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

July 10, 1990
BW/90-0695

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 90-009-00; Docket No. 50-456.

Very truly yours,

for R. E. Querio
Station Manager
Braidwood Nuclear Station

REQ/JDW/sjs
(7126z)

Enclosure: Licensee Event Report No. 90-009-00

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

IE22
1/1

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

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

Title (4) Failure to Perform Containment Air Lock Leak Test within the Allowable Time due to Programmatic Deficiency

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)
									None	0 5 0 0 0
0 6	1 5	9 0	9 0	0 0 9	0 0	0 7	0 6	9 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 8 9	___	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 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
	AREA CODE
Jerry Wagner, HPES Evaluator Ext. 2457	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 System Engineer (STE) had been monitoring the High High Radiation Area (HHRA) Key Control Log, on a regular basis to determine when a leakage test of the Containment Personnel Air Lock (CPA) was required. This was the existing program. During the week of June 11 the STE reviewed the HHRA Key Log on a regular basis and did not observe any key issuance for containment entry. On June 15, 1990 the STE made his HHRA Key Log review and did not observe any new entries. Later that morning the STE was informed that a containment entry had been made. At 1030 the STE reviewed the HHRA Key Log. He observed that the last entry on the log sheet was dated June 8, 1990. Puzzled by this discrepancy, the STE leafed through the blank pages of log sheets. When the STE turned to the last blank log sheet he discovered that a second log sheet had been initiated. There were two entries on the second log sheet, one for that morning, and one for a containment entry made on June 8, 1990. The STE immediately performed the CPA leak test and the results were found acceptable. This resulted in exceeding the allowed time by 3 days. The cause of this event was a programatic deficiency. The program will be revised. Dividers have been placed in the HHRA Key Log as an interim action. Previous corrective actions are not applicable.

A. Plant Conditions Prior to Event:

Unit: Braidwood 1; Event Date: June 15, 1990: Event Time: 1030;
Mode: 1 - Power Operation; Rx Power: 89%;
RCS [ABe] 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.

A System Test Engineer (SiE) (Non-Licensed Techncial Personnel) had been monitoring the High-High Radiation Area (HHRA) Key Control Log, on a regular basis to determine when containment entries had been made. This was the existing program to determine when the non-routine surveillance requirement, Technical Specification 4.6.1.3.a, needed to be performed. This specification required that a leakage test of the Containment Personnel Air Lock be performed within 72 hours of Air Lock door closure.

At June 8, 1990 the STE observed that a containment entry had been made during the day. The STE performed the Leakage test and the results were found acceptable.

During the week of June 11 the STE reviewed the HHRA Key Log on a regular basis and did not observe any key issuance for contaiment entry.

On June 15, 1990 the STE made his HHRA Key Log review and did not observe any new entries. Later that morning the STE was informed through discussions with Operating Personnel that a Unit 1 Containment entry and been made that morning. The STE then proceeded to the Radiation Protection Office, where the log was maintained, to review the HHRA Key Log.

At 1030 the STE reviewed the HHRA Key Log. He observed that the last entry on the log sheet was dated June 8, 1990. The STE had performed the most recent Leak test for this entry. Puzzled by this discrepancy, the STE leafed through the blank pages of log sheets. When the STE turned to what he had perceived as the last blank Log sheet, approximately six pages back, he discovered that a second log sheet had been initiated. There were two entries on the second log sheet, one for a Unit 1 Containment entry that had been made that morning, and one for a Unit 1 Containment entry that had been made on the afternoon shift of June 8, 1990. The STE, who realized that a leak test had not been performed for that entry, immediately initiated performance of the Unit 1 Containment Personnel Air Lock leak test.

At 1200 the leak test was completed and the results were acceptable. This resulted in exceeding the allowed time, including allowable extension time, by approximately 3 days.

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 this event was programatic deficiency. The scheme of the existing program was simple; "To open the Air Lock requires a key. Monitor the key log to identify when to perform the leak test." The developers of the scheme failed to consider the potential discrepancies in usage methodology that may normally occur when a group the size of the Station Radiation Protection Department, which is staffed with 24 technicians, maintains a log which normally contains less than ten entries a month.

The HHRA key log was a small three ring note book that contained a copy of the Braidwood Administrative Procedure (BwAP) 1450-2, Access to High Radiation Areas. This was a five page procedure. Immediately following the procedure was what the STE perceived as the active log sheet. This contained nine log entries dating between May 10, 1990 and June 8, 1990. The sheet also contained blank space for an additional seven entries. This sheet was followed by five blank log sheets and then the last page of the book which was the second log sheet containing two entries.

Even with the usage discrepancies identified above , the log did perform its intended function in an acceptable manner. The deficiency occurred when the log was included in an activity for which it was not intended, determination of when Containment Air Lock leak testing is required. The determination to perform required non-routine testing should be made within the structure of a program that provides positive action notification and sign off that the notification has been completed. The failure to develop a program that contained these elements 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. The results of the leak test indicated that both the inner and outer doors of the Unit 1 Containment Personnel Air Lock were fully intact and individually capable of performing their containment function. Had one of the door's sealing capability become degraded there would still be no effect. The sealing capability of the second door would have provided the required containment function provided by the Containment Personnel Air Lock.

E. Corrective Actions:

The leak test was immediately performed and the results were found acceptable.

As an interim measure dividers have been placed in the HHRA Key Log separating the procedure, active log, and blank log sheet sections. Additionally the STE is checking all log sheets active or blank until development of the new program is completed.

The program for Containment Air Lock Leakage testing will be revised to provide for Technical Staff Notification that an operation of an Air Lock Door has occurred. This action will be tracked to completion by action item 456-200-90-02401.

An amendment to the Technical Specification has been submitted to request for implementation of the Continuous Leakage Monitoring System (CLMS). This system, when in operation, will eliminate the requirement to perform the Air Lock Leak Test following Containment Entries. However, when the CLMS is not in operation positive Technical Staff notification will be required. This action will be tracked to completion by 456130886.1.3-0100.

F. Previous Occurrences:

There have been previous occurrences of failing to perform surveillance specifications within the specified time intervals.

The 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.