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April 22, 1991

William J. Cahill, Jr.  
Executive Vice President

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

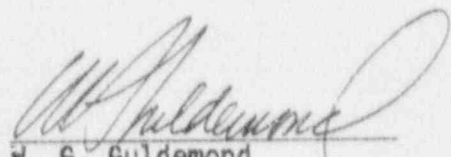
SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)  
DOCKET NO. 50-445  
CONDITION PROHIBITED BY THE PLANT'S TECHNICAL SPECIFICATIONS  
LICENSEE EVENT REPORT 91-011-00

Gentlemen:

Enclosed is Licensee Event Report 91-011-00 for Comanche Peak Steam Electric Station Unit 1, "Oversight in Preparation of a Temporary Modification Resulted in the Failure to Fully Satisfy a Technical Specification Surveillance Requirement."

Sincerely,

W. J. Cahill Jr.

By:   
W. G. Guldemon  
Manager, Site Licensing

JAA/bm

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

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400 North Olive Street L.B. 81 Dallas, Texas 75201

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NRC FORM 366A  <b>LICENSEE EVENT REPORT (LER)</b> <b>TEXT CONTINUATION</b>		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.													
Facility Name (1)	Docket Number (2)	LER Number (6)	Page (3)												
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COMANCHE PEAK - UNIT 1 01510101415911-0111-010012 OF 016															
Text (If more space is required, use additional NRC Form 366A's) (17)															
<p><b>I. <u>DESCRIPTION OF THE REPORTABLE EVENT</u></b></p> <p><b>A. EVENT CLASSIFICATION</b></p> <p>Any operation or condition prohibited by the plant's Technical Specifications.</p> <p><b>B. PLANT OPERATING CONDITIONS BEFORE THE EVENT</b></p> <p>On March 22, 1991, at approximately 2000 CST, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 5, Cold Shutdown, with the Reactor Coolant System at a temperature of 130 degrees F and a pressure of approximately 325 psig.</p> <p><b>C. STATUS OF STRUCTURES, SYSTEMS, OR COMPONENTS THAT WERE INOPERABLE AT THE START OF THE EVENT AND THAT CONTRIBUTED TO THE EVENT</b></p> <p>On February 7, 1991, a 48 inch containment purge exhaust isolation valve (EIIIS:(ISV)(VA)) had failed to demonstrate operability in accordance with the Technical Specification surveillance requirement for verification of leakage rate. As a result, a temporary modification had been initiated to install a blind flange on the penetration (EIIIS:(PEN)(NH)) outside containment beyond the outer isolation valve.</p> <p><b>D. NARRATIVE SUMMARY OF THE EVENT, INCLUDING DATES AND APPROXIMATE TIMES</b></p> <p>On February 7, 1991, one of the 48 inch containment purge exhaust isolation valves failed the leakage rate test performed to satisfy a portion of the surveillance requirements for the containment ventilation system. As a result, a blind flange was installed in the penetration, testing was successfully completed, and system operability was restored. The CPSES Technical Specification related to containment integrity requires that at least once per 31 days all penetrations not capable of being closed by operable automatic isolation valves and required to be closed during accident conditions, be verified closed by valves, blind flanges, or deactivated automatic valves secured in their positions (except as allowed by the exceptions). The blind flange installed on February 7 is subject to this requirement.</p>															



NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104  
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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.

Facility Name (1)

DocId Number (2)

LER Number (6)

Page (3)

COMANCHE PEAK - UNIT 1 0151010101415911 - 01111 - 010 013 OF 016

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

On February 8, a change was initiated to the corresponding operations test procedure to include the 31 day surveillance requirement on the flange and the associated leak test apparatus test connection plug (E1IS:(CON)(VA)). The change requires that personnel performing the surveillance verify the proper position of the flange and plug. The change became effective on March 4, 1991; however, the regularly scheduled surveillance test had been performed on March 2, prior to the effective date of the change, and the blind flange and plug were not explicitly required by the test procedure to be verified in place. On March 22, 1991, at approximately 2000 CST, the on-duty shift supervisor (utility, licensed) was reviewing the Limiting Condition for Operation Action Requirement (LCOAR). Upon further review, it was determined that the surveillance performed on March 2 had not included verification of proper position of the blind flange and test connection plug.

**E. THE METHOD OF DISCOVERY OF EACH COMPONENT OR SYSTEM FAILURE OR PROCEDURAL ERROR**

As a result of a review of the LCOAR tracking the installed blind flange, the shift supervisor recognized that the required procedure change had not been implemented at the time of test performance. Further review revealed that the time limit including the allowable extension had been exceeded on March 10, 1991.

**II. COMPONENT OR SYSTEM FAILURES****A. FAILED COMPONENT INFORMATION**

Not applicable - there were no component failures associated with this event.

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

Not applicable - there were no component failures associated with this event.

**C. CAUSE OF EACH COMPONENT OR SYSTEM FAILURE**

Not applicable - there were no component failures associated with this event.

NRC FORM 366A		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92	
<b>LICENSEE EVENT REPORT (LER)</b> <b>TEXT CONTINUATION</b>				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-690), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC, 20555, 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)	
				Year	Sequential Number
					Revision Number
COMANCHE PEAK - UNIT 1		015101010141415		911	01111
					010014
					OF 016

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

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

Not applicable - there were no component failures associated with this event.

**III. ANALYSIS OF THE EVENT**

**A. SAFETY SYSTEM RESPONSES THAT OCCURRED**

Not applicable - there were no safety system responses associated with this event.

**B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY**

Not applicable - there were no safety systems rendered inoperable due to a failure.

**C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT**

The containment purge supply and exhaust valves are required to be locked closed during plant operations to ensure that excessive quantities of radioactive material are not released to the environment via the containment ventilation system. Leakage rate testing of those valves is required to be performed once per 184 days to demonstrate operability of the components, ensuring that the site boundary doses specified in 10CFR100 are not exceeded. Verification of component position at least once per 31 days is performed to ensure that components remain in the position required to maintain containment integrity. In the event that a containment isolation valve cannot be demonstrated to be operable, the CPSES Unit 1 Technical Specifications allow isolation of the affected penetration by use of a blind flange. The flange is subject to the surveillance requirement to demonstrate containment integrity at least once per 31 days by verifying penetrations are closed as specified.

Following installation of the blind flange on February 7, 1991, the penetration was successfully tested to ensure that the measured leakage rate did not exceed the value allowed by the Technical Specifications. Surveillance testing to verify correct valve position was performed within the required surveillance interval, but the

NRC FORM 366A		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92	
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Facility Name (1)	Docket Number (2)	LER Number (6)		Page (3)	
		Year	Sequential Number	Revision Number	
COMANCHE PEAK - UNIT 1	0151010141415911	-	0111	-	010 015 OF 016

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

procedure used to perform the surveillance did not explicitly require verification of the position of the flange and test connection plug. However, administrative control to prevent plug removal had been exercised by safety tagging the test connection. Successful testing of the affected penetration along with administrative control over the plug provides reasonable assurance that the penetration was at all times capable of performing the intended safety function of limiting radioactive emissions from containment. It is concluded that the condition did not adversely affect the safe operation of CPSES Unit 1 or the health and safety of the public.

#### IV. CAUSE OF THE EVENT

##### IMMEDIATE CAUSE

The immediate cause of the event is the failure to process a change to an affected surveillance test procedure prior to the first required performance of the test following installation of a temporary modification.

##### ROOT CAUSES

**Root Cause No. 1** : Personnel error resulted in the failure to recognize that a temporary modification would impact a surveillance test procedure. The administrative procedure controlling temporary modifications requires that all required procedure changes be completed prior to acknowledgement by the shift supervisor of completion of the temporary modification installation. However, personnel responsible for preparing and reviewing the temporary modification initially failed to recognize that a change to the related operations test procedure was required to satisfy the related Technical Specification surveillance requirement. As a result, the required procedure change was not issued and effective prior to acceptance of the temporary modification.

**Root Cause No. 2** : Following recognition of the need for a change to the surveillance test procedure, the temporary modification was not revised to reflect that requirement. The Shift Supervisor would have been procedurally prevented from accepting the installation as complete until the required procedure changes were issued.



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Facility Name (1)  <b>COMANCHE PEAK - UNIT 1</b>	Docket Number (2)  <b>01510101445</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3">LER Number (6)</th> <th>Page (3)</th> </tr> <tr> <th>Year</th> <th>Sequential Number</th> <th>Revision Number</th> <th></th> </tr> <tr> <td style="text-align: center;">91</td> <td style="text-align: center;">011</td> <td style="text-align: center;">1</td> <td style="text-align: center;">016 OF 016</td> </tr> </table>	LER Number (6)			Page (3)	Year	Sequential Number	Revision Number		91	011	1	016 OF 016	
LER Number (6)			Page (3)												
Year	Sequential Number	Revision Number													
91	011	1	016 OF 016												

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

**CONTRIBUTING FACTOR**

Personnel responsible for processing the required change to the test procedure failed to recognize and communicate to Control Room personnel the need for performance of the surveillance.

**V. CORRECTIVE ACTIONS**

1. The administrative procedure controlling the temporary modification process will be enhanced to clarify the need to consider the impact on Technical Specification surveillance requirements of temporary modifications installed on plant equipment that must remain operable.
2. The operations test procedure for verification of containment penetration non-automatic isolation component position has been changed to ensure that the proper position of any valve closed to isolate an inoperable containment isolation valve is verified at the proper frequency. The procedurally required review of the LCOAR index will identify any penetration isolated by use of a blind flange as a result of the action requirement of the Technical Specification for containment isolation valves.
3. This event will be reviewed by the System Engineering and Operations organizations via the "Lessons Learned" process.

**VI. PREVIOUS SIMILAR EVENTS**

There have been no previous similar events attributable to the causes of this event reported pursuant to 10CFR50.73.