

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

**ComEd**

February 28, 1996  
BW/96-0030

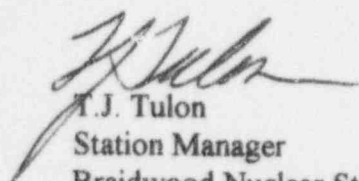
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Washington, D.C. 20555

Gentlemen:

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

This report is number 96-001-00, Docket No. 50-456.

Yours truly,

  
T.J. Tulon  
Station Manager  
Braidwood Nuclear Station

TJT/MO/ema  
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Encl: Licensee Event Report  
No. 456-96-001-00

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

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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT

FACILITY NAME (1)  
Braidwood Unit 1

DOCKET NUMBER (2)  
05000456

PAGE (3)  
1 OF 7

TITLE (4)  
Missed Technical Specification Required Diesel Oil Sample Due To Personnel Error and Procedure Deficiency

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	
1	30	96	96	01	00	2	29	96	None		
OPERATING MODE (9) 1 POWER LEVEL (10) 99 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)											
			20.2201(b)			20.2203(a)(2)(v)			X 50.73(a)(2)(i)		50.73(a)(2)(viii)
			20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)		50.73(a)(2)(x)
			20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)		73.71
			20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)		OTHER
			20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)			X 50.36(c)(2)			50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME  
Phil Lau, Maintenance Staff

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 NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS
A				N					
D				N					

SUPPLEMENTAL REPORT EXPECTED (14)

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

On January 5, 1996, Unit 1, B Train work window jobs were being performed. The Work Control Scheduler (WCS) contacted an A Fuel Handler to sample the 1B Diesel Generator fuel oil storage tanks for particulates and water. The Fuel Handling Supervisor (FHS) assigned the same Fuel Handler who received the message to perform the 1B Diesel Generator monthly accumulated water surveillance. The task was done that morning. The FHS reviewed the surveillance and marked it as a "Complete Surveillance" vice a "Partial Surveillance". On January 30, 1996, a Work Control Planner questioned why samples were being sent for analysis on an irregular schedule and found that 1BWOS 8.1.1.2.C-2, "1B Diesel Generator Fuel Oil Storage Tank Accumulated Water Monthly Surveillance" had a scheduled date of 2/28/96, yet a due date of 2/5/96, and a critical date of 2/12/96. Further investigation found that the "D" fuel oil tank for the 1B Diesel Generator had not been sampled. Operating entered LCOAR 8.1.1-1a for the 1B Diesel Generator at 1730 on January 30, 1996. Fuel oil samples for the "D" fuel oil tank for the 1B Diesel Generator were immediately pulled and sent for analysis. The station was notified the results of the sample were satisfactory and the LCOAR was exited at 2142 on January 30, 1996. This event was caused by a combination of personnel error and inadequate procedure. Corrective actions include personnel retraining and procedure revisions.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT

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Braidwood Unit 1	05000456	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 7
		96	-- 01 --	00	

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

**A. PLANT CONDITIONS PRIOR TO EVENT:**

UNIT: Braidwood Unit 1                      EVENT DATE: 01/30/96  
 EVENT TIME: 0854  
 MODE: 1                      RX POWER: 99%  
 RCS [AB] TEMPERATURE/PRESSURE: NOP/NOT

**B. DESCRIPTION OF EVENT:**

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

All Diesel Fuel Oil Storage Tanks were sampled for Particulate Contaminants and Accumulated Water on December 19, 1995. Previous to this date the sampling had occurred on approximately the same date every month to ensure no samples were missed. Sampling of these tanks is required monthly by the Braidwood Technical Specifications.

As part of the station's new 12 week scheduling process, equipment/train work windows are being used to perform maintenance and surveillance's on major plant equipment. This is done to minimize the on line risk incurred by working on multiple trains of equipment simultaneously.

During the last two weeks of December, a Work Control Scheduler (WCS) (non licensed) noted that Fuel Handling was performing diesel oil samples on the opposite train diesels as opposed to the scheduled train window. The WCS and a Fuel Handling Supervisor (FHS) (non licensed) discussed the situation, and the decision was made that in the future the samples would be done in the applicable work windows. The FHS expressed his reservations to changing to the work window process for the diesel oil surveillance's, and trusting the Electronic Work Control System (EWCS) and Work Control to do the scheduling was going to increase the likelihood of missing a surveillance. He also felt that by doing them in the third week of every month, the consistency was there that ensured a surveillance would not be missed, Fuel Handling and System Materials Analysis Department (SMAD) all expected this to happen the same time every month.

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)**

On January 5, 1996 Unit 1, B Train work window jobs were being performed. The WCS attempted to contact the FHS about 0730 to sample the 1B Diesel Generator fuel oil storage tanks for particulate and water. The FHS was not in the office, so the WCS contacted an A Fuel Handler ("A"FH"), whom he had dealt with previously when he was in an upgraded position. The WCS passed on to the "A"FH two work request numbers which he requested to be performed that same day. The "A"FH wrote a note to the FHS saying Work Planning wanted the two work requests listed completed.

The FHS printed out copies of the Surveillance Cover Sheets for the Work Requests. The surveillance cover sheet for Work Request 950120139, Task 03 had a title of "1B DIESEL GEN FL OIL STRG TNK ACCUMULATED WTR MNTLY SR". The Task Title was listed as "UNIT 1 DIESEL FUEL OIL SURVEILLANCES/SAMPLES", and the Activity was listed as "A01DO-TANK-B-T05-01S". Based on the Activity listing only "TANK-B", the FHS thought Work Planning only wanted the B-Tank sampled. In actuality the work request is meant to sample both the "B" and "D" tanks for the 1B Diesel Generator.

At 0755 on January 5, 1996, the same "A"FH who received the message was assigned the 1B Diesel Generator monthly accumulated water surveillance. He questioned the FHS as to why the "D" tank was not being sampled. The FHS replied that Work Planning only wanted the "B" tank sampled. This was based on the activity on the Surveillance Cover sheet being listed as "A01DO-TANK-B-T05-01S". The steps in the surveillance for the "D" tank were marked N/A by the "A"FH per the FHS's instructions during performance of the surveillance. The surveillance was completed at 0854 on January 5, 1996. The Supervisor Review was immediately performed and the surveillance was marked as a "Complete Surveillance" vice a "Partial Surveillance" by the FHS. Again, this was based on the activity on the work request being listed as "A01DO-TANK-B-T05-01S". The FHS closed out the surveillance in EWCS as complete and forwarded the hard copy of the surveillance to the surveillance clerk for final closure.

Based on the surveillance being closed out as a "Complete Surveillance" it was automatically rescheduled with a due date of 2/5/96. The "D" tank had not been sampled and still had a critical date of 1/27/96.



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

**B. DESCRIPTION OF EVENT (continued)**

At approximately 0800 on January 30, 1996, a Work Control Planner (WCP) (non licensed), who had previously been a Fuel Handling Supervisor, received a call from SMAD questioning why samples were being received on an irregular schedule. SMAD expected samples based on the previous sampling frequency.

The WCP contacted the temporary replacement FHS (Temp. FHS), who was filling in for the injured FHS. The Temp FHS explained to the WCP that he was following the Daily Schedule and he had no items past the scheduled date. The Daily Schedule lists work activities by their scheduled dates, and also lists the due and critical dates for each activity. While reviewing the Daily Schedule with the Temp. FHS the WCP noticed an activity listed which had a scheduled date which exceeded both the due date and critical date. At that point the WCP ran a detailed report of Fuel Handling activities sorted by critical date. The following discrepancies were found, 1) 1BWOS 8.1.1.2.E-2, "Unit 1B Diesel Generator Fuel Oil Tanks Particulate Contaminant Monthly Surveillance" had a scheduled date of 3/2/96, and 2) 1BWOS 8.1.1.2.C-2, "1B Diesel Generator Fuel Oil Storage Tank Accumulated Water Monthly Surveillance" had a scheduled due date of 2/5/96.

At that point the WCP contacted the Work Control Surveillance Coordinator (WCSC), and informed him of the potential that surveillances had been missed. The WCSC in turn stopped the offgoing Shift Engineer, who happened to be in Work Control at the time. They collectively, along with an Operating Engineer, determined after reviewing past SMAD test results and past Fuel Handling Surveillances the "D" fuel oil tank for the 1B Diesel Generator had not been sampled.

At that time a PIF was generated and delivered to Operating. Operating entered LCOAR 8.1.1-1a for the 1B Diesel Generator at 1730 on January 30, 1996. Fuel oil samples for the "D" fuel oil tank for the 1B Diesel Generator were immediately pulled and sent to SMAD for analysis. The station was notified the results of the sample were satisfactory and the LCOAR was exited at 2142 on January 30, 1996.

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.

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

C. CAUSE OF EVENT:

The primary causes of this event were Personnel Error, which are attributed to less than adequate decisions made by the Fuel Handling Supervisor(FHS). A misleading procedure title also contributed to this event. The details of these are as follows:

1. The Fuel Handling Supervisor did not realize that when the Work Control Scheduler said do the work requests for the 1B Diesel Generator Fuel Oil Tank that he meant the whole surveillance and not just Tank "1B". The Fuel Handling Supervisor believed that the Work Control Scheduler only needed samples taken on the "1B Tank". This was based upon the Surveillance Cover Sheet for Work Request 950120139, Task 03 having a title of "1B DIESEL GEN FL OIL STRG TNK ACCUMULATED WTR MNTLY SR, and the Activity being listed as "A01DO-TANK-B-T05-01S". Diesel Generator Fuel Oil Storage Tank "1D" is only identified in the main steps of Surveillance Procedure 1BwOS 8.1.1.2.C-2, and not shown on the work request or the surveillance cover sheet.
2. The Fuel Handling Supervisor (FHS) had a less than adequate questioning attitude when he signed off the surveillance as complete even though the steps in the surveillance for the "1D Tank" were marked N/A. The FHS was unaware that a surveillance could be marked as complete only if all steps were successfully completed as described.
3. The Fuel Handling Supervisor(FHS)was aware that the surveillance for the "D" tank needed to be completed and was scheduled to be done on 01/19/96 as shown on the non-OOS sampling sheets. The FHS broke his arm the next day and was still out on sick leave when the problem was discovered.
4. A contributing factor to the event was the temporary Fuel Handling Supervisor was unaware that the surveillance was still showing on the nonOOS sampling sheets.

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

D. SAFETY ANALYSIS:

This event had no effect on plant or public safety. The 1B Emergency Diesel Generator would have automatically started and all ESF safe shutdown loads sequenced onto the ESF buses as designed. The Unit SAT's were available to supply offsite AC power at all times during the event. Unit 2 remained stable at 100% power throughout the event. A loss of offsite power concurrent with a design basis accident is enveloped by the Station's Final Safety Analysis Report.

E. CORRECTIVE ACTIONS:

Upon discovering the missed surveillance, LCOAR 8.1.1-1a for the 1B Diesel Generator was entered at 1730 on January 30, 1996. Fuel oil samples for the "D" fuel oil tank for the 1B Diesel Generator were immediately pulled and sent to SMAD for analysis. The station was notified the results of the sample were satisfactory and the LCOAR was exited at 2142 on January 30, 1996.

This event and its ramifications will be discussed with the Fuel Handling supervisor upon his return from sick leave. This discussion will include, as a minimum, the need for a more questioning attitude, the need to identify a surveillance as partial if not all steps are completed (add comments to the surveillance cover sheet stating whether partial or no credit is to be taken for the surveillance, and ensuring that communications are complete and accurate. This action will be tracked to completion by action item 456-180-96-00101.

The pre-define Work Request Title for the surveillances for the "1A" and "1B" Diesel Generator Fuel Oil Storage Tank Accumulated Water Monthly Surveillance will be revised to include both tanks 1A & 1C for the 1A Diesel Generator Fuel Oil Storage tank Accumulated Water Monthly Surveillance and 1B & 1D for the 1B Diesel Generator Fuel Oil Storage tank Accumulated Water Monthly Surveillance. Additionally, the Activity field on the surveillance cover sheet will be changed to include both tanks 1A & 1C for the 1A Diesel Generator Fuel Oil Storage tank Accumulated Water Monthly Surveillance and 1B & 1D for the 1B Diesel Generator Fuel Oil Storage tank Accumulated Water Monthly Surveillance. This action will be tracked to completion by action item 456-180-96-00102.

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

F. PREVIOUS OCCURRENCES:

There have been previous occurrences of missed Technical Specification Surveillances. A review of those occurrences yielded three LERs which are similar in nature. However, the root causes and corrective actions for these previous events do not apply and would not have prevented the occurrence of this event.

LER NUMBER	TITLE
20-1-94-006	Braidwood Lake Essential Service Water Cooling Pond Surveillance not complete in the required time. The root cause of this event was a personnel error in that the individual involved did not realize the surveillance needed to be completed by the critical date.
20-1-94-011	Failure to close the 1/2 CS007 A/B The cause of this event was a management deficiency.
20-1-95-009	OPR032 Erroneously Taken Off-line at 1127. The cause of this event was personnel error and equipment failure. The less than adequate teamwork and a less than adequate questioning attitude on the part of operations personnel was the personnel error.

G. COMPONENT FAILURE DATA:

None