LICENSEE EVENT REPORT (LER) Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
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Title (4) Control Room Ventilation Switchover Due to Spurious Noise

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 9	1 6	8 8	8 8	0 2 0	0 0	0 9	2 7	8 8	NONE	0 5 0 0 0
										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)			
	3	20.402(b)	20.405(c)	X 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)	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 AREA CODE	
Paul Stanczak, Tech Staff Engineer Ext. 2486	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
X	I L	P T *	G 0 6 3	NO					

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)

On September 16, 1988 at 1752 the Control Room Train B Ventilation automatically switched to its make up mode of operation due to a high radiation signal on the Control Room Outside Air Intake gas Channel. A high radiation alarm also occurred in the Control Room at the Radiation Monitor (RM) - 11 console. The root cause of this event is not known. A noisy pressure transducer, located on the skid itself, was suspected of inducing noise into the monitor. Equipment operation is presently normal and no further corrective action is planned. Troubleshooting by the Instrument Maintenance Department did not reveal any problems with the equipment. The System Technical Staff Engineer had noticed the pressure transducer st cking, so he had it replaced. There have been two previous occurrences of Control Room Ventilation shift to Emergency Mode due to spurious noise.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			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: September 16, 1988; Event Time: 1752;

Mode: 3 - Hot Standby; Rx Power: 0%;

RCS [AB] Temperature/Pressure: NOT/NOP

Unit: Braidwood 2; Event Date: September 16, 1988; Event Time: 1752;

Mode: 2 - Startup; Rx Power: 2%;

RCS [AB] Temperature/Pressure: NOT/NOP

B. DESCRIPTION OF EVENT:

There were no structures, systems, or components inoperable or degraded at the beginning of the event that contributed to the event.

On September 16, 1988 at 1752 the Control Room Train B Ventilation (VC) [VI] automatically switched to its make up mode of operation due to a high radiation signal on the Control Room Outside Air Intake gas Channel 0RE-PR033B (PR) [IL]. A high radiation alarm also occurred in the Control Room at the Radiation Monitor (RM) - 11 console.

There was no increase in activity levels on any other channels and the event was considered to be spurious. An investigation into the event revealed no work activity in the area and the VC system was returned to normal operation.

Operator actions neither increased nor decreased the severity of the event and plant conditions were always stable.

The appropriate NRC notification via the ENS phone system was made at 1910 on September 16, 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 root cause of the event is not known. A noisy pressure transducer, located on the skid itself, was suspected of inducing noise into the monitor. Equipment operation is presently normal and no further corrective action is planned.

D. SAFETY ANALYSIS:

There was no affect on the the plant or the public safety. There was no abnormal level of radioactivity present. ORE-PR033B operated as designed and generated an Engineered Safety Features actuation on a high radiation signal occurrence. ORT-PR034 was available for redundant indication of the activity level.

E. CORRECTIVE ACTIONS:

Troubleshooting of ORE-PR033B by the Instrument Maintenance Department did not reveal any problems with the equipment. The System Technical Staff Engineer had noticed the pressure transducer sticking, so he had it replaced.

F. PREVIOUS OCCURRENCES:

DVR/LER Number	Title
DVR 20-1-87-335/ LER 87-051	Control Room Ventilation Switchover Due to Spurious Noise on Channel ORE-PR003B
DVR 20-1-88-088/ LER 88-011	Control Room Ventilation Shift to Emergency Makeup Mode Due to Spurious Radiation Monitor Noise Spike

G. COMPONENT FAILURE DATA:

Manufacturer	Nomenclature	Model Number	MFG Part Number
General Atomics (Sorento Electronics)	Pressure Transducer	P61K188	N/A

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

BW/88-1205

September 30, 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 88-020-00; Docket No. 50-456.

Very truly yours,

R. E. Querio
Station Manager
Braidwood Nuclear Station

REQ/AJS/jab
(7126z)

Enclosure: Licensee Event Report No. 88-020-00

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

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