TU ELECTRIC

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File # 10200

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50.73(a)(2)(i)

April 26, 1990

William J. Cahill, Jr.
*Executive Vice President*

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION
DOCKET NO. 50-445
CONDITION PROHIBITED BY THE PLANT'S TECHNICAL SPECIFICATIONS
LICENSEE EVENT REPORT 90-005-00

Gentlemen:

Enclosed is Licensee Event Report 90-005-00 for Comanche Peak Steam Electric Station Unit 1, "Inadequate Implementation of Procedural Requirements Resulting in the Failure to Perform a Visual Inspection of Containment Required by Technical Specifications."

Sincerely,

William J. Cahill, Jr.

RHS/daj

Enclosure

c - Mr. R. D. Martin, Region IV
Resident Inspectors, CPSES (3)



IE22
1/1

Enclosure to TXX-90157

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC. 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC. 20503.

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Title (4) INADEQUATE IMPLEMENTATION OF PROCEDURAL REQUIREMENTS RESULTING IN THE FAILURE TO PERFORM A VISUAL INSPECTION OF CONTAINMENT REQUIRED BY TECHNICAL SPECIFICATIONS

| 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 Numbers |
| 0 3 | 2 7 | 9 0 | 9 0 | - 0 0 1 5 | - 0 0 | 0 4 | 2 6 | 9 0 | N/A | 0 5 0 0 0 |
| | | | | | | | | | N/A | 0 5 0 0 0 |

Operating Mode (9): 3

Power Level (10): 0 0 0

This report is submitted pursuant to the requirements of 10 CFR §: (Check one or more of the following) (11)

- 20.402(b)
- 20.405(a)(1)(i)
- 20.405(a)(1)(ii)
- 20.405(a)(1)(iii)
- 20.405(a)(1)(iv)
- 20.405(a)(1)(v)
- 20.405(c)
- 50.36(c)(1)
- 50.36(c)(2)
- [X] 50.73(a)(2)(i)
- 50.73(a)(2)(ii)
- 50.73(a)(2)(iii)
- 50.73(a)(2)(iv)
- 50.73(a)(2)(v)
- 50.73(a)(2)(vii)
- 50.73(a)(2)(viii)(A)
- 50.73(a)(2)(viii)(B)
- 50.73(a)(2)(x)
- 73.71(b)
- 73.71(c)
- Other (Specify in Abstract below and in Text, NRC Form 366A)

Licensee Contact For This LER (12)

| Name | Telephone Number |
|---|---|
| D. NORMAN HOOD SUPERVISOR, COMPLIANCE | Area Code 8 1 1 7 8 1 9 7 1 - 1 5 1 8 1 8 1 9 |

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 Date (15) | Month | Day | Year |
|---|---|---|---|
| | | | |

Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On March 27, 1990, it was determined that the procedural requirement for the performance of a visual inspection of affected areas following a containment entry was not being fully satisfied. The inspection is required to ensure that no loose debris is present which could be transported to the containment sumps during a loss of coolant accident. No significant safety concerns have been identified. The successful completion of a containment visual inspection prior to entry into the mode for which the Technical Specification is applicable and again subsequent to the event, along with the existence of Station Administrative Procedures governing housekeeping practices, provide a high level of assurance that if a loss of coolant accident had occurred, there would not have been an accumulation of trash on the sump screens causing flow restriction. The root cause of the event was inadequate implementation of a procedural requirement. Administrative controls will be improved to ensure that the required visual inspection is performed.

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Text (If more space is required, use additional NRC Form 366A's) (17)

## I. DESCRIPTION OF EVENT

### A. PLANT OPERATING CONDITIONS BEFORE THE EVENT

On March 27, 1990, at 1100 CST, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 3, Hot Standby. The Reactor Coolant System (RCS) (EIIS: (AB)) was at a temperature of 557 degrees F and pressure of 2300 psig.

### B. REPORTABLE EVENT DESCRIPTION (INCLUDING DATES AND APPROXIMATE TIMES OF MAJOR OCCURRENCES)

**Event Classification:** Any operation or condition prohibited by the plant's Technical Specifications.

On March 27, 1990, at approximately 1020 CST, a system engineer (contractor, non-licensed) entered the containment building (EIIS: (NH)) to perform a system walkdown. He exited containment at approximately 1100 CST. At approximately 1300 CST, a discussion between the system engineer and his supervisor (utility, licensed) revealed that the system engineer had not satisfied the procedural requirement of the Station Administrative Procedure governing containment entry. The procedure requires that a visual inspection be conducted in affected areas within containment to verify that no loose debris is present. The documentation of this inspection is required to satisfy the surveillance requirement of Technical Specification 4.5.2c.2. The intent of Technical Specification 4.5.2c.2 is to ensure that no loose debris is present in the containment which could be transported to the containment sump (EIIS: (DRN)(BP)(BE)) and cause restriction of the pump (EIIS: (P)(BP)(BE)) suctions during loss of coolant accident (LOCA) conditions. Upon discovery of the condition, the Shift Supervisor (utility, licensed) was notified, and Technical Specification 4.0.3 was entered. Operations personnel (utility, non-licensed) performed a visual inspection of all accessible areas of containment in accordance with Operations Testing Procedures, and Technical Specification 4.0.3 was exited at approximately 1755 CST. The preliminary investigation of the event determined that adequate controls did not exist to provide assurance that additional examples of noncompliance with the procedure governing containment entries had not occurred since Mode 4 was entered on March 16, 1990, when the affected Technical Specification became applicable.

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**C. STATUS OF STRUCTURES, SYSTEMS, OR COMPONENTS THAT WERE INOPERABLE AT THE START OF THE EVENT AND THAT CONTRIBUTED TO THE EVENT**

There were no inoperable structures, systems, or components which contributed to this event.

**D. CAUSE OF EACH COMPONENT OR SYSTEM FAILURE, IF KNOWN**

There were no system or component failures which contributed to this event.

**E. FAILURE MODE, MECHANISM, AND EFFECT OF EACH FAILED COMPONENT**

There were no component failures which contributed to this event.

**F. FOR FAILURES OF COMPONENTS WITH MULTIPLE FUNCTIONS, LIST OF SYSTEMS OR SECONDARY FUNCTIONS THAT WERE ALSO AFFECTED**

There were no component failures which contributed to this event.

**G. FOR FAILURES THAT RENDERED A TRAIN OF A SAFETY SYSTEM INOPERABLE, AN ESTIMATE OF THE ELAPSED TIME FROM THE DISCOVERY OF INOPERABILITY UNTIL THE TRAIN WAS RETURNED TO SERVICE**

There were no component or system failures which rendered a train of a safety system inoperable.

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## H. THE METHOD OF DISCOVERY OF EACH COMPONENT OR SYSTEM FAILURE OR PROCEDURAL ERROR

The failure to follow the procedural requirement to conduct a visual inspection of the affected areas of containment was identified approximately 2 hours after the containment entry during a discussion between the system engineer and his supervisor. The procedure noncompliance was documented and reviewed in accordance with Station Administrative Procedures. During the disposition process it was determined that sufficient programmatic controls could not be demonstrated to provide assurance that additional examples of noncompliance with procedures governing containment entries had not occurred subsequent to entry into Mode 4.

## I. CAUSE DETERMINATION

The root cause of this event is inadequate implementation of a procedural requirement. A contributing factor is considered to be insufficient training of plant personnel on the procedural guidance governing containment entry. Although the procedural guidance related to the Technical Specification requirement for a visual inspection has been in place since 1987, no specific group within the utility organization was assigned responsibility for developing a positive control mechanism to ensure procedural compliance.

## J. SAFETY SYSTEM RESPONSES THAT OCCURRED

There were no manual or automatic safety system responses as a result of this event.

## K. FAILED COMPONENT INFORMATION

There were no component failures associated with this event.

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## II. ASSESSMENT OF THE SAFETY CONSEQUENCES AND IMPLICATIONS OF THIS EVENT

Prior to entry into Mode 4, Hot Shutdown, a visual inspection of containment is performed in accordance with Operations Testing Procedures to verify that no loose debris is present in the containment which could be transported to the containment sump and cause restriction of pump suctions during LOCA conditions. Immediately following discovery of the event, Operations personnel reperformed the visual inspection. All acceptance criteria for the containment closeout inspection were satisfied, and the inspection was completed on March 27, 1990 at 1755 CST. Additional administrative controls provide a measure of assurance that trash and debris will not accumulate in containment. Station Administrative Procedures governing housekeeping practices provide guidance to employees regarding their responsibilities for the removal of tools, equipment, materials, trash or debris from the work area upon completion of work activities. The successful performance of the containment closeout inspection along with the existence of housekeeping controls for work activities provides a high level of assurance that if a LOCA had occurred, flow restriction resulting from the accumulation of trash on the sump screens would not have occurred. It is therefore concluded that this event did not adversely affect the safe operation of CPSES Unit 1 or the health and safety of the public.

## III. CORRECTIVE ACTIONS

### A. IMMEDIATE CORRECTIVE ACTIONS

Immediate corrective actions focused on establishing administrative control over containment entry activities and satisfying Technical Specification Surveillance requirements. The following actions were taken:

1. The Security Post Order for the containment access point was changed to require the Security officer to check that each work party entering containment has the correct documents for performance of the required visual inspection.

2. A sign was placed at the containment access point advising work parties entering containment of the documentation requirements for containment entry.

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3. The Operations Department performed a visual inspection in accordance with the applicable station procedure to verify that no loose debris was present in all accessible areas of containment.

4. The Operations Department began keeping a Control Room log of containment entries to ensure that affected Technical Specification requirements are satisfied following completion of each containment entry.

The desirability of continued reliance on the temporary administrative controls over containment access will be evaluated following full implementation of actions to prevent recurrence.

## B. ACTIONS TO PREVENT RECURRENCE

Station Administrative Procedures will be revised to include a mechanism for ensuring that a visual inspection of the areas affected within containment is performed and documented following the completion of a containment entry, once containment integrity is established. Responsibility for ensuring that the procedural requirements are satisfied has been assigned. The development of administrative barriers ensuring procedural compliance eliminates the need to perform extensive training of plant personnel while assuring a more positive control on containment entry.

## IV. PREVIOUS SIMILAR EVENTS

There have been no previous similar events reported pursuant to 10CFR50.73.