

Commonwealth Edison Company
Braidwood Generating Station
Route #1, Box 84
Braidwood, IL 60407-9619
Tel 815-458-2801



August 31, 1995
BW/95-0086

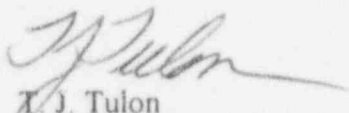
Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Gentlemen:

The enclosed Licensee Event Report from Braidwood Generating Station is being transmitted in accordance with the requirements of 10 CFR 50.73(a)(2)(i) and 10 CFR 50.36(c)(2), which require a 30-day written report.

This report is number 95-006-00, Docket No. 50-456.

Yours truly,


T. J. Tulon
Station Manager
Braidwood Nuclear Station

TJT/BJM/dla
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Encl: Licensee Event Report
No. 456-95-006-00

cc: NRC Region III Administrator
NRC Resident Inspector
INPO Record Center
CECo Distribution Center
I.D.N.S.
I.D.N.S. Resident Inspector

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9509060258 950831
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Handwritten signature/initials

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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)
Braidwood 1DOCKET NUMBER (2)
05000456PAGE (3)
1 OF 5

TITLE (4) Missed Control Room Ventilation one hour LCOAR due to procedural deficiency and 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
08	10	95	95	-- 006 --	00	08	31	95	Braidwood Unit 2	05000457
									FACILITY NAME	DOCKET NUMBER
			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
OPERATING MODE (9) 1			20.402(b)			20.405(c)			50.73(a)(2)(iv) 73.71(b)	
POWER LEVEL (10) 99.5			20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v) 73.71(c)	
			20.405(a)(1)(ii) X			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)(iii)(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. Studdard, System EngineeringTELEPHONE NUMBER (Include Area Code)
(815) 458-2801 x3110

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
X	IL	P	Thomas Industr	N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On 8/10/95 surveillance OBwOS 7.6.B-1 was in progress on the 0A VC makeup filter train with the charcoal absorber in bypass. At 0845 the RM-11 alarmed for the ORE-PR032B. The Nuclear Station Operator (NSO) reported this alarm to the Unit Supervisor precipitating a discussion concerning the status of LCOAR 3.3.1-1a for the OPR32J calibration. After completing a current task, the Unit Supervisor determined that the LCOAR in question had been exited and entered the LCOAR 3.3.1-1a. This was reported to the Shift Engineer at 0915. The Unit Supervisor determined the action requirements were met by the 0A VC train being in the makeup mode per the surveillance in progress. At 0950 the Unit Supervisor recognized that with the charcoal absorber in bypass it was questionable if the action requirements were being met. The Unit Supervisor informed the Shift Engineer and a discussion between the Shift Engineer and both Unit Supervisors determined the 0B VC train needed to be placed in service to ensure meeting the action requirements. OBwOS 7.6.b-1 was terminated and the 0A VC train absorber was placed in service. At 1022 the 0B VC train was placed in service. Requirements of the one hour LCOAR were not met for 1 hour and 24 minutes. Repairs to the OPR32J skid were completed on 8/29/95. Surveillance OBwOS 7.6.b-1 was completed satisfactorily on 8/15/95. The Unit Supervisor and Shift Engineer were counseled concerning their actions.

NRC FORM 366A
(5-92)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95LICENSEE 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 (MNBB 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 1	05000456	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
		95	-- 006 --	00
2 OF 5				

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

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: Braidwood 1; Event Date: August 10, 1995;
 Event Time: 0845;
 Mode: 1 - Power Operation; Rx Power: 99.5%;
 RCS [AB] Temperature/Pressure: NOT/NOP

Unit: Braidwood 2; Event Date: August 10, 1995;
 Event Time: 0845;
 Mode: 1 - Power Operation; Rx Power: 100%;
 RCS [AB] Temperature/Pressure: NOT/NOP

B. DESCRIPTION OF EVENT:

There were no systems or components inoperable at the beginning of the event that contributed to the severity of the event.

On 8/10/95 OBwOS 7.6.b-1 (Unit Common Control Room Ventilation Staggered Monthly Surveillance (Train A)) was in progress on the 0A Control Room Ventilation (VC) makeup filter train with the charcoal absorber in bypass. At 0845 the RM-11 (Central Processing Unit for radiation monitors) alarmed for the ORE-032B (Gas Activity Channel for Control Room Air Outside Intake for Train A) on the OPR32J (Control Room Air Intake Train A) skid. The Unit 1 NSO (licensed reactor operator) reported this to the Unit Supervisor (licensed senior reactor operator). A short discussion ensued concerning the status of the LCOAR for calibration of the monitor. At 0910, after the Unit Supervisor completed a current task, the LCOAR status was reviewed and noted that the LCOAR for calibration had been exited on 8/9/95. The Unit Supervisor entered the LCOAR 3.3.1-1a for the failed monitor. This was reported to the Shift Engineer (licensed senior reactor operator) at 0915. After reviewing OBwOS 3.3.1-1a LCOAR action chart, the Unit Supervisor determined that the action requirements were met by the 0A train being in the makeup mode per the on-going surveillance.

At 0950 the Unit Supervisor recognized that with the charcoal absorber in bypass it was questionable that the action requirement was being met. The Unit Supervisor contacted the Shift Engineer for assistance in making the determination. A discussion between the Shift Engineer and both Unit Supervisors determined that the 0B VC train should be placed in service to ensure meeting the action requirement. The surveillance in progress was terminated and personnel were dispatched to place the 0B VC train in service. At 1009 the charcoal absorber for the 0A VC train was placed in service while waiting for the shift to the 0B VC train. The one hour LCOAR requirements were not met for 1 hour and 24 minutes. At 1012 the 0A VC train was secured and at 1022 the 0B VC train was placed in service.

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(5-92)

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Braidwood 1	05000456	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 5
		95	- 006 -	00	

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

B. DESCRIPTION OF EVENT (continued):

Repairs to the OPR32J skid were completed on 8/29/95 and the LCOAR was exited.

This event is being reported pursuant to 10CFR50.36(c)(2) - When a limiting condition for operation of a nuclear reactor is not met and 10CFR50.73(a)(2)(i)(B) - Any operation or condition prohibited by the plant's Technical Specifications.

C. CAUSE OF THE EVENT:

The causes of the event were a defective procedure and personnel error.

Procedure OBwOS 3.3.1-1a was determined to be inadequate in that the LCOAR Action Charts for the Train A/B Main Control Room Outside Air Intake Monitors were not specific in the process required to isolate the Control Room Ventilation System or initiate operation of the Control Room Make-up System.

Personnel error complicated the process in that the actions taken were not performed in a timely manner and were not adequate in ensuring the action requirements were met within the one hour time frame.

D. SAFETY ANALYSIS:

This event had no effect on the safety of the plant or the public. The radiation monitor that failed senses the minimum outside air intake for the VC system. There are two redundant radiation monitors in the minimum outside air intake. Plant safety was not effected during this event because the redundant radiation monitor remained operable and was capable of realigning the VC system if a high radiation level was detected. Public safety was not effected because the VC system does not exhaust air to the atmosphere, therefore there was no chance of an unmonitored release from the VC system.

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Braidwood 1	05000456	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
		95	-- 006 --	00
				4 of 5

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

E. CORRECTIVE ACTIONS:

The Unit Supervisor and the Shift Engineer were counseled concerning their performance relating to the event and management's expectations regarding supervisor involvement, standards and a questioning attitude.

Information concerning this event was disseminated to Operating Department personnel.

OBwOS 3.3.1-1a was revised to provide specific requirements for isolating the Control Room Ventilation System and to initiate operation of the Control Room Make-up System.

Repairs to the OPR32J skid were completed on 8/29/95 and the LCOAR was exited.

F. PREVIOUS OCCURRENCES:

There has been one similar incident of failure to meet LCOAR action requirements due to inadequate or no procedure and personnel error at Braidwood Station in the past:

On April 19, 1993, Unit 2 was in Mode 5. Two NSOs performed the task of blocking the Source Range (SR) monitors in tandem. The two NSOs did not clearly communicate their actions to each other. One of the NSOs informed a third, oncoming NSO of the blocking of the SR monitors. The oncoming NSO was given an inaccurate turnover of the SR monitor status. A LCOAR was entered for having the SR monitors blocked. Later, when unblocking the SR monitors, the second NSO unblocked the "Hi Flux at Shutdown" alarm and reset the "Boron Dilution Prevention System" (BDPS) but failed to unblock the "Source Level Hi Reactor Trip" function. The NSO was not aware that the latter function had been blocked. The NSO then exited the LCOAR based on this action. Approximately eight hours later, the blocked trip was identified and unblocked. The cause of this event was personnel error and procedural deficiency. Corrective actions included counseling of the individuals involved, and the development of a procedure for properly blocking the SR monitors.

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Braidwood 1	05000456	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	5 OF 5
		95	-- 006 --	00	

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

G. COMPONENT FAILURE DATA:

<u>MANUFACTURER</u>	<u>NOMENCLATURE</u>	<u>MODEL</u>	<u>MFG PART NO.</u>
Thomas Industries Inc.	Pump	2737CM39	N/A