LICENSEE EVENT REPORT (LER)

Facility Name (1)	Docket Number (2)	Page (3)
Braidwood, Unit 1	0 5 0 0 0 4 5 6	1 of 0 3

Title (4) Loss of 0B Control Room Chiller Due to Determination of Temperature Controller

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 Names	Docket Number(s)
										Braidwood Unit 2	0 5 0 0 0 4 5 7
0 4	0 7	8 8	8 8	0 0 9		0 0	0 4	2 6	8 8		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)			
		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0 0 0	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 (Specify in Abstract below and in Text)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		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	TELEPHONE NUMBER
Louis Redmond, Technical Staff Engineer Ext. 2294	AREA CODE 8 1 5 4 5 8 - 2 8 0 1

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

SUPPLEMENTAL REPORT EXPECTED (14)		Expected Submission Date (15)	Month	Day	Year
Yes (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)

A request was made to determinate the temperature element (TE) on Containment Chiller 1TE-WO082 to facilitate replacement. A Work Traveler was prepared and issued by Project Construction Department (PCD). The traveler had 3 errors, which included the wrong equipment number, wrong prints and wrong piece number being referenced. On March 16, 1988, using the Work Traveler the Control Room Chiller Temperature Controller was incorrectly determinated. On April 7, 1988, during routine maintenance of the Control Room Chiller th s error was discovered. The Control Room Chiller was reterminated and declared operable. The root cause is attributed to a planning error by contractor management in that the subject work traveler was improperly prepared and reviewed by PCD personnel. This event has been reviewed with all available individuals involved. Contractor Corrective Action request 88-001 nas been written and is being reviewed with the contract management to prevent recurrence. There have been no previous occurrences involving transposition of an EPN resulting in maintenance activity on the wrong equipment.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) Year	Sequential Number	Revision Number	Page (3)
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TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [xx]

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: Braidwood 1 : Event Date: 4-7-88 : Event Time: 1130
MODE: 5 - Cold Shutdown : Rx Power: 0% : RCS [AB] Temperature/Pressure: 106 Degrees F/98 psig

Unit: Braidwood 2 : Event Date: 4-7-88 : Event Time: 1130
MODE: 5 - Cold Shutdown : Rx Power: 0% : RCS [AB] Temperature/Pressure: 100 Degrees F/95 psig

B. DESCRIPTION OF EVENT:

There were no system or components inoperable at the beginning of the event which contributed to the severity of the event.

In early March 1988 Project Construction Department (PCD) requested the electrical contractor to determinate the temperature element on Containment Chiller (VP) [VI], 1TE-WO082, to facilitate replacement.

On March 7, 1988, to accomplish the determination, Project Work Request (PWR), 20W0015, was initiated, and Work Traveler WT-EE-21108 was issued with the following errors:

1. The Work Traveler referenced temperature controller 1TC-WO082, not the temperature element 1TE-WO082.

2. The Work Traveler referenced the Control Room Chiller by Equipment Piece Number (EPN) 0W001CB and physical Auxiliary Building location (8 - 10M EL 383), and not the Containment Chiller 1W001CB and its corresponding physical location.

3. The Work Traveler referenced electrical print 6/20E-1-4791B, Revision C for temperature controller 1TC-WO082, not temperature element 1TE-WO082 on print 20E-1-4792B, Revision E.

On March 16, 1988, using the erroneous print and location reference in the Work Traveler, an employe of the electrical contractor determinated Control Room Chiller Temperature Controller 0TC-WO228, and not the temperature element on the Containment Chiller, 1TE-WO082.

On April 7, 1988, during routine maintenance of the Control Room Chiller, 0W001CB, contractor Instrument Technicians found the leads to the 0TC-WO228 temperature controller lifted and taped. A Shift Foreman was dispatched to investigate. After the preliminary investigation by the Shift Foreman, it was discovered that all the leads to the 0TC-WO228 temperature controller were lifted and taped. No authorized work other than that of the contractor Instrument Technicians was in progress on the 0W001CB Control Room Chiller.

At 1123 on April 7, 1988, the 0W001CB Control Room Chiller was declared inoperable and Limiting Condition for Operation (LCOAR) 0BwOS 7.6.1a, Control Room Ventilation System LCOAR Action Chart, was entered. Nuclear Work Request (NWR) A21726 was initiated to restore the chiller.

On April 8, 1988, the 0W001CB Control Room Chiller was reterminated and functionally tested.

At 1000 on April 10, 1988 the 0W001CB Control Room Chiller was declared operable and LCOAR 0BwOS 7.6-1a was exited.

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

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

C. CAUSE OF EVENT:

The root cause of the event is attributed to a planning error by a management contractor in that Work Traveler WT-EE-21108 associated with PWR 20W0015 was improperly prepared and inadequately reviewed by PCD personnel. The Traveler referenced the wrong chiller and chiller location and also requested determination of the incorrect equipment.

D. SAFETY ANALYSIS:

This event had no affect on the safety of the plant or public as the Control Room Chiller 0W001CB was at no time required to perform its safety function. If this incident had taken place under worse case conditions, such as a safety injection, high radiation or smoke in the control room, the 0W001CB Chiller could have been started but would not have maintained load. Full air cleanup capabilities of both trains of control room ventilation were available at all times as control room filters were not affected. The 0W001CA Control Room Chiller and DA Control Room Ventilation System were operable to mitigate the event. If this incident had resulted in or taken place under high temperatures in the Control Room boundaries, the 0W001CA Control Room Chiller and DA Control Room Ventilation System were operable to ensure normal cooling.

E. CORRECTIVE ACTIONS:

NWR A21726 was written to reterminate the temperature control module and the 0W001CB Control Room Chiller was functionally tested.

This event has been reviewed with all available individuals involved with the event.

A Contractor Corrective Action Request (CAR) 88-001 has been written and is being reviewed with the contractor management to prevent recurrence. Closure of this CAR will be tracked to completion by Open Item Number 456-200-88-08201.

As part of CAR 88-001, open travelers on turned over systems, as of 4-13-88, are being reviewed to assure proper equipment identification. This is being done for all turned over systems.

Action to prevent recurrance was implemented with revision 9 to page 1 of Quality Procedure QP 3-1. This revision requires all maintenance and modificaton work which is to be done by the Projects and Construction Services Departments or Substation Department to be controlled by the station under the Work Request System.

F. PREVIOUS OCCURRENCES:

There have been no previous occurrences involving transposition of an EPN resulting in maintenance activities on the wrong component.

G. COMPONENT FAILURE DATA:

This event was not caused by component failure, nor did any components fail as a result.

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

BW/88-318

May 2, 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) (i) which requires a 30 day written report.

This report is number 88-009-00; Docket No. 50-456.

Very truly yours,

R. E. Querio
Station Manager
Braidwood Nuclear Station

REQ/PMB/jab
(7031z)

Enclosure: Licensee Event Report No. 88-009-00

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

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