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Commonwealth Edison Company
Braidwood Generating Station
Route #1, Box 84
Braceville, IL 60407 9619
Tel 815-458-2801

ComEd

June 4, 1996
BW/96-0063

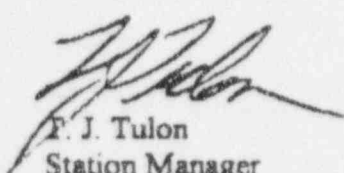
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U.S. Nuclear Regulatory Commission
Washington, D.C.

To All Concerned:

The enclosed Licensee Event Report from Braidwood Generating Station is being transmitted in accordance with the requirement of 10 CFR 50.73(a)(2)(i), which requires a 30-day report.

This report is number 96-004-00, Docket No. 50-457.

Yours truly,


P. J. Tulon
Station Manager
Braidwood Nuclear Station

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Encl.: Licensee Event Report
No. 457-96-004-00

cc: NRC Region III Administrator
NRC Resident Inspector
INPO Record Center
ComEd Distribution Center
I.D.N.S.
I.D.N.S. Resident Inspector

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NRC FORM 366 (4-95)						U.S. NUCLEAR REGULATORY COMMISSION						APPROVED BY OMB NO. 3160-0104 EXPIRE 04/30/98											
LICENSEE EVENT REPORT (LER)												ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 60.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-8 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT.											
FACILITY NAME (1) Braidwood Unit 2												BUCKET NUMBER (2) 05000457						PAGE (3) 1 OF 5					
INCIDENT (4) Unplanned Entry Into Technical Specification 3.0.3 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 NAME						BUCKET NUMBER								
5	23	96	96	-- 004	-- 00	8	4	96	None														
									FACILITY NAME						BUCKET NUMBER								
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 1. (Check one or more) (11)																				
1			20.2201(b)			20.2203(a)(2)(v)			X 50.73(a)(2)(i)			50.73(a)(2)(viii)											
POWER LEVEL (10)			20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)			50.73(a)(2)(x)											
97%			20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)			73.71											
			20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)			OTHER											
			20.2203(a)(2)(iii)			50.38(c)(1)			50.73(a)(2)(v)			Specify in Abstract below or in NRC Form 366A											
			20.2203(a)(2)(iv)			50.38(c)(2)			50.73(a)(2)(vii)														
LICENSEE CONTACT FOR THIS LER (12)																							
NAME Dennis Higinbotham, Operations Department												TELEPHONE NUMBER (Include Area Code) (815) 458-2801 x2202											
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																							
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC													
SUPPLEMENTAL REPORT EXPECTED (14)																							
YES (If yes, complete EXPECTED SUBMISSION DATE).												X NO		EXPECTED SUBMISSION		MONTH	DAY	YEAR					
ABSTRACT (Limit to 1400 spaces, i.e., approximately 18 single-spaced typewritten lines) (16)																							
<p>On 5/23/96 and 5/24/96, Technical Specification 3.0.3 was not entered as required during a period when Leak Detection Systems, as required by Technical Specification 3.4.6.1, were inoperable. The plant was placed in this condition on these two days for five and six minutes, respectively, during routine filter changes on the Containment Atmosphere Radiation Monitor skid concurrent with the Containment Floor Drain Leak Detection System flow transmitter being inoperable. The cause of both events was personnel error. Corrective actions include the counseling and retraining of the individuals involved, and the dissemination of the details of the event to all Licensed personnel at the site. The event resulted in no impact on the health and safety of the public. There have been no previous occurrences of this problem at Braidwood.</p>																							

NRC FORM 1467 (5-92)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/98			
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION				ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 60.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-8 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20655-0001, AND TO THE PAPERWORK REDUCTION PROJECT			
FACILITY NAME (1)		DOCKET NUMBER (2)		LER NUMBER (6)		PAGE (3)	
Braidwood Unit 2		05000457		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 5
				96	-- 004 --	00	
NOTE: If more space is required, use additional copies of NRC Form 1467A (17)							
A. PLANT CONDITIONS PRIOR TO EVENT:							
UNIT: Braidwood Unit 2 EVENT DATE: 5/23/96							
EVENT TIME: 0308							
MODE: 1 RX POWER: 97%							
RCS [AB] TEMPERATURE/PRESSURE: NOP/NOT							
B. DESCRIPTION OF EVENT:							
There were no systems or components inoperable at the beginning of this event that contributed to the severity of the event.							
<u>Background Information</u>							
Braidwood Station Technical Specification 3.4.6.1, Reactor Coolant System Leakage Detection Systems reads as follows:							
3.4.6.1 The following Reactor Coolant System Leakage Detection Systems shall be OPERABLE:							
a. The Containment Atmosphere Particulate Radioactivity Monitoring System,							
b. The Containment Floor Drain and Reactor Cavity Flow Monitoring System, and							
c. The Containment Gaseous Radioactivity Monitoring System.							
Action Requirements are specified when either a. or b. or c. are inoperable, and for when a. and c. are inoperable. In all other combinations of inoperable systems, Technical Specification 3.0.3 applies, which requires the unit to be put in a mode where the specification does not apply. For this specification, the inability to follow it would require reactor shutdown and cooldown to Mode 5 (Cold Shutdown).							
<u>Event Narrative</u>							
On May 23, 1996 at 0020 the Containment Floor Drain Leak Detection System flow transmitter, 2FT-RF008, was declared inoperable due to erratic indication. Limiting Condition for Operation Action Requirement (LCOAR) 3.4.6.1, action b, was entered at that time. This LCOAR requires the leakage detection system to be restored to operable status within seven days or shutdown the reactor. At 0308, 5/23/96, the Containment Atmosphere Radiation Monitor skid, 2PR11J, was removed from service to allow a Radiation Protection technician to perform							

NRC FORM 305 (4-85)

NRC FORM 305A
(5-92)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
Braidwood Unit 2	05000457	96	-- 004 --	00	3 OF 5

Note: (If more space is required, use additional copies of NRC Form 305A) (17)

B. DESCRIPTION OF EVENT (continued)

filter changes, which are routinely performed during midnight shifts. At this time LCOAR 3.4.6.1, action c, was applied. The Unit Supervisor and the Unit NSO did not recognize the fact that the combination of both the 2FT-RF008 transmitter and the 2PR11J monitor being inoperable simultaneously requires entry into Technical Specification 3.0.3. The 2PR11J filters were changed and the monitor was restored to service at 0313, after a total of five minutes.

The following evening on May 24, 1996, at 0334, the 2PR11J monitor was again removed from service for filter changes by the same operating crew, with the 2FT-RF008 still in LCOAR. At the time of the shutdown of the monitor, the Unit NSO conferred with the Unit Supervisor as to the proper application of Technical Specification 3.4.6.1, and as to the required course of action with both leak detection systems inoperable. After reviewing the Specification, the Unit Supervisor incorrectly concluded that the final sentence in the action statements, "Otherwise, be in at least HOT STANDBY within the next 6 hours and in COLD SHUTDOWN within the following 30 hours." applied to this situation; when in reality, Technical Specification 3.0.3 was again required. (In reality, the above statement only applies to action c. of the Tech Spec.) The Unit Supervisor conferred with the Shift Engineer, who agreed with the incorrect conclusion. The Unit Supervisor informed the Unit NSO as to the results of the discussion with the Shift Engineer, and that the Unit Log entry should reference LCOAR 4.6.1-1a, as opposed to Specification 3.0.3. The 2PR11J monitor was restored to service at 0340, after being inoperable for six minutes.

At 0512, the Unit Supervisor dispatched a message via electronic mail to selected supervisors involved with Shift Operations, as well as Work Control, advising them of the situation regarding the simultaneous inoperability of 2FT-RF008 and 2PR11J. In the message, the Unit Supervisor again referenced the statement of Specification 3.4.6.1 which he had previously interpreted incorrectly. This message was evaluated by personnel in Operations, as well as Regulatory Assurance, during the day shift of 5/24/96. At 1210 that day, a Problem Identification Form was issued concerning these events, identifying that Tech Spec 3.0.3 should have been entered during the two previous days but had not been recognized. At 1813, the LCO for 2FT-RF008 was exited.

NRC FORM 308 (4-95)

NRC FORM 308A
(5-92)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104

EXPIRES 04/30/98

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (4)
Braidwood Unit 2	05000457	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	4 OF 5
		96	-- 004 --	00	

NOTE (If more space is required, use additional copies of NRC Form 308A) (1)

B. DESCRIPTION OF EVENT (continued)

This report is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B), which requires the reporting of any operation or condition prohibited by the Plant's Technical Specifications. On two consecutive evenings the plant operated in a condition prohibited by the Tech Specs - once for five minutes and once for six minutes.

C. CAUSE OF EVENT:

The primary cause of this event was Personnel Error. There was a failure by the Unit Supervisor, Shift Engineer, and Unit NSO to recognize the impact of the inoperability of additional Leak Detection System components

D. SAFETY ANALYSIS:

The occurrence at Braidwood resulted in no impact on the health and safety of the public.

VCT level is frequently monitored and would have given indication of any gross increase in Primary System leakage, should this have occurred. Redundant methods of obtaining Containment radiation levels were in place, and operable, and would have alarmed if high Containment radiation levels had developed during the periods where the redundant leak detection systems were inoperable. The 2PR11J was restored to service 5 minutes after being shutdown during the first occurrence, and restored 6 minutes after shutdown during the second occurrence. In each occurrence, radiation levels were satisfactory prior to the shutdown of 2PR11J, and indications upon restoration showed no appreciable change in levels.

E. CORRECTIVE ACTIONS:

The Unit Supervisor, Shift Engineer, and Unit NSO were counseled and retrained after the event as to the impact of the loss of Leak Detection Systems and correct entry into the applicable Technical Specifications.

Additionally, all Licensed personnel will be retrained on the details of this event. Also, this same information will be distributed for information to the remainder of the Operations Department. This action will be tracked to completion by commitment 457-180-96-00401.

NRC FORM 366 (4-95)

NRC FORM 366A
(5-92)

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EXPIRES 04/30/98

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Braidwood Unit 2	05000457	96	-- 004 --	00	5 OF 5

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

E. CORRECTIVE ACTIONS (cont.):

Enhancements to the corresponding LCOAR paperwork will also be pursued, outside of the realm of this LER, along with a possible interpretation of the applicable Technical Specification.

F. PREVIOUS OCCURRENCES:

There has been one other event involving a missed LCOAR entry at Braidwood in the past two and a half years (LER 456-95-011 regarding conflicting surveillance procedures); none have involved the misinterpretation of the plant's Technical Specifications. A similar event involving this same Tech Spec occurred at Byron Station in 1995 (ref. LER 454-95-003). The details surrounding the Byron event had been presented to all licensed operators at Braidwood in 1995.

G. COMPONENT FAILURE DATA:

None