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Ref. # 10CFR50.73(a)(2)(iv)

November 14, 1994

C. Lance Terry
Group Vice President

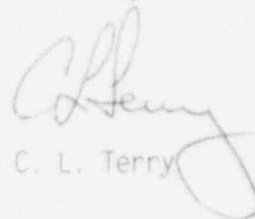
U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES) - UNIT 2
DOCKET NO. 50-446
MANUAL OR AUTOMATIC ACTUATION OF ENGINEERED SAFETY FEATURE
LICENSEE EVENT REPORT 446/94-015-00

Gentlemen:

Enclosed is Licensee Event Report (LER) 94-015-00 for Comanche Peak Steam Electric Station Unit 2, "Containment Ventilation Isolation Due To No Available Bypass Power When Normal Power Was Deenergized."

Sincerely,



C. L. Terry

OB:bm
Enclosure

cc: Mr. L. J. Callan, Region IV
Mr. D. D. Chamberlain, Region IV
Resident Inspectors, CPSES

180031

9411210377 941111
PDR ADDCK 05000446
S PDR

P. O. Box 1002 Glen Rose, Texas 76043

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NRC FORM 368		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED OMB NO.3150-0104 EXPIRES: 4/30/92																																													
LICENSEE EVENT REPORT (LER)																																																	
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COMANCHE PEAK-UNIT 2				05101010446																																													
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Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16) On October 14, 1994, a Containment Ventilation Isolation (CVI)(EIIS:(IK))signal occurred when a clearance (to deenergize) was hung on Instrument Inverter IV2C3 (EIIS:(INVT)(IK)). The required bypass power for the inverter was not available due to a scheduled bus outage. When the panel was transferred to bypass power, a relay was deenergized causing a CVI to occur. The event was caused when the outage planning personnel and personnel approving the clearance, did not consider that placing the clearance was not compatible with the electrical bus outage. Cognizant personnel were made aware of this event, as a lessons learned.																																																	

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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)	
COMANCHE PEAK-UNIT 2	01510101416	Year	Sequential Number	Revision Number		
		94	- 0115	- 010	2	OF 5

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

I. DESCRIPTION OF THE REPORTABLE EVENT

A. REPORTABLE EVENT CLASSIFICATION

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

B. PLANT OPERATING CONDITIONS PRIOR TO THE EVENT

On October 14, 1994, prior to the event, Comanche Peak Steam Electric Station Unit 2 was in Mode 6, first refueling outage.

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

The scheduled electrical bus outage contributed to the event.

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

On October 14, 1994, at approximately 2:15 p.m. CDT, during hanging of a Unit 2 clearance to deenergize Instrument Inverter IV2C3, an Auxiliary Operator (utility, non-licensed) was to swap Inverter IV2C3 from normal power to bypass power per station procedure. Bypass power is provided by a step-down transformer fed from normal (non-1E) electrical busses which were in a scheduled outage. When normal power was transferred to bypass power on IV2C3 (non-safety panel) per the outage schedule, a relay in the Solid State Protection System (SSPS) deenergized causing a Containment Ventilation Isolation (CVI). The CVI signal resulted in closure of containment purge valves. Normal power was immediately restored to inverter IV2C3 and the CVI signal was reset.

An event or condition that results in an automatic actuation of an ESF including the RPS, is reportable within 4 hours under 10CFR50.72(b)(2)(ii). At 3:30 p.m. on October 14, 1994, the Nuclear Regulatory Commission Operations Center was notified of the event via the Emergency Notification System.

LICENSEE EVENT REPORT (LER)
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E. THE METHOD OF DISCOVERY OF EACH COMPONENT OR SYSTEM FAILURE, OR
PROCEDURAL OR PERSONNEL ERROR

On October 14, 1994, numerous alarms were received on the Control Room Radiation Monitor Display Panel (EIIS:(PL)(IL)).

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.

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

Not applicable - there were no failed components with multiple functions that affected this event.

III. ANALYSIS OF THE EVENT

A. SAFETY SYSTEM RESPONSES THAT OCCURRED

Containment Ventilation (EIIS:(BK)) Isolation activated automatically as a result of the event.

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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B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY Not applicable - no safety system trains were rendered inoperable due to a failure. C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT In this event, the Containment Particulate, Iodine, and Gas radiation monitor was operable and there was no increase in detectable activity in the containment atmosphere. The event occurred because bypass power was not available to the instrument inverter IV2C3 resulting in a CVI signal and was not due to an actual high radiation condition. It is concluded that this event did not adversely affect safe operation of the plant or the health and safety of the public. IV. CAUSE OF THE EVENT The cause of the event was that the clearance placement and outage schedule processes were implemented in a manner that allowed the Auxiliary Operator to be the final barrier. The AO did not properly verify the available indications on the inverter panel, when placing the clearance, that the bypass power was not available. Since bypass power was not available swapping the instrument inverter from normal power to bypass power led to a CVI. V. CORRECTIVE ACTION The immediate action was to restore power to the bus, reset the CVI signal, and reinitiate containment purge. Cognizant personnel involved with this event have reviewed this event and have been counselled on management expectations with respect to procedure compliance and scheduling impacts have been reemphasized.															

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VI. PREVIOUS SIMILAR EVENTS

There have been no previous reportable CVI actuation events with similar root cause with respect to CVI.