

August 21, 1992 BW/92-0438

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 numbered 92-007-00, Docket No. 50-456.

K. L. Kofron Station Manager

Braidwood Nuclear Station

KLK/AJS/dla 19ZCREG

Encl.: Licensee Event Report

No. 92-007-00

cc: NRC Region III Administrator

NRC Resident Inspector INPO Record Center CECo Distribution List

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At approximately 1226, on July 25, 1992, the detector for Area Radiation Monitor ORT-AR055J experienced a spike that caused a high radiation alarm. As a result, this caused the fuel handling building (FHB) charcoal booster fan OVA04CA to auto start and dampers OVA051Y, OVA058Y, OVA059Y, and OVA060Y to reposition in order to provide flow through the charcoal adsorbers. It was verified that an actual high radiation condition did not exist. Monitor OAR055J was declared inoperable, and an investigation was immediately initiated to determine the cause of the actuations. During the next several days the monitor and its associated instruments, and control circuits were tested. No problems were identified. At 2113, on July 30, 1992, OAR055J was declared operable. There has been no previous occurrences of external noise spiking associated with this monitor.

	LICENSEE EVENT REPORT (LER)	TEXT CONTINUATION	Form Rev 2.0		
FACILITY NAME (1)	DOCKET NUMBER (2)	LER MAMBER (6)	Page (3)		
		Year /// Sequential /// Revision Number Number			
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A. PLANT CONDITIONS PRIOR TO EVENT:

LWIT: BRAIDWOOD 1:

EVENT DATE: July 25, 1992; EVENT TIME: 1226; 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 which contributed to the severity of the event.

At approximately 1226, on July 25, 1992, the detector for Area Radiation Monitor ORT-AR055J experienced a spike that caused a high radiation alarm. As a result, this caused the fuel handling building (FHB) charcoal booster fan (VA) [VG] OVA04CA to auto start and dampers OVA051Y, OVA058Y, OVA059Y, and OVA060Y to reposition in order to provide flow through the charcoal adsorvers.

Control room personnel verified automatic actions upon receipt of the alarms. It was also verified that an actual high radiation condition did not exist by trending OAROSSJ and Train B Fuel Handling Building Incident Area Radiation Monitor ORT-AROSSJ. Monitor OAROSSJ was declared inoperable, and an irvestigation was immediately initiated to determine the cause of the actuations. During the next several days the monitor and its associated instruments, and centrol circuits were tested. No problems were identified. At 2113, on July 30, 1992, OAROSSJ was declared operable.

The appropriate NRC notification via the ENS phone system was made at 1424 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 feacure, including the reactor protection system.

2. CAUSE OF EVENT:

The root cause of this event was a spike of the electronics associated with area radiation monitor DAROSSJ. Further testing and monitoring over several days could not recreate the spike. It is suspected that the spike was incurred by external noise. Therefore, the spike is considered an isolated occurrence.

D. SAFETY ANALYSIS:

This event had no offect on the safety of the plant or the public. All systems operated as designed.

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D. SAFETY ANALYSIS: (continued)

The control circuits for DAROSSJ reverted to their ESF safe configuration on loss of power. A FHB Charcoal Booster Fan alto star' and containment ventilation isolation occurred as designed. The redundant radiation monitors ORI-AROSS and IRT-ARIZ were operable and available to provide indication and the appropriate ESF actuation function.

The worst case condition would be an extended loss of power to a radiation monitor providing input to ESF actuation functions. The radiation monitoring and ESF input logic are designed so that on loss of power to the monitor its ESF input reverts to the tripped condition as was the case in this event. This is enveloped in section 7 of the Updated Final Safety Analysis Report (UFSAR).

E. CORRECTIVE ACTIONS:

Radiation monitor OAR55J was immediately declared inoperable. Also, it was immediately verified that a high radiation condition did not exist. The monitor was tested and observed over the next several days. No additional spikes occurred. The monitor was then declared operable.

F. PREVIOUS OCCURRENCES:

There have been previous occurrences of Engineered Safety Features Actuation due to external noise spiking of radiation monitors.

The corrective actions were implemented addressing both root and contributing causes. The previous events involved different radiation monitors, therefore the previous corrective actions are not applicable to this event. This is the first occurrence of an externally generated noise spike on this monitor. The previous events are listed below:

DVR/LER	TITLE
20-1-87-244/87-038	Engineered Safety Feature Actuation of Control Room Ventilation Due to Noise Spike From Radiation Monitor DPR32J
20-1-87-339/87-051	Spurious Spiking on OPR33J
20-1-88-088/88-011	Control Room Ventilation Shift to Emergency Make-up Mode Due to Spurious Radiation Monitor Noise Spike
20-1-88-010/88-001	Spike on Gas Channel Radiation Monitor OPR32J For Unknown Reasons
20-1-90-042/90-019	Control Room Ventilation Shift to Makeup Mode Due to 0:31J spike

G. COMPONENT FAILURE DATA:

This event was not the result of component failure, nor did any components fail as a result of 'as event.