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Facility Name (1) Braidwood, Unit 1				Oocket Number (2) Page (3)   Q  5  0  0  0  4  5  6 1 of 0							
itle (4) Los	s of Pulsi	es to Fuel Ha	andling Ir	icident Mo	nitor OR	T-AROS	6 for Un	known Reason	ns		
Event Date (	5)	LER NUM	per (6)		Report Date (7)			Other Facilities Involved (8)			
onth Day		ar /// Sequi			Month	Day	Year	Facility I	Names Do	cket Number(s)	
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Yes (If ye ABSTRACT (Lin	s, comple	PPLEMENTAL R	SUBMISSIO	N DATE)	x.	11.8			Expected Submission Date (1)	5)	

At 1910 on January 13, 1988, Fuel Handling Building Incident Monitor ORT-AR056 went into an alarm condition due to a loss of pulses.

The root cause of the event is unknown. An immediate investigation revealed no work activities in the vicinity of monitor ORT-AR056. The detector was inspected, and no physical damage was found. The detector cable was checked for tightness and was able to be tightened two turns. The cable slackness is not considered to have caused the loss of pulses which resulted in the fuel handling building to shift to its emergency makeup mode of operation. The loss of pulses immediately cleared and has not recurred.

There has been one previous occurrence.

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FACILITY NAME (1)	DOCKET NUMBER (2)		CT CONTINUATION					Page (3)		
		Year	111	Sequential Number	/// Revision					
Braidwood, Unit 1	0   5   0   0   0   4  5  0 dentification System (EIIS) codes	5 8   8	-	0   0   3	- 0 10	0 2	OF	01		

# A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: <u>Braidwood 1</u>; Event Date: <u>January 13, 1988</u>; Event Time: <u>1910</u> MODE: <u>5</u> - <u>Cold Shutdown</u>; Rx Power: <u>02</u>; RCS [AB] Temperature/Pressure: <u>100°F/0 psig</u>

#### 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 1910 on January 13, 1988, the Fuel Handling Building Incident Radiation Monitor ORT-AR056 [IL] went into an alarm condition on a loss of pulses as indicated at the control room radiation monitor console (RM-11). This started the Auxiliary Building Ventilation [VF] Fuel Handling Building Charcoal Booster Fan OVA04CA with the flow through the Train B Fuel Handling Building Charcoal Filter. The loss of pulses immediately cleared and was considered spurious. Equipment operation was immediately returned to normal.

Operator action neither increased nor decreased the severity of the event. Plant conditions remained stable throughout the event.

The appropriate NRC notification via the ENS phone system was made at 1951 on January 13, 1988, pursuant to 10CFRS0.72(b)(2)(i1).

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 the event is unknown. An immediate investigation revealed no work activities in the vicinity of monitor ORT-AR056. The detector was inspected, and no physical damage was found. The detector cable was checked for tightness and was able to be tightened two turns. This cable slackness is not considered to have caused the loss of pulses which resulted in the fuel handling building ventilation to shift to its emergency makeup mode of operation. The loss of pulses immediately cleared and has not recurred.

### D. SAFETY ANALYSIS:

There was no effect on the safety of the plant or the public. There is no fuel in the fuel handling building. Both Unit 1 and 2 are in Mode 5.

Had this event occurred under worst case conditions of the units operating with spent fuel in the pool, there would be no effect on plant or public safety. The charcoal booster fans and filter are designed to activate on a failure of ORT-ATOS6 or the presence of actual radiation. Redundant monitor ORT-AROS5 was available throughout the event.

	LICENSEE EVENT REPORT (LER) TE	XT CONTINUATION			
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	Page (3)		
		Year /// Sequential /// Revision /// Number /// Number			
Braidwood, Unit 1	0   5   0   0   0   4   5   6	are identified in the text as [xx]	01 3 OF 0		

## E. CORRECTIVE ACTIONS:

The immediate corrective action was to determine that the source of the actuation was spurious in nature and not due to actual radioactivity.

Work Request A19066 was written to further inspect the monitor. If this investigation reveals any additional information, it will be documented in a supplement to this report. This will be tracked to completion by Action Item 456-200-88-01101.

## F. PREVIOUS OCCURRENCES:

OVR/LER NUMBER	TITLE
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Containment Ventilation Isolation Signal Due To Loss Of Pulses From IRE-AR012 DVR 20-1-87-009 LER 87-003

This has been the only previous occurrence of a loss of pulses to a radiation monitor. However, this event was due to a failure of the monitor's sensor as a result of construction activity which physically damaged it.

#### G. COMPONENT FAILURE DATA:

Component failure was neither the cause nor the result of this event.



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

EEF/88-180

February 3, 1988

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 number 88-003-00; Docket No. 50-456.

Very truly yours,

EE July patin K 2/5/88 E. E. Fitzpatrick

Station Manager Braidwood Nuclear Station

EEF/PMB/jab (6570z)

Enclosure: Licensee Event Report No. 88-003-00

cc: NRC Region III Administrator T. Tongue, NRC Resident Inspector INPO Record Center CECo Distribution List