



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

DCD

September 24, 1990
BW/90-0967

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 90-016-00; Docket No. 50-456.

Very truly yours,

K. L. Kofron
Station Manager
Braidwood Nuclear Station

KLK/JDW/clf
(7126z)

Enclosure: Licensee Event Report No. 90-016-00

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

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

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

Title (4) Spurious Auto Start of the Auxiliary Building Inaccessible Filter Plenum A Charcoal Booster Fan OB due to Unknown Cause

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)
0 8	2 8	9 0	9 0	0 1 6	0 0	0 9	2 4	9 0	None	0 5 0 0 0 1 1
										0 5 0 0 0 1 1

OPERATING MODE (9) 1

POWER LEVEL (10) 0 9 9

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	<input type="checkbox"/> 50.73(a)(2)(x)	<input type="checkbox"/> 73.71(b)	<input type="checkbox"/> 73.71(c)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)
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LICENSEE CONTACT FOR THIS LER (12)

Name Al Ficcardi, Technical Staff Engineer Ext. 2832 TELEPHONE NUMBER B 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)

Yes (If yes, complete EXPECTED SUBMISSION DATE) NO Expected Submission Date (15) _____

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

At 0537 on August 28, 1990 the Auxiliary Building Inaccessible Filter Plenum A Charcoal Booster Fan OB, OVA03CB, spuriously auto started. The Nuclear Station Operator (NSO) examined the control switch position and identified that the switch was in the after trip position. This indicated that the fan had not been started from the Main Control Room. An Equipment Attendant (EA) was dispatched to a local panel that contained a control switch and a transfer switch which selected the control point for the OVA03CB as either the Main Control Room or that panel. The fan was selected for control from the Main Control Room. The NSO inspected the automatic actuation relays on both Unit 1 and Unit 2. The relays, which are latching style relays that actuate as a function of a Safety Injection, were found in the "unlatched" state. Additionally, no other components associated with the relays had operated on either unit. The NSO secured the OVA03CB and the fan did not restart when the switch was released to the after trip position. The cause of this event is undetermined. The fan circuitry and breaker were checked and found to be functioning properly. Relay tests were performed on both units and all components functioned as designed. Previous corrective actions are not applicable to this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				Page (3)		
		Year	Sequential Number	Revision Number				
Braidwood 1	0 5 0 0 0 4 5 6	9 0	- 0 1 6	- 0 0	0 2	OF	0 3	

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

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: Braidwood 1; Event Date: August 28, 1990; Event Time: 0537;
 Mode: 1 - Power Operation; Rx Power: 99%;
 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.

At 0537 on August 28, 1990 the Auxiliary Building Inaccessible Filter Plenum A Charcoal Booster Fan OB (VA) [VF], OVA03CB, spuriously auto started. The Nuclear Station Operator (NSO) (Licensed Reactor Operator) verified proper damper alignment. No other components actuated. The NSO examined the OVA03CB control switch position and identified that the switch was in the after trip position. This indicated that the fan had not been started from the Main Control Room.

An Equipment Attendant (EA) (non-Licensed Operator) was dispatched to local panel OVA01JB. This panel contained a local control switch and a transfer switch which selected the control point for the OVA03CB as either the Main Control Room or that panel. The EA identified that the fan was selected for control from the Main Control Room.

The NSO then inspected the automatic actuation relay K-602 in the OB train of the Solid State Protection System (SSPS) [JE] on both Unit 1 and Unit 2. The relays were latching style relays that actuate as a function of a Safety Injection Signal on the associated unit. The relays were found in the "unlatched" state. Additionally, none of the other components that actuate from a K-602 relay actuation had operated on either unit. Based on this inspection it was concluded that the fan had not started as a function of the SSPS.

At 0551 the NSO secured the OVA03CB by placing the Main Control Room control switch in the trip position. The fan did not restart when the NSO released the switch to the after trip position.

The appropriate NRC notification via the ENS phone system was made at 0926 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 is undetermined. The fan circuitry and breaker were checked and found to be functioning properly. Slave relay tests were performed for the OB Train K-602 relay on both units. All components functioned as designed. The fan could not have been started from the Main Control room because the control switch must be placed in the "Trip" position to arrive at the as found "After Trip" position. The possibility that the fan could have been started either inadvertently or deliberately from local panel OVA01JB is considered remote. Placing the transfer switch for OVA03CB in a position that would permit control from the local panel would isolate control and light indication from the Main Control Room. The fan run light indication in the Main Control Room was the NSO's method of identification for the spurious auto start.

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D. SAFETY ANALYSIS:

This event had no effect on the safety of the plant or the public. The fan start was neither desired or required and was inappropriate for existing plant conditions. There are no reasonable or credible alternate conditions that would have been more severe.

E. CORRECTIVE ACTIONS:

Fan OVA03CB was secured after verification that it was not required.

The fan breaker and control circuitry were checked and found to be functioning properly.

The SSPS slave relay tests for the OB Train K-602 relay were performed for both units. All components functioned as designed.

F. PREVIOUS OCCURRENCES:

There have been previous occurrences of spurious ESF actuations. The 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 the result of component failure, nor did any components fail as a result of this event.