

Log # TXX-90338 File # 10200 Ref. # 50.73(a)(2)(iv)

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October 9, 1990

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

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

COMANCHE PEAK STEAM ELECTRIC STATION SUBJECT: DOCKET NO. 50-445 MANUAL OR AUTOMATIC ACTUATION OF ANY ENGINEERED SAFETY FEATURE LICENSEE EVENT REPORT 90-028-00

Gentlemen:

Enclosed is Licensee Event Report 90-028-00 for Comanche Peak Steam Electric Station Unit 1, "Automatic Reactor Trip Caused by Lightning Strike."

Sincerely

William J. Cahill, Jr. For

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Enclosure

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

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Enclosure to TXX-90338

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### A. PLANT OPERATING CONDITIONS PRIOR TO THE EVENT

On September 8, 1990 at 1428, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 1, Power Operation, operating at 38 percent power.

### B. REPORTABLE EVENT CLASSIFICATION

An event or condition that resulted in an automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS)(EIIS:(JC)).

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

Not applicable - no structures, systems or components were inoperable at the start of the event that contributed to the event.

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

On September 8, 1990, during a lightning storm, two out of ten 25 Voltage Direct Current (VDC) power supply overvoltage protection circuits actuated (located in the rod drive (EIIS:(AA)) power cabinets). This actuation resulted in loss of control power to the rod drive system and allowed the rods controlled by the two 25 VDC power supplies to fall into the core. The dropped control rods actuated the Nuclear Instrumentation System (EIIS:(JC)) power range high negative neutron flux rate reactor trip. All safety systems responded as expected.

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E.	An event or condition RPS is reportable w on September 8, 19 notified of the event Mode 3, Hot Standt THE METHOD OF FAILURE OR PRO The overvoltage pro tripped upon investi received at the time	on that results in an au within 4 hours under 10 990, the Nuclear Regu t via the Emergency N by. DISCOVERY OF EAC CEDURAL ERROR Discovery of the 25 VD0 gation of a non-urgent of the trip.	tomatic actuation of any ESF, including the OCFR50.72(b)(2)(ii). At approximately 1618 latory Commission Operations Center was otification System. The plant was stable in CHCOMPONENT OR SYSTEM
II. <u>CO</u>	MPONENT OR SYS	TEM FAILURES	
Α.	FAILURE MODE, M	AECHANISM, AND ER	FECT OF EACH FAILED
	Not applicable - no	failed components hav	ve been identified.
В.	CAUSE OF EACH	COMPONENT OR SY	STEM FAILURE
	Not applicable - no	component or system	failures have been identified.
C.	SYSTEMS OR SEC FAILURE OF COM	CONDARY FUNCTION PONENTS WITH MU	IS THAT WERE AFFECTED BY
	Not applicable - the this event.	re were no failed com	ponents with multiple functions that affected

Enclosure to TXX-90338

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### D. FAILED COMPONENT INFORMATION

Not applicable - no failed components have been identified.

## III. ANALYSIS OF THE EVENT

## A. SAFETY SYSTEM RESPONSES THAT OCCURRED

The Reactor Protection System (EIIS:(JC)) and Auxiliary Feedwater System (EIIS:(BA)) actuated during the event; all associated components within these systems functioned as designed.

## B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY

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

## C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

The event consisted of a multiple control rod drop resulting in a reactor trip. This is bounded by FSAR, Section 15.4.3 and concludes that the successful automatic actuation of the reactor trip will ensure there is no reduction in the margin to core thermal limits and that the Departure from Nucleate Boiling design basis is met. Consequently, there were no adverse impacts to plant safety or the health and safety of the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION	APPROVED DME NO. 3150-0104 EXPIRES: 4/30/32 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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### IV. CAUSE OF THE EVENT

### ROOT CAUSE

The initiating cause of this event is a lightning strike on the containment causing a surge in the 120 Voltage Alternating Current (VAC) input power creating a voltage surge in the 25 VDC output of the rod control power supplies. This surge actuated the overvoltage protection circuit on two 25 VDC power supplies which isolated the output of the supply. The loss of this output voltage to the rod control system caused the rods controlled by the affected power supplies to fall.

### V. CORRECTIVE ACTIONS

#### A. IMMEDIATE

The Operator responded appropriately to the RPS actuation. Plant Emergency Operating Procedures were implemented and the plant was stabilized in Mode 3.

### B. CORRECTIVE ACTIONS TO PREVENT RECURRENCE

The rod control power supplies tripped from the surge on the 120 VAC input. To prevent this, a design modification to install surge suppressors on the 120 VAC lines feeding for the system has been submitted. The installation of this modification will minimize the potential for an overvoltage trip of the 25 VDC power supplies from a lightning induced surge.

#### Enclosure to TXX-90338

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# VI. PREVIOUS SIMILAR EVENTS

Although there have been previous events that resulted in RPS actuation, the root cause of those events were unrelated to the root cause of this event. The corrective actions taken to resolve the root causes of the previous events would not have prevented this event. Therefore, no previous similar events have been reported pursuant to 10CFR50.73.

### VII. ADDITIONAL INFORMATION

The times listed in the report are approximate and Central Daylight Savings Time (CDT).