

LICENSEE EVENT REPORT (LER)

Facility Name (1) Braidwood, Unit 1 Docket Number (2) 0 | 5 | 0 | 0 | 0 | 4 | 5 | 6 | 1 | of | 0 | 7 Page (3) 1
 Title (4) Control Room Ventilation to Makeup Mode of Operation From a High Radiation Alarm Due to Incorrect Setpoint

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)	
0 4	1 0	8 8	8 8	0 1 0	0 0	0 4	2 8	8 8	Braidwood Unit 2	0 5 0 0 0 4 5 7	

OPERATING MODE (9) 5 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name Paul Stanczak, Technical Staff Engineer Ext. 2486 TELEPHONE NUMBER 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 NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14) YES (If yes, complete EXPECTED SUBMISSION DATE) X | NO

Expected Submission Date (15) _____

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

At 0103 on April 10, 1988, the Control Room Ventilation System automatically shifted to the Emergency Makeup Mode of Operation. This was in response to a high radiation setpoint being exceeded on the Control Room Outside Air Intake Particulate Channel ORE-PR033A. Samples by Radiation Chemistry Department verified that there were no abnormal levels of radioactivity present. It was discovered that the incorrect setpoint had been entered for the monitor. This was due to a management deficiency in that permanent changes to the instrument data sheets were not properly implemented in accordance with the procedure when the setpoint was modified by a change to the Final Safety Analysis Report. The proper setpoint was entered, operation of the monitor returned to normal and the Control Room Ventilation System lineup was returned to normal. Radiation monitor setpoints have been reviewed and verified to be correct on all Control Room Ventilation Monitors and the setpoint data sheet documentation has been reviewed and corrected. Dual verification is now required on the data sheets and the instrument procedure will be revised to required Technical Staff notification when a discrepancy between the As Found and the data sheet is identified. There have been no previous occurrences.

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TEXT Energy Industry Identification System (EIS) codes are identified in the text as [xx]							

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: Braidwood 1; Event Date: 4-10-88; Event Time: 0103
 MODE: 4 - Cold Shutdown; Rx Power: 0; RCS [AB] Temperature/Pressure: 100 degrees F/99 psig

Unit: Braidwood 2; Event Date: 4-10-88; Event Time: 0103
 MODE: 5 - Cold Shutdown; Rx Power: 0; RCS [AB] Temperature/Pressure: 96 degrees F/110 psig

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 0103 on April 11, 1988, Control Room Ventilation (VC) [VI] Train B automatically shifted to the Emergency Makeup mode of operation due to a high radiation signal on the Control Room Outside Air Intake Particulate Channel, ORE-PR033A, [IL]. A high radiation alarm was received in the Control Room on the Radiation Monitor (RM)-11 console.

Radiation Chemistry Department was notified and samples taken verified that there were no abnormal levels of radioactivity present. Upon further investigation, it was discovered that the setpoint for channel ORE-PR033A was incorrectly set to a value much lower than normal.

At 0252 on April 10, 1988, the operator returned the setpoint to its proper value and channel ORE-PR033A operation returned to normal. Normal control room ventilation lineup was established.

Operator actions neither increased nor decreased the severity of the event. Plant operations were not affected.

The appropriate NRC notification via the ENS phone system was made at 0305 on April 10, 1988 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 Feature, including the Reactor Protection System.

C. CAUSE OF EVENT:

The intermediate cause of the event was that an exceptionally low setpoint had been entered for channel ORE-PR033A. The equipment operated as designed when the background activity exceeded the setpoint.

ORE-PR033A is a particulate detector that works in conjunction with gas detector ORE-PR033B; however, only the gas detector is required to meet Technical Specification requirements. Final Safety Analysis Report (FSAR) paragraph 11.5.1.2.1 precludes ORE-PR033A from performing a high radiation Engineered Safety Feature (ESF) interlock function by having its setpoint raised above the range of the detector. Channel ORE-PR033A Particulate Detector correct setpoint is 1.0 E+10 as opposed to the as found value of 1.0 E-10.

The root cause of this event was a management deficiency in that permanent changes to the setpoints data sheets were not properly implemented in accordance with BWRP 1280-7, AR/PR Setpoint and Background Changes when the setpoints were modified by a change to the FSAR. The previous setpoint for ORE-PR033A was 1.0 E-10. The appropriate data sheet was temporarily changed, but the permanent change was not completed. The exact cause of the failure to complete the permanent change is unknown. On March 15, 1988, an unrelated setpoint change was made and the review process failed to identify the incorrect value listed for ORE-PR033A, as it's setpoint was not being changed.

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C. CAUSE OF EVENT: (continued)

On March 30, 1988, the Instrument Maintenance Department performed planned maintenance on ORE-PR033A. As part of the normal work practice, they verified that the equipment was operating properly using the appropriate setpoint data sheet. The incorrect value of 1.0 E-10 was entered at that time since the permanent change had not been made to the data sheet.

D. SAFETY ANALYSIS:

There was no affect to plant or public safety as there was no abnormal radiation levels present during the time the incorrect setpoint was in use. Also, the setpoint change was conservative with respect to actuation at an extremely low background radiation level. Both units were shutdown throughout the event. Under worst case conditions of actual radioactivity present during normal operations, the channel would have functioned as it did in this event. The redundant Control Room Outside Air Intake Particulate Channel, ORE-PR034A was operable throughout the event.

E. CORRECTIVE ACTIONS:

Control Room Outside Air Intake Particulate Channel, ORE-PR033A, setpoint was corrected to the proper value. The control room ventilation system was returned to normal operation.

Radiation monitor setpoints have been reviewed and verified to be correct on all control room ventilation monitors.

The setpoint data sheet documentation has been reviewed and corrected.

Health Physics has included dual verification for each setpoint data sheet.

Instrument Maintenance Department is incorporating into their procedure steps that will require Technical Staff notification when a discrepancy between the as found and the data sheet is identified. This will be tracked to completion by Action Item 456-200-08-08301.

F. PREVIOUS OCCURRENCES:

There have been no previous occurrences.

G. COMPONENT FAILURE DATA:

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



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

BW/88-321

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) (iv) which requires a 30 day written report.

This report is number 88-010-C9; Docket No. 50-456.

Very truly yours,

R. E. Querio
Station Manager
Braidwood Nuclear Station

REQ/PMB/jab
(7031z)

Enclosure: Licensee Event Report No. 88-010-00

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

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