

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



October 24, 1996
BW/96-0087

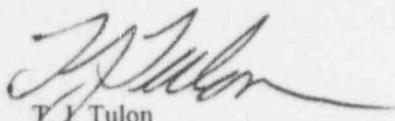
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U.S. Nuclear Regulatory Commission
Washington, D.C.

To Whom It May Concern:

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

This report is Number 96-011-00, Docket No. 50-456.

Yours truly,


T. J. Tulon
Station Manager
Braidwood Nuclear Station

TJT/WK/vak
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Encl.: Licensee Event Report
No. 456-96-011-00

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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EXPIRES 04/30/98

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 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-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT

FACILITY NAME (1)

Braidwood Unit 1

DOCKET NUMBER (2)

05000456

PAGE (3)

1 OF 8

TITLE (4)

Management Deficiencies Leading To Not Testing The Installation Of The Roll-Up Fire Door Modification In A Timely Manner Resulted In An Unanalyzed Condition

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	DOCKET NUMBER
09	24	96	96	-- 011	-- 00	10	24	96	Braidwood Station Unit 2	05000457
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)							
1			20.2201(b)		20.2203(a)(2)(v)		50.73(a)(2)(i)		50.73(a)(2)(viii)	
POWER LEVEL (10)			20.2203(a)(1)		20.2203(a)(3)(i)		X 50.73(a)(2)(iii)		50.73(a)(2)(x)	
100			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)		50.36(c)(1)		X 50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A	
			20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)			

LICENSEE CONTACT FOR THIS LER (12)

NAME

D. Pierce, Site Engineering

TELEPHONE NUMBER (Include Area Code)

(815) 458-2801 x2706

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)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO	EXPECTED SUBMISSION	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

During a surveillance of fire doors, four roll-up doors that separate areas containing safety related equipment from the Turbine Building failed to fully close under full ventilation conditions. The surveillance was reperformed with the ventilation secured and the doors closed completely. A subsequent review by System Engineering indicated that the doors were not tested following installation. The roll-up fire door installation was a plant design change for Unit One and initial construction for Unit Two. Immediate corrective actions were to close and secure the doors. Additional testing was performed and demonstrated that the doors would: a) close completely under minimum ventilation, b) close partially under full ventilation and complete closing when ventilation was secured. The investigation concluded that the cause of this event was a Management Deficiency resulting in not testing the doors in a timely manner. Corrective actions include correcting identified door deficiencies, performing the appropriate door testing, revising relevant portion of the surveillance procedure, revising the modification process and reviewing other open modifications for similar problems. This event has minimal safety consequences.

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

A. PLANT CONDITIONS PRIOR TO EVENT:

UNIT: Braidwood Unit 1 EVENT DATE: 09/24/96
EVENT TIME: 17:32
MODE: 1 RX POWER: 100
RCS [AB] TEMPERATURE/PRESSURE: NOT/NOP

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.

On 6/27/96, Mechanical Maintenance Department (MMD) started BwMS 3350-001, Fire and Security Doors Semi-Annual Inspection. This surveillance tests all security and fire doors in the station to assess the integrity of the door, door frame and any attached hardware. The test included single doors, double doors, removable doors, counter and roll-up doors. Initially, the single and double doors were tested. The final doors to be tested were the roll-up doors.

On 7/2/96, while testing the roll-up door for the 2A Diesel Generator (DG), the door failed to close completely. The MMD worker contacted the Control Room and requested that the ventilation in the 2A DG Room be secured so that he could retest the door. Ventilation was secured and the roll-up door closed satisfactory. The MMD worker, his First Line Supervisor (FLS) and the Fire Marshall concluded that the surveillance was satisfactory. However, the Fire Marshall and the MMD worker decided that a Problem Identification Form (PIF) should also be written to identify that the ventilation had to be turned off for the doors to close.

On 7/3/96, the MMD worker performed testing on four Engineered Safeguard Features (ESF) Switchgear Room Doors, two Non-ESF Switchgear Room Doors and two Miscellaneous Electric Equipment Room (MEER) Doors. In addition to the earlier 2A Diesel Generator Room Door, the roll-up doors to three other rooms did not close completely unless the ventilation was secured: ESF Division 21 Switchgear Room and Unit One and Two Non-ESF Switchgear Rooms. On 7/8/96, the MMD FLS approved the surveillance as satisfactory.

On 7/9/96, the FLS contacted the Fire Protection (FP) System Engineer to report that the doors did not close with the ventilation fans running. The FLS and the MMD worker wrote PIF 456-201-96-1532 addressing the concern with the doors not closing completely with the ventilation fans running. This PIF included all twelve doors that could have been affected by ventilation, even though only four of the doors did not close completely with the ventilation fans running. The other eight doors closed in the surveillance; however, the ventilation configuration was not documented.

The PIF was assigned to the FP System Engineer for action. The FP System Engineer incorrectly assumed that the door surveillance was unsatisfactory and he believed that Plant Barrier Impairments (PBI) and Action Requests (ARs) were already generated by MMD to resolve the problems with doors.

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(5-92)

U. S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
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B. DESCRIPTION OF EVENT (continued)

On 9/3/96, the FP System Engineer was informed by the FLS that the surveillance was closed as satisfactory because the surveillance only checks the mechanical attributes of the doors.

The FP System Engineer wrote PBIs for all twelve roll-up doors based on his conversation with the FLS. As part of the PBI paperwork, a HVAC review was performed which identified the possibility of both trains of ESF switchgear being affected. The HVAC System Engineer questioned the adequacy of the door surveillance and requested the original testing requirements from the Modification Approval Letter. The HVAC System Engineer determined that the modification testing for the Unit One doors was never completed and the modification was still identified as being in the installation phase. It was also determined that no testing was performed for the Unit Two doors installed as part of original construction. Based on information from the FLS and the original PIF, the FP System Engineer, System Engineering Supervisor, Regulatory Assurance Supervisor, and Operating personnel determined that the doors may not be capable of performing their design function. Operations personnel closed all eight normally open doors and placed Caution Cards. Since the four Diesel Generator Room Doors were not a part of the modification and are normally closed, their configuration was not affected.

The roll up fire doors were installed from 1988 to 1990 under modification M20-1-87-061 (Unit One) and as part of initial construction for Unit Two. The purpose of the design change was to replace the security doors to the ESF Switchgear Rooms, Non-ESF Switchgear Room and the MEER Room to eliminate nuisance security door alarms. The original doors were replaced with hinged security bars and roll-up fire doors. The design function of the roll-up fire doors was to provide a barrier in the event of a fire on either side of the door. The physical installation was completed on June 4, 1990. A modification test was never performed, nor was the Unit Two design tested. During the time the doors were in service, semi-annual surveillances were performed under PwMS 3350-001.

In March 1994, this and twenty-two other design changes were addressed in PIF 456-201-94-49600 as design changes were installed without being tested. The PIF recommended that these design changes be reviewed for safety significance and action plans be developed for close-out. Although individual PIFs were written to track the closure of each design change, the testing and close-out was not completed.

Specifically, on 4/25/94, PIF-201-94-07300 was written on the roll-up fire door modification and included actions were identified to complete testing and close-out. These actions have not been completed.

On 5/3/94, PIF 456-230-94-01000 was written to evaluate the trend of design changes not being tested in a timely fashion. Three corrective actions were developed to preclude design changes being open for testing for long periods of time: 1) revise the modification procedure to restrict the time allowed for a design change to remain open for testing 2) train System and Site Engineers on the new procedural requirements and 3) issue a monthly report to the Site Engineering Supervisor and System Engineering Supervisor for appropriate follow-up. Although the procedure revision was approved on 10/21/96, training was not completed and monthly reporting was sporadic.

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B. DESCRIPTION OF EVENT (continued)

On 9/17/96, a Service Representative visually inspected the fire doors and indicated that the surveillance procedure was inadequate because it did not address resetting the door. Special Test SPP 96-029 was written to test the three failed doors to determine if these doors could close satisfactorily under the full range of ventilation conditions.

On 9/24/96, the ESF Division 21 Switchgear Room Door was tested. This door closed satisfactorily with no ventilation running (minimum differential pressure). With maximum differential pressure, the door stopped approximately eighteen inches from fully closed. During this test, a piece of Thermafiber fire resistant material located in the wall between the ESF Division 21 and ESF Division 22 Switchgear Rooms was forced into the ESF Division 22 room. At this time, a one hour fire watch was established and PIF 457-201-96-0957 was written and further testing was secured. At 1732, a one hour ENS phone call was made because the roll-up fire doors would potentially not be capable of performing their design functions.

A review identified that the High Energy Line Break (HELB) analysis assumed that fire doors for the ESF switchgear and the MEER rooms would close within one to two seconds upon a HELB. Data from the 9/24/96 door testing indicated that the door closes in approximately eight seconds. On 9/25/96, SPP 96-029, revision three, was performed to test the door with maximum differential pressure. After the door partially closed, the fan was secured and the door closed the remaining distance verifying that the doors would fully close without ventilation.

On 10/23/96, the Unit One MEER door, the Division 11 and 12 ESF Switchgear Room doors were retested under the full range of HVAC conditions. The Division 11 and 12 ESF Switchgear doors failed to close fully under full ventilation. At 1457 and 1350, two one hour ENS phone calls was made because the Division 11 and 12 ESF Switchgear Room roll-up fire doors, respectively, failed to close and would potentially not be capable of performing their design functions. All doors completed closing when ventilation was secured.

This event is being reported pursuant to 10CFR50.73(a)(2)(ii)(B), any event or condition that resulted in the nuclear power plant being in a condition that was outside the design basis of the plant, and 10CFR50.73(a)(2)(v)(D), any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident.

C. CAUSE OF EVENT:

The investigation concluded that the causes of this event were Management Deficiencies. The two root causes of this event are: 1) The modification program was not being properly monitored by management through the various phases of installation and testing. 2) This modification was assigned a low priority leading to the modification not being installed and tested in a timely manner. In addition, although design change status is tracked, there is no formal process to review open design changes leading to specific actions.

Installation of modification M20-1-87-061 began in March of 1988 and was completed in June of 1990. During the period of June 1990 through September 1996, the roll-up fire doors were assumed to be operable and the semi-annual surveillances were being performed on these doors. During this time, when doors failed the surveillance, ARs were initiated, doors repaired and tests reperformed as needed.

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C. CAUSE OF EVENT (continued)

Contributing causes to this event were as follows:

In 1994, all long term design changes were individually evaluated with corrective actions assigned. These corrective actions were not completed in a timely manner.

In 1994, corrective actions were developed for the modification process including procedure revisions. The procedure revisions were not implemented until October 21, 1996.

The surveillance procedure did not specify door reset adjustment or required ventilation configuration for the testing.

D. SAFETY ANALYSIS:

The safety significance of the failure of the roll-up fire door to fully close on the Division 21 ESF Switchgear Room was determined by evaluating the impact of this condition on the High Energy Line Break (HELB) and fire protection function of the door. The impact of a Turbine Building HELB on the ESF Switchgear Rooms was first documented in a letter to the NRC on July 10, 1991. An NRC audit of this analysis was performed on January 22 and 23, 1992. Comments from this audit resulted in a supplemental response to the NRC dated April 15, 1992.

The transient analysis of the HELB utilizes a bounding methodology of assuming no ventilation. The failure of the roll-up fire door to fully close occurs when the room's respective ventilation system is operating. If the ventilation system remains operating, some heat removal capability is present and the resultant room temperature after two hours would be less than that predicted in the design basis analysis. Since the Turbine Building pressure will return to approximately atmospheric shortly after the HELB, any air flow from the operating ventilation system will be out of the ESF Switchgear Room to the Turbine Building, thus providing a positive ventilation flow path for heat removal.

The HELB analysis was reevaluated considering the roll-up doors and closure times from testing. This was not specifically analyzed in the original analysis. This reevaluation considered the increased open area resulting from the open roll-up door and a specified closure time of fifteen seconds. The closure time selected was based upon a measured closure time of approximately eight seconds and allowing time for the door's fusible link to melt. The results of this reanalysis concluded that the effects of the roll-up door design and its operation have negligible impact on the ESF Switchgear Rooms' heat-up after two hours as described in Updated Final Safety Analysis Report (UFSAR) Table 3-11.

This evaluation uncovered weaknesses in the original Turbine Building HELB analysis. As a result, the analysis is being reperformed to address these weaknesses. The completion of the reanalysis will be tracked using the Nuclear Tracking System (NTS).

The previous analysis which concluded that equipment in the ESF Switchgear Room would perform its design function under a Turbine Building HELB remains valid pending the finalization of our design basis reconstitution.

The effect of the ESF Switchgear Room roll-up doors' failure to fully close was evaluated in the event of a fire in either ESF Switchgear Room or the Turbine Building. The following HVAC configurations were assessed along with a failure of the roll up doors to fully close:

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D. SAFETY ANALYSIS: (continued)

- Credible fire in turbine building with the protected room's ventilation system in full outside air mode
- Fire in protected room with the protected room's ventilation system in full outside air mode
- Credible fire in turbine building with the protected room's ventilation system in recirculation air mode
- Fire in protected room the protected room's ventilation system in recirculation air mode
- Design basis fire in the turbine building

Physical separation of the two ESF Switchgear Rooms is achieved by a three hour fire wall between the two rooms and the physical distance between the openings (i.e., roll-up doors and ventilation penetrations). As a result, a single fire in either one of the rooms would not affect both divisions. The area outside of the ESF Switchgear Rooms in the turbine building contains minimal combustible materials. The redundant ESF Switchgear room roll-up doors are separated by approximately 31 horizontal feet along the wall that separates the ESF Switchgear Rooms from the Turbine Building (L wall). The closest in-place combustible materials consist of two groups of three cable risers located a minimum distance of 12 horizontal feet away from the "L" wall near each roll-up door. The area is protected by a fixed wet-pipe sprinkler system.

A credible fire in this area of the turbine building is identified as a local fire involving the cable risers and possibly transient combustibles in front of one of the ESF Switchgear Rooms. Because of the horizontal distance between the two roll-up doors, a single fire large enough to affect both doors is not considered to be credible.

The design basis fire for the 426 foot elevation of the Turbine Building (fire zones 8.5-1 and 8.5-2) is described in the Fire Protection Report. The design basis fire is a non-mechanistic fire which is assumed to consume all combustible materials in the fire zone. The design basis fire is not considered to be a credible fire, but it is considered bounding and is evaluated as follows:

The design basis fire could affect both ESF Switchgear Rooms. If the Switchgear Heat Removal (VX) system is operating in full outside air mode, and the roll-up fire doors failed to completely close, it is expected that the air flow out from the switchgear rooms would prevent the spread of heat and ionization products of combustion from the Turbine Building from entering the rooms as long as the fans continued to run. If the fans stop, the roll-up doors would close and protect the ESF Switchgear Rooms. If the VX system is operating in the recirculation mode, air will enter the ESF Switchgear Rooms from the Turbine Building. It is expected that the ionization detectors downstream of the supply fans would identify the products of combustion, would trip the fans, and the roll-up doors would close, protecting the ESF Switchgear Rooms from the Turbine Building fire. In either case, the fire would not spread into the ESF Switchgear Rooms. The VX system would be restarted within two hours of fire initiation, after the fire is extinguished. The ESF Switchgear Room temperature transient following a fire is bounded by the HELB transient analysis, since the initial room heat up due to steam influx into the rooms during the initial HELB pressure transient would not be present for the design basis fire. Therefore, as demonstrated by the HELB temperature transients, the room temperatures after two hours would be within the bounds of the previous analysis.

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C. CAUSE OF EVENT: (continued)

Based on the above, this event has minimal safety consequences.

E. CORRECTIVE ACTIONS:

Immediate corrective actions taken on 9/3/96 included closing all roll-up fire doors and placing Caution Cards on them.

In July 1996, management set expectations that all NTS items will have completion dates and any extensions will be approved by the Event Screening Committee.

The Thermafiber fire resistive material damaged between the Division 21 and 22 ESF switchgear rooms has been repaired.

Procedures BWAP 2321-12, Modifications, and BWAP 2321-21, Exempt Changes, will be revised to require that design changes be tested within 30 days after completion of installation and released for testing, or have a formal engineering evaluation performed. These revisions will be tracked by NTS items 456-180-96-01101 and 456-180-96-01102.

The Fire Door Service Representative will inspect and adjust all roll-up fire doors. This will be tracked by NTS item 456-180-96-01103.

The modification test for the roll-up fire doors will be performed and the modification closed out. This will be tracked by NTS item 456-180-96-01104.

The remaining corrective actions for Trend PIF 456-230-94-01000 (modification procedure revision training and implementation of a monthly report) will be completed.

Procedures BWAP 2321-12, Modifications, and BWAP 2321-21, Exempt Changes, will be revised to require that the Engineering Design Supervisor perform a monthly Design Change Status assessment to identify the current status of all design changes and determine if the design changes are progressing satisfactorily. Design Changes that are not being closed in a timely manner will be reviewed with the Plant Operations Review Committee (PORC). This will be tracked by NTS items 456-180-96-01105 and 456-180-96-01106.

Other identified design changes that have been in the installation or testing phase for an extended period of time have been reviewed with 50.59 screening performed as required. Actions required to close the identified design changes will be implemented. This will be tracked by NTS item 456-180-96-01107.

BWMS 3350-001, Fire and Security Doors Semi-Annual Inspection will be revised to clarify the conditions under which the surveillance is performed and the acceptance criteria. This will be tracked by NTS item 456-180-96-01108.

Re-evaluation of the High Energy Line Break (HELB) analysis will be tracked by NTS 456-180-96-01109.

Discuss this event with the Shift Engineers and Event Screening Committee (ESC) as to the importance of proper coding significant level of the PIF. This will be tracked by NTS item 456-180-96-01110.

An effectiveness review of all corrective actions contained in this report will be performed by Site Engineering Manager or his designee and tracked by NTS 456-180-96-01111.

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F. PREVIOUS OCCURRENCES:

In addition to previous occurrences described in this report, a review of the NTS database identified one previous event involving the modification process. NTS item 456-200-95-08600 identified that 125VDC battery terminal voltage was found below the Tech Spec minimum. When the batteries were replaced during outage AlR04, a different battery was installed. Once the modification was performed, the surveillance values were changed but operator rounds were not updated to reflect the new voltage values. Procedures did not identify a review of operator rounds as part of the change process. Corrective actions were to revise the Modification Procedure to review operator rounds for necessary changes as part of the process. A review of all previous modifications was performed to determine if other operator rounds changes were required but not none were identified. These corrective actions would not have prevented the current event.

G. COMPONENT FAILURE DATA:

MANUFACTURER	NOMENCLATURE	MODEL MFG PART NO.
N/A		