			LICENSE	E EVENT	REPOR'	(LER)					
Facility Name (1) Braidwood, Unit 1					Docket Number (2)						
itle (4) Containm	ent Ven	tilation Isola	tion for Train	A Due	to a L	oss of P	ower to a Ra	diation	Monitor		
Event Date (5)	Event Date (5) LER Number (6)			Report Date (7)			Other Facilities Involved (8)				
Month Day Year	1	/// Sequential Number	/// Revision Number	Month	Day	Year			Docket Number		
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OPERATING MODE (9) POWER LEVEL (10) 0 0		THIS REPORT IS (Check one or 20.402(b) 20.405(a)(20.405(a)(20.405(a)(20.405(a)(more of the for 1)(1) 51 1)(11) 51 1)(111) 51) (11) 1) 2) 2)(1)	50 50 50	0.73(a)(2)(1v) 0.73(a)(2)(v) 0.73(a)(2)(v) 0.73(a)(2)(v1 0.73(a)(2)(v1) (1) (1) (1)(A)		ct	
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At 1127 on January 7, 1987, the Engineered Safety Feature Bus 141 feed breaker tripped. This resulted in a loss of power to the containment area radiation monitor causing a containment Ventilation Isolation for Train A. The feeder breaker was closed after an inspection of the protective relays and meggering the power feed cables at 1210. This restored power to the area radiation monitor and allowed the containment ventilation isolation signal to be reset.

The cause of the event is indeterminate, however, it is believed to be attributed to construction activity by contractor personnel in the area. There were no "trip targets" indicated on Bus 141 for the breaker.

A letter was issued on January 21, 1987, to Construction Management Personnel reemphasizing the need for more awareness during construction activities and the potential impact on Unit Operations. This letter was written to address contractor work activity problems noted in the previous occurrences listed below:

Previous occurrences: 456/86-005-00 and 456/86-011-01

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER N	LER NUMBER (6)					Page (3)		
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Braidwood, Unit 1	0 5 0 0 0 4 5	16 8 1 7	-	0 0 2 -	010	01 2	OF	01		

A. PLANT CONDITIONS PRIOR TO EVENT:

MODE 5 - Cold Shutdown Rx Power 0% RCS [AB] Temperature/Pressure 146°F/380 PSIG

B. DESCRIPTION OF EVENT:

The plant was in Mode 5 operation with construction activity in the area of the event. There were no systems or components inoperable which contributed to the event.

At 1127 on January 7, 1987 a trip signal was received for Engineered Safety Feature (ESF) Bus 141 [AP]. This signal initiated a Containment Ventilation Isolation [VA] for Train A due to the loss of power to the containment area radiation monitor IRE-AROI1[IL]. Alarms were received in the main control room for the containment ventilation isolation for Train A and Bus 141 trip. The feeder breaker was closed after an inspection of the proctective relays and meggering the power feed cables at 1210. This restored power to IRE-AROI1 and allowed the containment ventilation isolation signal to be reset. Operator action neither increased or decreased the severity of the event.

This is reportable under 10CFR50.73(a)(2)(iv) - Any event or condition that results in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS).

C. CAUSE OF EVENT:

The root cause of this event is indeterminate. The cause is believed to be attributed to construction activity by contractor personnel working in the area at the time of the breaker trip, although there were no "trip targets" indicated on the bus. All loads fed by ESF Bus 141 were de-energized which included IRE-AROII. The IRE-AROII monitor provided the containment ventilation isolation signal through the Solid State Potection System [JG] to close the containment ventilation valves.

D. SAFETY ANALYSIS:

This event had no affect on the safety of the plant or public since the unit has not been taken critical and no radioactive effluent is being produced. In addition, the valves that are actuated upon receipt of an isolation signal were already in the engineered safety feature position, (closed.). Under worst case conditions, with the unit at full power, the valves would have already been closed. Had all A.C. power to the valves been lost during an irradiated fuel handling accident, the valves are designed to fail closed. The redundant containment Area Radiation Monitor, IRE-ARO12 was not affected by this event.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NU	JMBER	Page (3)				
		Year	3/4	Sequential Number		Revision Number		
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E. CORRECTIVE ACTIONS:

The immediate corrective action was inspection of the protective relays and meggering of the power feed cables to the breaker by the Operational Anaylsis Department. There were no discrepancies noted and the bus was re-energized.

A letter was issued by the Projet Construction Department management on January 21,1987, to Contractor Management Personnel reemphasizing the need for more awareness during construction activities and the potential impact on Unit operations. This letter was written to address the contractor work activity problems noted in the previous occurrences listed below.

F. PREVIOUS OCCURRENCES:

LER NUMBER	TITLE
456/86-005-00	Containment Purge Isolation From a Voltage Trasient Caused by Construction Activity
456/86-011-01	Containment Ventilation Isolation Due to Spurious Signal

G. COMPONENT FAILURE DATA

NONE

EEF/87-142 File: AGNC-14

February 4, 1987

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 87-002-00; Docket No. 50-456.

Very truly yours,

E. E. Fitzpatrick Station Manager

Braidwood Nuclear Station

EEF/PMB/jab (4448z)

Enclosure: Licensee Event Report No. 87-002-00

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