TU ELECTRIC

Log # TXX-93238
File # 10020
Ref. # 50.73(a)(2)(B)

June 11, 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. 50-446
A CONDITION PROHIBITED BY TECHNICAL SPECIFICATIONS
LICENSEE EVENT REPORT 93-004-00

Gentlemen:

Enclosed is Licensee Event Report 93-004-00 for Comanche Peak Steam Electric Station Unit 1 "Failure to Satisfy Technical Specification Surveillance Requirement for Verification of Valve Positions".

Sincerely,

William J Cahill Jr

William J. Cahill, Jr.

By: J J Kelley Jr

J. J. Kelley, Jr.
Vice President of Nuclear Operations

OB:tg
Enclosure

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

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Enclosure to TXX-93238

NRC FORM 366 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.

LICENSEE EVENT REPORT (LER)

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Title (4)

FAILURE TO SATISFY TECHNICAL SPECIFICATION SURVEILLANCE FOR VERIFICATION OF VALVE POSITION

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
									N/A	0 5 0 0 0
0 5	1 4	9 3	9 3	- 0 0 4	- 0 0	0 6	1 1	9 3	N/A	0 5 0 0 0

Operating Mode (9): 1

Power Level (10): 0 2 9

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	Area Code	Telephone Number
D. J. REIMER, MANAGER, SYSTEM ENGINEERING	8 1 7	8 9 7 - 5 5 8 4

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	
				N							

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 May 14, 1993, an operations procedure reviewer discovered that position verification, as required by Technical Specifications (T/S) for some Process Sampling valves, was not incorporated into CPSES Unit 2 procedures. The overall cause of this event was a lack of requirements for reviews by Operations personnel of design changes issued during Unit 2 construction and a lack of attention to detail concerning the specific design change involved in the event. Corrective actions included verifying valve positions, incorporating the position verification for the valves in appropriate procedures and performing reviews for generic implications.

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

I. DESCRIPTION OF THE REPORTABLE EVENT

A. REPORTABLE EVENT CLASSIFICATION

Any operation or condition prohibited by the Technical Specifications. A required Technical Specification surveillance was not performed.

B. PLANT OPERATING CONDITIONS PRIOR TO THE EVENT

On May 14, 1993, Comanche Peak Steam Electric Station (CPSES) Unit 2 was at 29 percent rated thermal power. Integrated Startup Testing was in progress.

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 that contributed to the event.

D. NARRATIVE SUMMARY OF THE EVENT, INCLUDING DATES AND APPROXIMATE TIMES

Technical Specification Surveillance Requirement 4.6.1.1a requires in part that at least once per 31 days, CONTAINMENT INTEGRITY be demonstrated by verifying that all manual valves outside containment, needed to isolate a penetration, are closed.

On February 26, 1992, and on June 25, 1992, Design Change Authorizations (DCAs) were initiated by CPSES Unit 2 Engineering to incorporate Process Sampling Containment Isolation manual valves (EIIS: (ISV)(KN)) into vital station drawings. The DCAs failed to document on these drawings that the valves were to be locked closed and capped. Because these drawings were used to prepare the procedures to verify closure of containment isolation valves per T/S 4.6.1.1a, Process Sampling valves 2PS-0030, 2PS-0510, 2PS-0511, and 2PS-0512 (drain valves adjacent to containment penetrations) were not incorporated into these procedures.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION

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

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

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

On May 14, 1993, an Operations procedure reviewer (utility, licensed) performed a review of a draft revision to Design Basis Document (DBD) -ME-013 "Containment Isolation System." During this review, the procedure reviewer discovered that the Primary Sampling Valves were not properly identified as Containment Penetration Non-Automatic Isolation Valves on the flow diagram, in the DBD or in Operations and Chemistry procedures.

II. COMPONENT OR SYSTEM FAILURES

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

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

B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY

Not applicable - there was no safety related equipment rendered inoperable during or as a result of the event.

C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

The field conditions and programs for Containment Isolation consist of: 1) use of double isolation barriers, 2) periodic testing, 3) administrative control of manual isolation valves, and 4) surveillance of automatic isolation valves. These activities meet requirements and ensure the Containment Isolation System performs its intended function. Incorrect positioning of a manual isolation valve on these penetrations would have been detected via normal plant activities. Under postulated accident conditions the Containment Isolation System would have satisfactorily performed its intended safety function.

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III. CAUSE OF THE EVENT

The following causes contributed to this event. A review of the design change process used during the construction phase indicated that procedures did not require that changes affecting a DBD be included in the design change document being prepared. Rather, the DBD was to be reviewed to roll up all affected changes as the Unit 2 work scope neared completion. The valve discrepancies were discovered during the DBD review to roll up all design changes.

The procedures also did not require an Interdisciplinary Review (IDR) by Systems Engineering or a review by Operations personnel for impact on Operations programs and procedures unless the system had been turned over to Operations.

More attention to detail by the design change engineers during origination, review and approval may have precluded the event. Neither the originator nor reviewers identified the need for locked closed valves (similar to Unit 1), the need for a DBD change, or the need to change Operations procedures.

IV. CORRECTIVE ACTION

A. IMMEDIATE

Upon discovery, Operations personnel were dispatched to verify the valve positions. The as-found condition of the valves (May 14, 1993) were:

2PS-0030 - CLOSED, uncapped.
2PS-0510 - CLOSED, capped.
2PS-0511 - CLOSED, capped.
2PS-0512 - CLOSED, capped.

Immediate corrective actions included installing the valve cap and hanging a clearance to administratively maintain the valves closed.

A review of Unit 1 drawings and procedures indicated that the valves were listed and designated correctly on Unit 1 documents.

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B. ACTIONS TO PREVENT RECURRENCE

Applicable design documents and operations procedures will be updated to reflect the position and status of the valves discussed in this report. The appropriate surveillances will be performed.

Operations performed a review of other Unit 2 Containment penetrations as depicted on vital station mechanical drawings. This review compared the valves associated with each penetration to the valves listed in surveillance procedures. Additionally, the results of the comparison were reviewed against the DBD-ME-013 listing of these valves. This review determined that the drawings, surveillance procedures and the DBD contained the required valves and were consistent with each other.

Engineering reviewed the Design Change Notice in question and a sampling of other Design Change Notices prepared by Unit 2 Engineering (construction phase) personnel that affected DBDs. A design drawing and FSAR figure were identified to be incorrect. These discrepancies did not affect operability and applicable documents will be corrected.

The Unit 2 construction program is no longer in effect. Design activities are being performed under Unit 1/Unit 2 procedures. Under these procedures, Engineering personnel perform IDR on plant changes. In addition, Design Modifications or Minor Modifications receive Operations Impact Assessments. This process assesses the impact of a design change on Nuclear Operations programs and procedures. The two unit program has not produced errors similar to the one described in this event.

V. PREVIOUS SIMILAR EVENTS

CPSES Units 1 and 2 have submitted a number of Licensee Event Reports (LER) concerning missed surveillances. This report identifies the causes of this event to be a lack of requirements for operational reviews of design changes during Unit 2 construction and inattention to detail during the design change process. None of the previous LERs associated with missed surveillances identified the cause(s) as inadequate design control. Although some of the LERs discussed personnel error or inattention to detail, none were related to the design change process. LER 50-445/92-015-00 "Personnel Error Leading to Potential Inoperability of Blackout Sequencer" (which did not discuss a missed

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surveillance) identified the root cause and contributing factors to be related to inadequate design controls; however, the causes and contributing factors were different from those described in this event. The corrective actions taken for LER-92-015-00 would not have precluded this event.