



Nebraska Public Power District

COOPER NUCLEAR STATION
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CNSS933133

June 5, 1993

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

Dear Sir:

Cooper Nuclear Station Licensee Event Report 93-020, Revision 0, is forwarded as an attachment to this letter.

Sincerely,

R. L. Gardner
Plant Manager

RLG/ju

Attachment

cc: J. L. Milhoan
G. R. Horn
J. M. Meacham
R. E. Wilbur
V. L. Wolstenholm
D. A. Whitman
INPO Records Center
NRC Resident Inspector
R. J. Singer
CNS Training
CNS Quality Assurance

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PDR ADOCK 05000298
S PDR

Handwritten initials/signature

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Cooper Nuclear Station										DOCKET NUMBER (2) 0 5 0 0 0 2 9 8										PAGE (3) 1 OF 0 3													
TITLE (4) Hydrogen/Oxygen Monitors Not Subjected To Primary Containment Testing Requirements																																	
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															
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OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																															
N		20.402(b)										20.405(c)										50.73(a)(2)(iv)										73.71(b)	
POWER LEVEL (10)		20.405(a)(1)(i)										50.36(a)(1)										50.73(a)(2)(v)										73.71(c)	
0 1 0 0		20.405(a)(1)(ii)										50.36(a)(2)										50.73(a)(2)(vi)										OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
		20.405(a)(1)(iii)										X 50.73(a)(2)(i)										50.73(a)(2)(vii)(A)											
		20.405(a)(1)(iv)										50.73(a)(2)(ii)										50.73(a)(2)(vii)(B)											
		20.405(a)(1)(v)										50.73(a)(2)(iii)										50.73(a)(2)(ix)											
LICENSEE CONTACT FOR THIS LER (12)																																	
NAME												TELEPHONE NUMBER																					
John R. Myers												AREA CODE 4 10 12 8 12 5 1 3 8 1 1																					
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)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR																	
YES (If yes, complete EXPECTED SUBMISSION DATE)												X NO																					

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

On May 7, 1993, while reviewing the design and testing of the Hydrogen/Oxygen Monitoring (H2/O2) system, it was determined that the H2/O2 system had not been leak tested in accordance with the requirements of the Technical Specifications. Technical Specification 4.7.A.2 requires that an Integrated Leak Rate Test (ILRT) be conducted to verify primary containment integrity. Additionally, the monitors had not been subjected to appropriate pressure during post maintenance testing in those instances where maintenance activities breached the pressure boundary of the monitors.

The 1988 design change for installation of the H2/O2 monitors listed the ILRT procedure as an affected document. A records search did not locate any procedure changes which addressed testing requirements for the monitors. The monitors were routinely secured during outages; it was not recognized that this would result in the inlet and outlet solenoid operated isolation valves being closed during performance of the ILRT. Additionally, administrative controls were insufficient to ensure that the necessary post maintenance pressure testing of the monitors would be accomplished.

Testing of the monitors was satisfactorily conducted. Appropriate administrative controls will be established to ensure necessary testing of the monitors is performed for future maintenance and ILRT performances. A review is being conducted to verify that no similar situations exist. Other design changes will be reviewed to ensure that appropriate procedure changes have been made. The design change process has been substantially upgraded since monitor installation, including more stringent controls on the identification and processing of procedure revisions associated with new or replacement equipment.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Cooper Nuclear Station	0 5 0 0 0 2 9 8	9 3	— 0 2 0	— 0 0	0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 306A's) (17)

A. Event Description

On May 7, 1993, while reviewing the design and testing of the Hydrogen/Oxygen Monitoring (H2/O2) system, it was determined that the H2/O2 system had not been leak tested in accordance with the requirements of the Technical Specifications. Technical Specification 4.7.A.2 requires that an Integrated Leak Rate Test (ILRT) be conducted to verify primary containment integrity. The monitoring system was installed in 1988, and ILRTs were conducted in 1988, following installation, and 1991. The monitoring system was secured during outages as monitoring of primary containment oxygen content is not required. Removing the system from service causes the suction and discharge solenoid operated isolation valves to close. With the solenoid operated valves closed, the monitors were not subjected to the ILRT pressure. Additionally, administrative controls were not established to ensure the monitors were subjected to post maintenance pressure testing in those instances where maintenance activities breached the pressure boundary of the monitors.

B. Plant Status

Shutdown for the 1993 Refueling Outage.

C. Basis for Report

Since the test methodology did not meet the requirements of Technical Specification 4.7.A.2, this is a condition reportable in accordance with 10CFR50.73(a)(2)(i).

D. Cause

Configuration Control. The design change for the H2/O2 monitors listed the ILRT procedure as an affected document. A records search did not locate any procedure changes which addressed testing requirements for the monitors. It was apparently not recognized that the monitors would be secured during the performance of the ILRT, and therefore the solenoid operated isolation valves would be closed. Additionally, appropriate administrative controls were not in place to ensure that the necessary post maintenance pressure testing of the monitors would be accomplished whenever the pressure boundary was breached.

E. Safety Significance

Since testing of the monitors was not conducted in accordance with Technical Specification requirements, potential leakage would not have been identified and, if required, corrected. For leakage to have actually exceeded the allowable leakage, a gross failure of the tubing or connectors within the monitors would have been required. It is unlikely that gross failure of the high pressure rated tubing or connections would occur. More likely, minor leakage would occur which would not substantially affect the overall primary containment leakage rate.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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FACILITY NAME (1) Cooper Nuclear Station	DOCKET NUMBER (2) 0 5 0 0 0 2 9 8 9 3 — 0 2 0 — 0 0 0 3 OF 0 3	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

TEXT (If more space is required, use additional NRC Form 365A's) (17)

F. Safety Implications

The safety implications associated with this lack of testing are fully addressed above.

G. Corrective Action

Pressure testing of the monitors has been satisfactorily conducted. Appropriate administrative controls will be established to ensure necessary testing of the monitor is performed for future maintenance and ILRT performances. A review is being conducted to verify that no similar testing situations exist.

Other design changes from 1987 through 1990 will be reviewed to ensure that appropriate procedure changes have been made. The design change process has been substantially upgraded since monitor installation, including more stringent controls on the identification and processing of procedure revisions associated with new or replacement equipment.

H. Similar Events

None.