



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

November 11, 1994
BW/94-0168

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 in accordance with the requirement of 10 CFR 50.73(a)(2)(i)(B), which requires a 30-day written report.

This report is number 94-007-00, Docket No. 50-457.

K. L. Kofron
Station Manager
Braidwood Generating Station

CP/da
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Encl: Licensee Event Report
No. 457/94-007-00

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

FACILITY NAME (1) **Braidwood 2** DOCKET NUMBER (2) **05000457** PAGE (3) **1 OF 4**

TITLE (4) **Core alterations performed without establishing proper communications 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
10	15	94	94	-- 007 --	00	11	11	94	None	None
									None	None

OPERATING MODE (9) 6	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
POWER LEVEL (10) 000	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
	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
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)
	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 **P. Lau, Regulatory Assurance** TELEPHONE NUMBER (Include Area Code) **(815) 458-2801 x2957**

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
				N					

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 15 single-spaced typewritten lines) (16)

While performing the lift of the Reactor Vessel Upper Internals, the Communications between the Control Room and the Containment where the core alteration was being performed was lost, contrary to Technical Specification 3.9.5. The Fuel Handling Supervisor in the containment filling the role of the Senior Operator License holder assumed the speaker phone with the open communications could be heard from his viewing area. As a result the control room could not contact the Fuel Handling Supervisor in the containment. The root cause for the event was determined to be Personnel Error. Corrective actions included personal counselling and the change to the phone used to maintain communication.

NRC FORM 366A (5-92)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95	
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION				ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNB 7714), 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.	
FACILITY NAME (1)		DOCKET NUMBER (2)	LER NUMBER (6)		PAGE (3)
Braidwood 2		05000457	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
			94	-- 007 --	00
					2 OF 4

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

A. PLANT CONDITIONS PRIOR TO THE EVENT:

UNIT: 2 EVENT DATE: OCTOBER 15, 1994
 EVENT TIME: 0623
 MODE: 6 RX POWER: 0%
 RCS [AB] TEMP/PRESS: AMBIENT

B. DESCRIPTION OF EVENT

There was no plant equipment inoperable at the beginning of this event that contributed to the severity of the event.

The lifting and removal of the Reactor Vessel Upper Internals was scheduled to be performed during shift 1 or shift 2 on October 15, 1994. The fuel handling supervisor (FHS) (Licensed Operator) duties had been split into two shifts. The night shift FHS was unlatching control rods in preparation of the upper internals lift with the last control rod being unlatched about 0500. Because of this activity he did not attend the Infrequent Plant Activity (IPA) meeting for the upper internals lift, which was held during the night shift.

At approximately 0545 the day shift FHS arrived in the containment, a turnover occurred with the night shift FHS, and was told the upper internals were about ready to be lifted. The turnover included the need to maintain communications between the containment and the control room. The day shift FHS verified the speaker phone was open and operating between the control room and the containment. Shortly after 0600 the FHS told the control room the upper internals were going to be lifted in the next 5 to 20 minutes and received concurrence from the control room. Additionally, the containment ventilation purge was discussed as going to be secured for the lift.

About 0620 the FHS again contacted the Control Room and informed them the lift would commence in 2 to 5 minutes. The FHS positioned himself approximately 35 feet from the speaker phone, and he believed he could still hear if someone was trying to contact him from the control room. At this location he had the remote TV monitors in view to determine if a bundle or a control rod was being lifted as well as being able to hear the source range count in the containment while ensuring his dose would be as low as reasonably achievable.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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

B. DESCRIPTION OF EVENT (continued):

At 0622 the containment ventilation purge was stopped by the control room personnel. Around 0623 the Mechanical Maintenance Supervisor (MMS) [non-licensed] in charge of the work was ready to lift the upper internals. The MMS asked the FHS if they could begin the lift, and his response was OK. The upper internals began to move slowly while the FHS verified no control rods or fuel assemblies were being lifted with the upper internals via the remote TV monitors, no movement could be detected and the lift of the upper internals continued. Additionally, the FHS was in constant communication with Health Physics personnel for any unusual radiation level changes.

At about 0625 the control room was unsure of when the moment the lift was to begin. At this time the Unit Nuclear Station Operator (NSO) [licensed operator] was directed to try to contact the containment via the dedicated phone line. Voice communications could not be established. By 0640 the area radiation monitor had been checked by the Unit NSO as an alternate method of determining if the upper internals lift had occurred. The indications were the lift had occurred and the radiation levels were back down to 50 mrem per hour and decreasing. Personnel were contacted in the Fuel Handling Building by the Unit NSO, to tell the FHS to contact the control room. Voice communications were re-established.

This event is being reported pursuant to 10CFR50.73(A)(2)(i)(B) - any operation prohibited by the plant's Technical Specifications.

C. CAUSE OF EVENT:

Personnel Error on the part of the Fuel Handling Supervisor in that the communications link was not maintained with the control room. The Fuel Handling Supervisor erroneously assumed he could hear the speaker phone from his location.

D. SAFETY ANALYSIS:

This event had no effect on plant or public safety. The upper internals were lifted with no motion from any other component which could have affected reactivity. No change in the core thermal power occurred as a result of the less than adequate communications. Operations personnel did not have to take any additional action on the part of the reactor due to this event. At all times during the movement of the upper internals the fuel handling supervisor could have immediately made contact with the control room.

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TEXT CONTINUATION

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

E. CORRECTIVE ACTIONS:

The individual involved was spoken to with respect to proper communications techniques when performing the role of Fuel Handling Supervisor by the Senior License Holder.

A telephone handset with a long cord has been identified as the proper method of communications during these conditions. This method has since been used successfully for the replacement of the upper internals as well as for the placement of the Reactor Vessel Head.

F. PREVIOUS OCCURRENCES:

None.

G. COMPONENT FAILURE DATA:

None.