential for an Engineered Safety Feature actuation will be reviewed to ensure that the same deficiency does not exist. The procedures will be revised as necessary. Previous corrective actions are not applicable to this event.

A. Plant Conditions Prior to Event:

Unit: Braidwood 1; Event Date: December 15, 1989 Event Time: 1318;
Mode: 1 - Power Operation; Rx Power: 18%; RCS(AB)Temperature/Pressure: NOT/NOP

B. Description of Event:

There were no systems or components inoperable at the beginning of the event which contributed to the severity of the event. Braidwood Technical Staff Surveillance 1BwVS 3.3.1-2, Monthly Digital Channel Operational Test of 1RT-AR011 and 1RT-AR012 was in progress.

1BwVS 3.3.1-2 is performed with an Instrument Maintenance (IM) Technician (non-licenced) in the field and a System Test Engineer (STE) (non-licensed) in the Main Control Room (MCR). The STE and IM were maintaining continuous communications in accordance with the procedure. The STE read the steps, which included directing the IM to:

1) lift field lead at TB2 terminal 16,

2) Using a Volt Ohm Meter (VOM), verify contacts at TB2 terminals 16 and 17 are open or closed several times, and

3) land field lead at TB2 terminal 16.

At 1318 on December 15, 1989, as the IM was landing the field lead at TB2 terminal 16, the Containment Building Fuel Handling Incident Area Radiation Monitor 1RT-AR011 (AR)(IL) went into alert alarm and interlock actuation. The interlock function of monitor 1RT-AR011 initiated a Train A Containment Ventilation Isolation Signal. The signal annunciated an alarm in the MCR. No components repositioned as the associated containment isolation valves were already closed.

Plant conditions remained stable throughout the event. Operator actions neither increased or decreased the severity of the event.

At 1349 on December 15, 1989, the appropriate NRC notification via the ENS phone system was made pursuant to 10CFR50.72(b)(2)(ii).

This event is being reported pursuant to 10CFR50.73(a)(2)(iv) - any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature, including the Reactor Protection System.

C. Cause of Event:

The root cause of this event was a deficient procedure. The procedure failed to direct removal of the VOM prior to landing the field lead at TB2 terminal 16. This allowed the spike to occur as the lead was landed.

D. Safety Analysis:

This event had no effect on the safety of the plant or the public as all systems responded as designed.

The Containment Purge Isolation valves were already closed at the time of the event. 1RT-AR012 was operable and available for redundant indication and actuation of the Train B Containment Ventilation Isolation Signal.

The worst case condition would be a failure of a Containment Fuel Handling Incident Radiation Monitor Detector during the purge of the containment. The redundant Fuel Handling Incident Radiation Monitor would generate a Containment Ventilation Isolation and the purge would be automatically secured as would have been the case in this event. This is enveloped in Section 6 of the Updated Final Safety Analysis Report (UFSAR).

E. Corrective Actions:

The containment isolation signal was reset following verification that it was due to the performance of the surveillance.

1/2 BwVS 3.3.1-2 will be revised to include a step for removal of the VOM prior to landing the field lead at TF2 terminal 16. This will be tracked to completion by action item 456-200-89-19801.

The other Technical Staff radiation monitor surveillance procedures that have a potential for an Engineered Safety Feature actuation will be reviewed to ensure that the same deficiency does not exist. The procedures will be revised as necessary. This will be tracked to completion by action item 456-200-89-19802.

F. Previous Occurrences:

There have been previous occurrences of spurious Containment Isolation Signals. In each case corrective actions were implemented addressing both root and contributing causes. Previous corrective actions are not applicable to this event.

G. Component Failure Data:

This event was not caused by component failure, nor did any component fail as a result of this event.