



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

November 2, 1990
BW/90-1089

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 require a 30-day written report.

This report is number 90-019-00; Docket No. 50-456.

Very truly yours,

K. L. Kofron
Station Manager
Braidwood Nuclear Station

KLK/JDW/clf
(7126z)

Enclosure: Licensee Event Report No. 90-019-00

cc: NRC Region III Administrator
NRC Resident Inspector
INPO Record Center
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

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		Year	Sequential Number	Revision Number			
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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: October 6, 1990;
Event Time: 0728;

Mode: 5 - Cold Shutdown;
Rx Power: 0%;

RCS [AB] Temperature/Pressure: 180 degrees F/360 psig.

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 0728 on October 6, 1990 the Gas Detector channel of Process Radiation Monitor (PR)[IL] OPR31J, Control Room Outside Air Intake A, experienced a spike that resulted in an High Radiation Alarm Setpoint being exceeded. This caused a Control Room Ventilation actuation for the OA Train of Control Room Ventilation (VC)[VI]. As a result the following occurred:

1. The OA VC supply Fan Dampers repositioned to provide flow through charcoal adsorbers.
2. The OA VC Makeup Fan started.
3. Dampers repositioned to provide flow through the OA Makeup Filter Unit.

The Nuclear Station Operator (NSO) (Licensed Reactor Operator) verified all automatic actions and confirmed that a High Radiation condition did not exist by trending the OPR31J and the redundant monitor, OPR32J. The monitor was declared inoperable and the appropriate Technical Specification Action Statement was entered and complied with.

The appropriate NRC notification via the ENS phone system was made at 0849 pursuant to 10CFR50.72(b)(2)(ii).

During the next several weeks the monitor and its associated instrument and control circuit were tested. No problems were identified, nor did any additional spikes occur.

At 0126 on October 20, 1990 after completion of all trouble shooting activities, the OPR31J was declared operable and the Technical Specification action statement was exited.

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 spurious spike of the Gas Channel of OPR31J for unknown reasons. Both the monitor and the detector were tested and all items functioned properly. The monitor was trended for several weeks and the monitor performed satisfactorily.

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D. SAFETY ANALYSIS:

This event had no effect on the safety of the plant or the public. There was no radioactivity present. OPR31J operated as designed and generated a Control Room Ventilation Actuation signal for the OA train of VC. The OPR32J was operable and available for redundant indication of the activity level.

Under more limiting conditions of actual radioactivity, the Control Room Ventilation would have shifted to the ESF safe configuration as was the case in this event.

E. CORRECTIVE ACTIONS:

All automatic actions were verified.

The NSO verified that a High Radiation condition did not exist using the redundant monitor and trends on the OPR31J.

The detector for the Gas Channel as well as monitor OPR31J were tested and trended for several weeks. No problems were identified and all items functioned as designed.

Discrepancies with Radiation Monitoring components are currently being trended in the Braidwood Station Trend Report program. This event has been added to that trend.

F. PREVIOUS OCCURRENCES:

There have been previous occurrences of spurious Control Room Ventilation Actuation 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 the result of component failure, nor did any components fail as a result of this event.