



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

April 25, 1990
BW/90-0443

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)(B) which requires a 30-day written report.

This report is number 90-003-00; Docket No. 50-456.

Very truly yours,

for 

R. E. Querio
Station Manager
Braidwood Nuclear Station

REQ/JDW/jfe
(7126z)

Enclosure: Licensee Event Report No. 90-003-00

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

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Braidwood 1										Docket Number (2) 0 5 0 0 0 4 5 6 1 of 0 4										Page (3) 1 of 0 4																													
Title (4) Failure to Trip Nuclear Instrumentation Bistables Within Six Hours Required by Technical Specifications Due to Personnel Error.																																																	
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)																
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0 3			2 6			9 0			9 0			0 0 3			0 0			0 4			2 5			9 0			0 5 0 0 0						0 5 0 0 0																
OPERATING MODE (9) 1										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)																																							
POWER LEVEL (10) 0 9 3										20.402(b)										20.405(c)										50.73(a)(2)(iv)										73.71(b)									
										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									
										20.405(a)(1)(iii)										X 50.73(a)(2)(i)										50.73(a)(2)(viii)(A)										in Abstract									
										20.405(a)(1)(iv)										50.73(a)(2)(ii)										50.73(a)(2)(viii)(B)										below and in									
20.405(a)(1)(v)										50.73(a)(2)(iii)										50.73(a)(2)(x)										Text)																			
LICENSEE CONTACT FOR THIS LER (12)																																																	
Name Phil Lau, HPES Coordinator															Ext. 2957															TELEPHONE NUMBER 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		MANUFAC-TURER		REPORTABLE TO NPRDS				CAUSE		SYSTEM		COMPONENT		MANUFAC-TURER		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)																																																	

At 0048 on March 26, 1990 Power Range Nuclear Instrument Channel N-41 (PR 41) quarterly calibration was initiated. The action statement of Technical Specification 3.3.1 required the bistables for PR-41 to be placed in the tripped condition within 6 hours. The Instrument Technician (CST) was informed by the Control Room Supervisor (SCRE) that the calibration must be completed within 6 hours or the channel would have to be placed in a tripped condition. This is accomplished by removing the control power fuses. At 0130 and 0400 the CST and the Instrument Maintenance (IM) Supervisor informed the SCRE that the calibration would not be completed within 6 hours. The SCRE perceived that the fuses were needed to perform portions of the calibration and assumed that the CST would remove them when they were no longer required. Prior to turnover the SCRE glanced at the PR-41 drawer and observed that Bistable Lights were illuminated and assumed that the fuses were removed, however this was a result of the calibration. At 0717 it was recognized that the fuses had not been removed. At 0719 the control power fuses were removed. The cause of this event was personnel error. Training will be conducted for Operating personnel. Nuclear Instrument procedures that require components positioned different from the action statement will be revised to provide for SCRE notification. Previous corrective actions are not applicable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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FACILITY NAME (1) Braidwood 1	DOCKET NUMBER (2) 0 5 0 0 0 4 5 6	LER NUMBER (6)						Page (3)		
		Year	///	Sequential	///	Revision				
				Number		Number				
TEXT		9 0	-	0 0 3	-	0 0	0 2	OF	0 4	

Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: Braidwood 1; Event Date: March 26, 1989; Event Time: 0648;
 Mode: 1 - Power Operation; Rx Power: 93%;
 RCS [AB] Temperature/Pressure: NOT/NOP;

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 0048 on March 26, 1990 the action statement for Technical Specification 3.3.1 was entered for Power Range Nuclear Instrument Channel N-41 (PR 41) [IG] to allow Instrument Maintenance to perform Braidwood Instrument Surveillance (Bwis) 3.1.1-223, Quarterly Excore/AFD Calibration on Power Range 41. The action statement required the bistables for PR 41 channel to be placed in the tripped condition within 6 hours. This is accomplished by removing the control power fuses for the bistables located in the PR 41 drawer.

Discussions between the Control System Technician (CST) (non-licensed instrument technician) and the Shift Control Room Engineer (SCRE) (Licensed Senior Reactor Operator) occurred prior to the start of the calibration. The SCRE informed the CST that it must be completed within 6 hours or the channel would have to be placed in a tripped condition.

At approximately 0130 the CST and the Instrument Maintenance (IM) Supervisor (non-licensed Instrument Maintenance Supervisor) informed the SCRE that the calibration would not be completed within 6 hours.

At approximately 0400 the IM Supervisor and the CST reminded the SCRE that the calibration would not be completed in 6 hours. The SCRE perceived that the Control Power Fuses were needed to perform portions of the calibration. This perception was based on previous experience with PR calibrations. This was not the case with this calibration. Based on this false perception the SCRE assumed that the CST would remove the Control Power Fuses when they were no longer required.

Prior to Shift Turnover the SCRE glanced at the PR-41 drawer. PR Bistable Lights were illuminated which is the status of the bistables when they are in the tripped condition. The SCRE assumed the CST had removed the Control Power Fuses. However, the bistables were tripped due to steps performed as a result of the calibration.

At 0600 the SCRE Turnover began with the on-coming SCRE. The SCRE Turnover Sheet identified that the action statement was entered at 0048. The actions required for PR-41 were discussed at the turnover.

At 0630 the on-coming SCRE left the Control Room to attend the Unit 2 Turnover Meeting.

At approximately 0645 the on-coming SCRE returned to the Control Room and relieved the off-going SCRE.

At 0717 it was recognized that control power fuses had not been removed. Limiting Condition for Operation (LCO) 3.0.3 was entered and complied with.

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At 0719 the control power fuses were removed. This placed the Bistables in the tripped condition. LCO 3.0.3 was exited.

At 0818 the calibration was completed and PR-41 was returned to operable status.

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

C. CAUSE OF EVENT:

The root cause of this event was a cognitive Personnel Error. The SCRE had the responsibility to verify the actions were completed within the specified time period. Based on assumptions and a false perception the SCRE incorrectly concluded that actions had been taken by others. The SCRE made this conclusion without verifying by either direct observation or a report from a person that had made a direct observation, that the actions had been completed. The failure to perform this verification created the event.

D. SAFETY ANALYSIS:

This event had no effect on the safety of the plant or the public. All systems operated as designed. Three redundant channels of Power Range Nuclear Instrumentation were operable and available to provide indication and protective functions as necessary had a situation requiring a reactor trip occurred. There are no reasonable or credible alternative conditions under which the event would have been more severe.

E. CORRECTIVE ACTIONS:

The PR-41 control power fuses were removed which placed the bistables in the tripped condition.

Based on the initial information associated with this event the personnel directly involved with this event participated in a "Braidwood Station Error Evaluation Presentation" to identify root and contributing causes of this event. Based on the conclusions of this presentation the following actions will be taken:

A training tailgate session will be held for appropriate Operating personnel. The session will stress the importance of the following:

1. Verification must be performed by either direct observation or report by a person who has made a direct observation of the item or activity being verified.
2. Communications must ensure responsibilities are appropriately assigned and clearly understood.
3. The Power Range Nuclear Instrumentation and other important calibrations should receive a Heighten Level of Awareness.
4. The responsibility of Licensed Operators to ensure Technical Specification Actions are completed in a timely manner.

This action will be tracked to completion by action item 456-200-90-01301.

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

E. CORRECTIVE ACTIONS: (cont'd)

Nuclear Instrument procedures that require components positioned different than their Technical Specification Action Statement Required position for performance of the calibration will be revised to provide for SCRE notification. This action will be tracked to completion by action item 456-200-90-01302.

F. PREVIOUS OCCURRENCES:

There have been previous occurrences of failure to perform Technical Specification Action Statements within the specified time periods. Corrective actions were implemented addressing both root and contributing causes. Previous corrective actions are not applicable to this event.

G. COMPONENT FAILURE DATA:

This event was not the result of component failure, nor did any components fail as a result of this event.