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CPSES-200003031
Log # TXX-00220
File # 10200
Ref. # 10CFR50.73(a)(2)(i)

December 11, 2000

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

**SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)-UNIT 1
DOCKET NOS. 50-445
CONDITIONS PROHIBITED BY TECHNICAL SPECIFICATIONS
LICENSEE EVENT REPORT 445/00-002-00**

Enclosed is Licensee Event Report (LER) 00-002-00 for Comanche Peak Steam Electric Station Unit 1, "Some Technical Specification Surveillances were not Adequately Documented as Required Due to Personnel Error."

IE22

TXX-00220
Page 2 of 2

This communication contains no new licensing basis commitments regarding CPSES Unit 1.

Sincerely,

C. L. Terry

By: *Roger D. Walker*
Roger D. Walker
Regulatory Affairs Manager

OAB:jrh
Enclosure

cc: Mr. E. W. Merschoff, Region IV
Mr. J. I. Tapia, Region IV
Resident Inspectors, CPSES

NRC FORM 366 (4-95)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3160-0104 EXPIRES 04/30/98 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-8 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.
LICENSEE EVENT REPORT (LER)		

Facility Name (1) COMANCHE PEAK STEAM ELECTRIC STATION UNIT 1	Docket Number (2) 05000445	Page (3) 1 OF 4
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Title (4)
SOME TECHNICAL SPECIFICATION SURVEILLANCES WERE NOT ADEQUATELY DOCUMENTED AS REQUIRED DUE TO PERSONNEL ERROR

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 Name	Docket Numbers	
11	19	00	00	002	00	12	11	00	CPSES UNIT 2	05000446	
Docket Numbers 05000											

Operating Mode (9) 1	This report is submitted pursuant to the requirements of 10 CFR: (Check one or more) (11)										
Power Level (10) 100	20.2201 (b)			20.2203 (a) (2) (v)			<input checked="" type="checkbox"/> 50.73 (a) (2) (i)			50.73 (a) (2) (viii)	
	20.2203 (a) (1)			20.2203 (a) (3) (i)			50.73 (a) (2) (ii)			50.73 (a) (2) (x)	
	20.2203 (a) (2) (i)			20.2203 (a) (3) (ii)			50.73 (a) (2) (iii)			73.71	
	20.2203 (a) (2) (ii)			20.2203 (a) (4)			50.73 (a) (2) (iv)			OTHER	
	20.2203 (a) (2) (iii)			50.36 (c) (1)			50.73 (a) (2) (v)			Specify in Abstract below or in NRC Form 366A	
20.2203 (a) (2) (iv)			50.36 (c) (2)			50.73 (a) (2) (vii)					

Licensee Contact For This LER (12) Name S. L. ELLIS - SHIFT OPERATIONS MANAGER								Telephone Number (Include Area Code) 254-897-8422			
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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)						EXPECTED SUBMISSION DATE (15)			Month	Day	Year
YES (If YES, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO										

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On November 20, 2000, while performing an administrative review and verification of the November 19, 2000 completed shift Surveillance, Operations staff personnel (Utility, Non-licensed) identified that entries on page 6 of 9 of the "Operations Shiftly Routine Tests" logs/forms were not annotated. Following the discovery, it was immediately verified that the missed surveillances were current and satisfactory on November 20, 2000.

TXU Electric's evaluation of the event deemed that less than adequate self-verification in recording of the data, and less than adequate review by the Supervisor of the completed surveillances led to this event. Management's expectations with respect to attention to detail and compliance with the Technical Specifications were reemphasized to the cognizant personnel. A Lessons Learned with respect to this event will be promulgated to the individuals who perform and review these type of surveillances.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Facility Name (1) COMANCHE PEAK STEAM ELECTRIC STATION UNIT 1	Docket 05000445	LER Number (6)	Page(3)						
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Year</td> <td style="width: 25%;">Sequential Number</td> <td style="width: 25%;">Revision Number</td> </tr> <tr> <td style="text-align: center;">00</td> <td style="text-align: center;">002</td> <td style="text-align: center;">00</td> </tr> </table>	Year	Sequential Number	Revision Number	00	002	00	2 OF 4
Year	Sequential Number	Revision Number							
00	002	00							

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

I. DESCRIPTION OF THE REPORTABLE EVENT

A. REPORTABLE EVENT CLASSIFICATION

Conditions prohibited by plants Technical Specifications.

B. PLANT OPERATING CONDITIONS PRIOR TO THE EVENT

On November 19 (the day of the event) and 20 (the day of discovery), 2000, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 1, Power Operation, at approximately 100 percent power.

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 structures, systems, or components that were inoperable that contributed to the event.

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

Operations shiftly routine surveillance procedure satisfies the requirements for certain routines, checks and operations that are performed on a scheduled basis, as required by Technical Specifications (TS) and commitments. The Surveillance test requires that the individual parameters be logged and a channel check performed when warranted. The specific TS surveillances are listed on forms (9 pages total) with the parameters and acceptance criteria. These parameters are recorded between the hours of 0630- 0930 for the day shift and 1830-2130 for the mid shift. The day shift records the reading of the parameters in their specified column, and the mid shift records in their specified column; these columns are adjacent to each other. After recording all data, and when all parameters are within the acceptance criteria the responsible Reactor Operator (Utility, Licensed) signs the page 9 of 9 and forwards them to his supervisor (Unit Supervisor (Utility, Licensed)). The Supervisor performs a review of the data recorded for acceptance signs and dates and forwards the completed forms to Operation Shift Personnel.

On November 20, 2000, at approximately 12:30 p.m., Operations Staff Personnel (Utility, Non-Licensed) while reviewing the Surveillance logs/forms, noted that the entire page 6 of 9 was filled in for the day shift activities for November 19, 2000; however, the mid shift entries were blank. This issue was immediately brought to the attention of the Shift Manager (Utility, Licensed).

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Facility Name (1) COMANCHE PEAK STEAM ELECTRIC STATION UNIT 1	Docket 05000445	LER Number (6)			Page(3)
		Year	Sequential Number	Revision Number	
		00	002	00	3 OF 4

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

The surveillances in question as identified above were for; a) Power Range Neutron Flux Parameters; b) Steam Line Pressure Parameters; and c) Steam Generator Water Level Parameters. The Surveillance test requires that the individual parameters be logged and a channel check performed.

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

Operation staff personnel (Utility, Non-licensed) identified that entries on page 6 of 9 of the "Operations Shiftly Routine Tests" logs/forms were not annotated. The event was deemed to be a procedure non-compliance due to a personnel error.

II. ANALYSIS OF THE EVENT

A. SAFETY SYSTEM RESPONSES THAT OCCURRED

Not applicable - no safety system responses occurred as a result of this event.

B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY

Not applicable - no safety system train was deemed inoperable.

C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

- CPSES Technical Specification (TS) Surveillance Requirements (SR) 3.3.1.1 and 3.3.2.1 requires the performance of the channel check every 12 hours to ensure that a gross failure or a excessive drift in the instrumentation between each channel calibration of instrumentation has not occurred.

The surveillances in question as identified above were for; a) Power Range Neutron Flux Parameters; b) Steam Line Pressure Parameters; and c) Steam Generator Water Level Parameters. The frequency of the surveillance is based on operating experience that demonstrates that channel failure is rare. The channel check supplements less formal, but more frequent, checks of the channels during normal operational use of the displays associated with the limiting conditions of operations required channels. The plant computers also monitor these parameters; if a significant deviation should occur, alarms would annunciate and plant operators would react as required. A review of the plant computer did not identify any significant deviation in the parameters. Additionally, this event was evaluated using the NRC's Significant Determination Process and was determined to be of very low safety significance. Hence, it was concluded that the missed surveillances did not adversely impact the safe operation of CPSES or the health and safety of the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Facility Name (1) COMANCHE PEAK STEAM ELECTRIC STATION UNIT 1	Docket 05000445	LER Number (6)			Page(3) 4 OF 4
		Year	Sequential Number	Revision Number	
		00	002	00	

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III. CAUSE OF THE EVENT

Extensive review of this event and interviews with the cognizant personnel revealed the following:

1. Individuals involved recall the observation of the control boards; however, they do not remember documenting the parameters as required by the procedures, and
2. The individuals involved with the surveillance recollect being distracted with other activities/tasks which is not unusual during the shift activities; however, they could not substantiate if that was the cause of less than adequate documentation of the required parameters.

To determine the cause of the human performance error, the event is being reviewed under the auspices of the CPSES Human Performance Enhancement System (HPES) Program. Attributes under the HPES Program are workload, fatigue, distraction, training, procedural adequacy, and other human factors. No matters of concerns have been identified to date with respect to the aforementioned factors. TXU Electric believes that the event was caused due to less than adequate self-verification in recording of the data, and less than adequate review by the Supervisor of the completed surveillances.

IV. CORRECTIVE ACTIONS

The immediate corrective action was to verify if there were any deviations with respect to the acceptance criteria of the parameters for the instruments that were to be observed. No matters of concerns were identified in the operating parameters. Management's expectation with respect to attention to detail and compliance with the Technical Specification has been reemphasized to the cognizant personnel. A Lessons Learned regarding this event will be promulgated to the individuals who perform and review these type of surveillances.

V. PREVIOUS SIMILAR EVENTS

Reportable events regarding missed surveillance for the past 3 years were reviewed in an attempt to ascertain a common cause. There have been previous similar events that pertain to missed surveillances. However, the causes for those events were sufficiently different than this event such that the corrective actions would not have prevented this event.