

TUELECTRIC

Log # TXX-93132
File # 10200
Ref. # 50.73(a)(2)(iv)

March 12, 1993

William J. Cahill, Jr.
Group Vice President

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

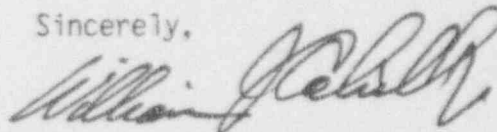
SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)
DOCKET NO. 50-445
REACTOR PROTECTION SYSTEM ACTUATION
LICENSEE EVENT REPORT 92-029-00

Gentlemen:

Enclosed is Licensee Event Report (LER) 92-029-00 for Comanche Peak Steam Electric Station Unit 1, "Flux Doubling Actuation From Loss of 1PC1 After Transfer to Temporary Power."

TU Electric initially determined that this actuation was not reportable to the NRC under 10CFR50.72 and 10CFR50.73. However, after an additional review of this event, TU Electric is conservatively reporting this actuation under 10CFR50.72 and 10CFR50.73. Details of this evaluation are provided in the enclosed LER.

Sincerely,



William J. Cahill, Jr.

OB:tg

Enclosure

cc: Mr. J. L. Milhoan, Region IV
Mr. L. A. Yandell, Region IV
Resident Inspectors, CPSES (2)

180026

JE28

Facility Name (3)

Order Number (2)

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FLUX DOUBLING ACTUATION FROM LOSS OF 1PC1 AFTER TRANSFER TO
TEMPORARY POWER

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------|-----|------|---|-------------------|-----------------|------------------|-----|------|---|---|---|--|---|------------------------------------|---|---|---|---|---|---|-----|--|--|--|--|-----------------|
| 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(s) N/A | | | | | Digital Numbers 0 5 0 0 0 0 1 1 | | | | | | | | | | | | |
| 1 | 2 | 0 | 8 | 9 | 3 | 9 | 2 | - | 0 | 2 | 9 | - | 0 | 0 | 0 | 3 | 1 | 2 | 9 | 3 | N/A | | | | | 0 5 0 0 0 0 1 1 |
| Operating Mode (9) | | | This report is submitted pursuant to the requirements of 10 CFR 50. (Check one or more of the following) (11) | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | 20.402(b) | | | 20.405(c) | | | <input checked="" type="checkbox"/> 50.73(a)(2)(iv) | | | 73.71(b) | | | | | | | | | | | | | | |
| Power Level (10) | | | 20.405(a)(1)(i) | | | 50.36(c)(1) | | | <input type="checkbox"/> 50.73(a)(2)(v) | | | 73.71(c) | | | | | | | | | | | | | | |
| 0 0 0 | | | 20.405(a)(1)(ii) | | | 50.36(c)(2) | | | <input type="checkbox"/> 50.73(a)(2)(vi) | | | Other (Specify in Abstract below and in Text, NRC Form 366A) | | | | | | | | | | | | | | |
| | | | 20.405(a)(1)(iii) | | | 50.73(a)(2)(i) | | | <input type="checkbox"/> 50.73(a)(2)(vii)(A) | | | | | | | | | | | | | | | | | |
| | | | 20.405(a)(1)(iv) | | | 50.73(a)(2)(ii) | | | <input type="checkbox"/> 50.73(a)(2)(vii)(B) | | | | | | | | | | | | | | | | | |
| | | | 20.405(a)(1)(v) | | | 50.73(a)(2)(iii) | | | <input type="checkbox"/> 50.73(a)(2)(viii) | | | | | | | | | | | | | | | | | |

Licensee Contact For This LER (12)

References

Ann. Cret.

Yersinia enterocolitica bio. 4/O:3

D. J. REIMER, MANAGER, SYSTEM ENGINEERING

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|---|---|---|---|---|---|---|---|---|---|---|
| 8 | 1 | 7 | 8 | 9 | 7 | - | 5 | 5 | 8 | 4 |
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Complete One Line For Each Component Failure Described In This Report (12)

| Cause | System | Component | Manufacturer | Reportable To NPSDS | | Cause | System | Component | Manufacturer | Reportable To NPSDS | |
|-------|--------|-----------|--------------|---------------------|--|-------|--------|-----------|--------------|---------------------|--|
| | 1 | 1 1 1 1 | 1 1 1 1 | Y | | | 1 | 1 1 1 1 | 1 1 1 1 | | |
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Supplemental Figure E extracted (74)

Yes (If yes, complete Expected Submission Date)

☒ 42

Expected
Submission
Date (15)

Month

129

☐ Yes

Abstract Limit to 1400 spaces (i.e., approximately fifteen single-space typewritten lines) (36)

On December 8, 1992 at 1608, after swapping the 118V AC panel 1PC1 from its alternate power supply to a temporary power supply, power was lost to the panel. Alternate power was then restored to the panel. During this time the flux doubling circuit actuated. The cause of the actuation was determined to be the nuclear instrumentation circuit response to the loss of temporary power and the restoration of the alternate power supply. The cause of the loss of temporary power was a personnel error in the design of the temporary modification which incorrectly connected a single phase 208 volt source to the single phase 118V panel 1PC1.

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| <div style="display: flex; justify-content: space-between; font-size: small;">NRC FORM 366AU.S. NUCLEAR REGULATORY COMMISSION</div> <div style="text-align: center; margin-top: 20px;">LICENSEE EVENT REPORT (LER) TEXT CONTINUATION</div> | | <div style="text-align: right; margin-bottom: 5px;">APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92</div> <div>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.</div> | | | | | | | | | |
| Facility Name (1) | Docket Number (2) | <div style="display: flex; justify-content: space-between;">LER Number (6)Page (3)</div> <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"><tr><td style="width: 15%;">Year</td><td style="width: 15%;">Sequential Number</td><td style="width: 15%;">Revision Number</td><td style="width: 55%;"></td></tr></table> | | Year | Sequential Number | Revision Number | | | | | |
| Year | Sequential Number | Revision Number | | | | | | | | | |
| COMANCHE PEAK-UNIT 1 | 05000445 | <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"><tr><td style="width: 15%;">92</td><td style="width: 15%;">-</td><td style="width: 15%;">029</td><td style="width: 15%;">-</td><td style="width: 15%;">00</td><td style="width: 15%;">02</td><td style="width: 10%;">OF</td><td style="width: 10%;">07</td></tr></table> | | 92 | - | 029 | - | 00 | 02 | OF | 07 |
| 92 | - | 029 | - | 00 | 02 | OF | 07 | | | | |
| Text (If more space is required, use additional NRC Form 366A's) (17) | | | | | | | | | | | |
| <p>I. DESCRIPTION OF THE EVENT REPORTABLE</p> <p>A. REPORTABLE EVENT CLASSIFICATION</p> <p>Any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System.</p> <p>B. PLANT OPERATING CONDITIONS PRIOR TO THE EVENT</p> <p>On December 8, 1992, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 5, Cold Shutdown, after having completed refueling operations.</p> <p>C. STATUS OF STRUCTURES, SYSTEMS OR COMPONENTS THAT WERE INOPERABLE AT THE START OF THE EVENT AND THAT CONTRIBUTED TO THE EVENT</p> <p>Inverter IV1PC1 was out of service before the event.</p> <p>D. NARRATIVE SUMMARY OF THE EVENT INCLUDING DATES AND APPROXIMATE TIMES</p> <p>On December 7, 1992, during the CPSES Unit 1 Refueling Outage, inverter (EISS:(INVT)(EF)) IV1PC1, which supplies power to channel 1 reactor protection instrumentation (EISS:(JC)) through panel 1PC1 (EISS:(PL)(EF)), failed. Alternate power was supplied to the panel. It was decided to implement a temporary modification in order that channel 1 would remain available on non 1E power during the Train A loss of power test. Because of a personnel error in the design of the temporary modification it incorrectly connected a single phase 208 volt source to the single phase 118V panel 1PC1. The temporary modification was installed on December 8.</p> | | | | | | | | | | | |

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| NRC FORM 366A | | U.S. NUCLEAR REGULATORY COMMISSION | | APPROVED OMB NO. 3150-0104 EXPIRES: 6/30/92 | |
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| Facility Name (1) | Docket Number (2) | LER Number (6) | | Page (3) | |
| COMANCHE PEAK-UNIT 1 | 05000445 | Year 92 | Sequential Number - 029 | Revised Number - 000 | 03 OF 07 |

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

On December 8, 1992 at 1608 an auxiliary operator transferred (utility, non-licensed) panel 1PC1 from alternate power to the temporary power source by operating the incoming breaker on 1PC1. Immediately power was lost to 1PC1 and several alarms were observed in the control room that indicated the channel 1 supply was lost. The auxiliary operator was instructed by the Unit Supervisor (utility, licensed) to return 1PC1 to its alternate power source. This was accomplished and channel 1 power was restored within a matter of seconds. At the same time, another operator (utility, non-licensed) was dispatched to determine the cause of the loss of power. He found that the Temp Mod breaker on panel 1C5-1 (EIS:(PL)(EE)) had tripped. During this time the flux doubling circuit activated automatically opening valves 1-LCV-112 D & E (charging pump suction from RWST (EIS:(TK)(BE))) and closing valves 1-LCV-112 B & C (charging pump suction from VCT (EIS:(TK)(CB))). This is the normal plant response for flux doubling activation. The operators realized what happened and responded correctly by resetting the flux doubling circuit and restoring the valves to the pre-event condition. This was the only safety system activation. After alternate power was restored to 1PC1 equipment fed by 1PC1 was observed to be functioning normally. Because the present Technical Specifications exempts the flux doubling system from operability requirements and the fact that the actuation was caused by an invalid signal, it was initially determined that the actuation was not reportable to the Nuclear Regulatory Commission under 10CFR50.72 and 10CFR50.73.

A Plant Incident Report (PIR) was initiated to determine the cause of the personnel error and to determine necessary corrective actions. As a result of the PIR review and the clarification of which CPSES systems are exempted from reporting it was decided that as a conservative measure this event would be reported under 10CFR50.72 and 10CFR50.73. On February 11, 1993 at 1259 the event was reported to the NRC via the Engineering Notification System as an unplanned ESF actuation.

II. COMPONENT OR SYSTEM FAILURES

A. FAILURE MODE, MECHANISM, AND EFFECT OF EACH FAILED COMPONENT

There have been no failed components identified as having contributed to this event.

B. CAUSE OF EACH COMPONENT OR SYSTEM FAILURE

No failed components have been identified.

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| NRC FORM 366A LICENSEE EVENT REPORT (LER) TEXT CONTINUATION | | U.S. NUCLEAR REGULATORY COMMISSION 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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Text (if more space is required, use additional NRC Form 366A's) (17)

C. SYSTEMS OR SECONDARY FUNCTIONS THAT WERE AFFECTED BY FAILURE OF COMPONENTS WITH MULTIPLE FUNCTIONS

No failed components have been identified.

D. FAILED COMPONENT INFORMATION

No failed components have been identified.

III. ANALYSIS OF THE EVENT

A. SAFETY SYSTEM RESPONSES THAT OCCURRED.

The flux doubling actuation automatically shifted centrifugal charging pump suction from the Volume Control Tank (VCT) to the Refueling Water Storage Tank (RWST) by closing the VCT outlet isolation valves and opening the RWST suction valves.

B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY

There were no safety systems or components rendered inoperable during or as a result of the event.

C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

The source range flux doubling actuation circuitry is designed to mitigate an inadvertent boron dilution of the reactor coolant with the reactor shutdown. The inadvertent actuation occurring on December 8 resulted in the automatic initiation of all actions required for the system to perform its design function. The successful repositioning of affected valves in the Chemical and Volume Control System demonstrates that the flux doubling actuation feature would have performed its intended function in response to an actual inadvertent boron dilution. Inadvertent actuation during another plant operational mode would result in no detrimental affects. It is concluded that the event did not adversely affect the safe operation of CPSES Unit 1 or the health and safety of the public.

IV. CAUSE OF THE EVENT

The CPSES Source Range (SR) Nuclear Instrumentation (EIIIS:(IG)) provides indication of the neutron flux level of the reactor core during reactor shutdown and startup. When the source range neutron flux level doubles within 10 minutes or less, a flux doubling actuation signal is generated. The flux doubling actuation signal initiates the shift of the Centrifugal Charging Pump (CCP) suction from the Volume Control Tank to the Refueling Water Storage Tank.

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

The flux doubling circuit provides two signals to the Solid State Protection System (SSPS) (EIS:(JC)), the flux doubling signal and the flux doubling bypass signal which blocks the flux doubling actuation while testing the circuit. Both signals are normally energized. The flux doubling trip signal deenergizes a relay (EIS:(RLY)(JC)) for a flux doubling condition. The test bypass signal deenergizes a separate relay to block the flux doubling input to SSPS.

A separate flux doubling block is also provided in the SSPS circuitry. A manual switch on the control board sets the block. There are two methods to reset this block. A manual switch is provided. The second reset is automatically generated when permissive signal P-6 resets. The P-6 signal is generated by the intermediate range nuclear instrumentation. This signal provides a permissive to block the source range high flux trip when the flux level has increased into the intermediate range. When power drops below the P-6 setpoint, the signal reenergizes the source range instrumentation and resets the flux doubling function.

When power is secured or restored, a flux doubling actuation may occur due to a "relay race" between the source range flux doubling trip and bypass signals. When power is secured, a flux doubling actuation will occur if the flux doubling relay contact closes prior to the bypass relay contact opening. Upon power restoration an actuation will occur if the bypass relay contact closes before the flux doubling contact opens. A flux doubling actuation may occur whenever power is removed or restored to the source range drawer.

On December 8 the flux doubling actuation was a result of the flux doubling block being reset and the flux doubling relay race in channel N-31 when it's power supply was lost and subsequently restored. The most likely cause for the flux doubling block being reset is from the intermediate range P-6 reset function.

When power was transferred, a momentary loss of power to intermediate range channel N-35 occurred. Since the intermediate range flux level was below the P-6 setpoint, the loss of power had no direct impact on the bistable (bistable was already in a deenergized state); however, securing power to the system can result in a short signal spike due to the discharge of the cable and detector when the high voltage is secured. If power is restored while the discharge spike is present, the circuitry will process the signal. Thus, when power was momentarily lost, this discharge signal may have exceeded the P-6 setpoint and toggled the flux doubling reset feature when power returned to the system.

The cause of the personnel error in the design of the temporary modification was that the engineer failed to perform self verification on his design.

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V. CORRECTIVE ACTIONS

The existence of a flux doubling actuation circuitry relay race and the potential intermediate range discharge spike and resulting P-6 reset of the flux doubling block was identified prior to this event. Previously this combination occurred during the transfer of panel 1PC2 from it's alternate to normal supply. The corrective action for that event was to revise the system operating procedure to maintain both Source Range Flux Doubling Reset & Block switches in the block position until the associated distribution panel has been re-loaded. (IV1PC1 or IV1PC2 only).

This corrective action would have prevented the December 8 event as well if the switches were maintained through the breaker trip and reload; however, the switches were released after the initial transfer and before the reload following the breaker trip, because the operator responded to other alarms that came in after the breaker trip. For normal reenergizations the operating procedure is adequate. For off normal situations (unplanned restorations) no further corrective action is planned in order to allow a quick operator response.

The corrective actions for the personnel design error in the temporary modification are:

- 1) Engineering will hold annual training in self-verification for all Engineering personnel.
- 2) Engineering will revise procedure STA-602 "Temporary Modifications" to require a review be performed by a cognizant (trained in the discipline of the TM) engineer not responsible for the initial TM design/evaluation.
- 3) Engineering will enhance their procedural training program for Engineering Outage team personnel unfamiliar with procedures they do not normally use in their non-outage tasks.
- 4) The labeling on the panel and the drawing showing the panel will be enhanced from a human factor standpoint to better identify the non-standard panel.

VI. PREVIOUS SIMILAR EVENTS

The causes of the flux doubling actuation events described in LERs 90-001, and 90-006 are sufficiently different from the causes of the December 8 actuation. The previous corrective actions could not reasonably be expected to prevent recurrence of the event. The actuation described in LER 90-002 resulted from a loss of power to the nuclear instrumentation channels caused by a blown fuse in the protection set inverter. Corrective action included revision of procedures which energize and deenergize busses for outage related activities. The corrective action did not anticipate the combination of factors leading to the December 8 event.

Enclosure to

TXX-93132

| NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION <div style="text-align: center; padding: 10px;"> LICENSEE EVENT REPORT (LER) TEXT CONTINUATION </div> | | 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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| 92 | - 029 | - 00 | 07 | OF 07 | | | | | | | | | | | | | | |
| Text (If more space is required, use additional NRC Form 366A's) (17) <p>The actuation described in LER 91-027 involved the transfer of the 1PC2 panel which resulted in a combination of factors similar to the December 8 event. The difference was the unanticipated trip of the breaker and subsequent reload of the bus. The corrective action for the LER 91-027 event was adequate for the circumstances.</p> | | | | | | | | | | | | | | | | | | |