



Commonwealth Edison

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

September 2, 1994
BW/94-0146

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 in accordance with the requirement of 10CFR50.73 (a)(2)(i)(B), which requires a 30-day written report.

This report is number 94-011-00, Docket No. 50-456.

K. L. Koffron
Station Manager
Braidwood Nuclear Generating Station

KLK/CP/dla
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Encl: Licensee Event Report
No. 456/94-011-00

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

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ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH
THIS INFORMATION COLLECTION REQUEST: 50.0 HRS.
FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO
THE INFORMATION AND RECORDS MANAGEMENT BRANCH
(MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION,
WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK
REDUCTION PROJECT (3150-0104), OFFICE OF
MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

PAGE (3)
1 OF 4

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NRC FORM 366A
(5-92)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95LICENSEE EVENT REPORT (LER)
TEXT CONTINUATIONESTIMATED BURDEN PER RESPONSE TO COMPLY WITH
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WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK
REDUCTION PROJECT (3150-0104), OFFICE OF
MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)		PAGE (3)
Braidwood 1	05000456	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
		94	-- 011 --	00
2 OF 4				

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

A. PLANT CONDITIONS PRIOR TO EVENT:

UNIT: Braidwood 1; EVENT DATE: August 3, 1994;
 EVENT TIME: 1400;
 MODE: 1; RX POWER: 100;
 RCS [AB] TEMPERATURE/PRESSURE: 580 degrees F / 2235 psig;

UNIT: Braidwood 2; EVENT DATE: August 3, 1994;
 EVENT TIME: 1400;
 MODE: 3; RX POWER: 0;
 RCS [AB] TEMPERATURE/PRESSURE: 557 degrees F / 2235 psig

B. DESCRIPTION OF EVENT:

During a review of IST/Technical Specification Requirements associated with a proposed UFSAR change, it was discovered that valves 1CS007A, 1CS007B, 2CS007A, and 2CS007B, were not stroke time tested in the closed direction prior to their addition to the Braidwood IST program. Technical Specification 3.6.3 lists these valves in table 3.6-1 as having a maximum isolation time of 30 seconds. As part of the data collection for the IST program, the four valves in question were stroke time tested in the closed direction. While the stroke times were taken to obtain reference values, they were within Tech. Spec. requirements. It should be noted that the valves have been stroke time tested in the open direction using a more conservative acceptance criteria (less than 30 seconds) since the beginning of the IST program.

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

C. CAUSE OF THE EVENT:

The cause of this event is a management deficiency due to a combination of factors. First, the only automatic signal that these valves receive is a signal to open on a Containment Spray Actuation signal. The valves never receive an automatic signal to close. Second, table 3.6-1 uses the words "Containment Spray Actuation" with a time of 30 seconds for the valve to go to its "isolation" position. The interpretation that the "isolation" position and most significant safety function for these valves is open, led both Byron and Braidwood Stations to believe that they were complying with

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

C. CAUSE OF THE EVENT: (continued)

Tech. Spec. 3.6.3 by stroke time testing the valves in the open direction. Third, the only analytical basis that associates a required stroke time with these valves is a requirement for the valves to open. Finally, testing of these valves in the open direction has been a part of the IST program at Braidwood station since the beginning of the program. It is postulated that this is due to an interpretation/philosophy which only required valves in the IST program to be stroked in one direction.

D. SAFETY ANALYSIS:

Since the beginning of the IST program, these motor operated valves have been tested quarterly in the open direction using a more conservative acceptance criteria. Braidwood station feels that the testing performed would have identified any valve degradation and gives a high confidence level that the requirements of Tech. Spec. 3.6.3. were indirectly satisfied. Additionally, there is no analytical basis for the stroke time in the closed direction. Based on this reasoning, this event is not safety significant.

E. CORRECTIVE ACTIONS:

Upon discussing the missed surveillance, LCOAR 4.0.3 and LCOAR 6.3-1A were immediately entered on Unit 1 and Unit 2 for failure to test the CS007s maximum close time of 30 seconds. The existing Braidwood procedures were changed to include time testing in the closed direction. The valves were immediately tested with satisfactory results. Testing will continue to be performed on a quarterly basis to satisfy the surveillance requirements of Tech. Spec. 3.6.3. Additionally, a scoping review of the Braidwood IST program was verified complete to ensure that valves which may have safety functions in both directions or have specific SAR requirements for stroke timing are being tested in accordance with each requirement. It should be noted that the CS007 valve was added to the IST program as a result of this scoping and is unique in that it is the only valve added to the program that has a stroke time requirement associated with it. The Braidwood IST program was changed to include time testing in the closed direction. The four valves were verified as being added to the Braidwood IST program to be stroke time tested in the closed direction in addition to already being timed in the open direction.

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F. PREVIOUS OCCURRENCES:

LER No. 457/93-005-00; Missed Surveillance on Containment Isolation Valve
The surveillance was missed due to it not being assigned to the correct department. A contributing cause to this event was a management deficiency.

G. COMPONENT FAILURE DATA:

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