TU ELECTRIC

Log # TXX-92049
File # 10200
Ref. # 10CFR50.73(a)(2)(i)

February 14, 1992

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 NOS. 50-445
CONDITION PROHIBITED BY TECHNICAL SPECIFICATIONS
LICENSEE EVENT REPORT 92-002-00

Gentlemen:

Enclosed is Licensee Event Report 92-002-00 for Comanche Peak Steam Electric Station Unit 1, "Personnel Error Leading to Failure to Satisfy Technical Specification Surveillance Requirement for Area Temperature Monitoring".

Sincerely,

William J. Cahill, Jr.

NH/tg

c - Mr. R. D. Martin, Region IV
Mr. T. A. Bergman, NRR
Resident Inspectors, CPSES (2)

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Enclosure to TXX-92049

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

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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Title (4)

PERSONNEL ERROR LEADING TO FAILURE TO SATISFY TECHNICAL SPECIFICATION SURVEILLANCE REQUIREMENT FOR AREA TEMPERTUARE MONITORING

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
01	15	92	92	- 002 -	00	02	14	92	N/A	0 5 0 0 0
									N/A	0 5 0 0 0

Operating Mode (9)	1
Power Level (10)	100

This report is submitted pursuant to the requirements of 10 CFR §: (Check one or more of the following) (11)

☐ 20.402(b)	☐ 20.405(c)	☐ 50.73(a)(2)(iv)	☐ 73.71(b)
☐ 20.405(a)(1)(i)	☐ 50.36(c)(1)	☐ 50.73(a)(2)(v)	☐ 73.71(c)
☐ 20.405(a)(1)(ii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(vii)	☐ Other (Specify in Abstract below and in Text, NRC Form 366A)
☐ 20.405(a)(1)(iii)	☒ 50.73(a)(2)(i)	☐ 50.73(a)(2)(viii)(A)	
☐ 20.405(a)(1)(iv)	☐ 50.73(a)(2)(ii)	☐ 50.73(a)(2)(viii)(B)	
☐ 20.405(a)(1)(v)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(x)	

Licensee Contact For This LER (12)

Name	Telephone Number: Area Code
D.E. BUSCHBAUM COMPLIANCE SUPERVISOR	8 1 1 7 8 9 7 - 1 5 8 5 1

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	

Supplemental Report Expected (14)

☐ Yes (If yes, complete Expected Submission Date)	☒ No	Expected Submission Date (15)	Month	Day	Year

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

On January 15, 1992, at approximately 0615 CST, Comanche Peak Steam Electric Station Unit 1 Control Room supervisory personnel made task assignments based on planned activities for the day. The unit supervisor became distracted by other activities and neglected to assign an auxiliary operator responsibility for taking shiftly local surveillance logs. The logs satisfy in part the requirement of Technical Specification 4.7.10 to determine at least once per 12 hours that temperatures in specified areas are within limits. The oversight was discovered at approximately 1300, and the surveillance was successfully completed. The cause of the event was personnel error. Corrective actions include improved control over assignment of duties and disposition of completed logs.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION

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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 plant's Technical Specifications.

B. PLANT OPERATING CONDITIONS PRIOR TO THE EVENT

On January 15, 1992, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 1, Power Operation, with the reactor operating at 100 percent of rated thermal 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 inoperable structures, systems or components that contributed to the event.

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

On January 15, 1992, at approximately 0615 CST, the day shift operating crew relieved the night shift, and Control Room supervisory personnel made assignments based on planned activities for the day. One auxiliary operator is assigned each day to a watch station in accordance with a watch rotation schedule prepared by the auxiliary operators, typically a week or two in advance. One of those assignments is completion of the local surveillance logs which require that local area temperatures be recorded for selected locations in the plant. Normal practice is for the unit supervisor to hand the local surveillance logs to the auxiliary operator assigned that watch. On January 15, the Unit 1 unit supervisor (utility, licensed) became distracted by other control room activities and neglected to hand the logs to the auxiliary operator as normal.

The shift staffing board in the Control Room lists the on-duty operating personnel and their respective duty assignments. On January 15, the auxiliary operator (utility, non-licensed) who should have performed the local surveillance logs was unaware of his assignment. He had been assigned responsibility for the local surveillance logs on the previous day, but because of watch rotation scheduling, thought that the local surveillance logs were assigned to another auxiliary operator on January 15. The auxiliary operator who had been assigned responsibility for the local surveillance logs for January 15 per the watch rotation schedule had, however, been transferred off shift on January 13.

At approximately 0830, the unit supervisor performed a review of logs and shiftly surveillances. The local surveillance log from the previous day was among the documents reviewed, but the unit supervisor failed to note the date on the logs, and thought that they had been performed on the 15th. He incorrectly assumed that he had reviewed and signed the local surveillance logs earlier in the day. Technical Specification Surveillance requirement 4.7.10 requires that the temperatures in specified areas be determined to be within limits at least once per 12 hours. Failure to perform the shiftly Unit 1 local surveillance logs on January 15, 1992, is considered a failure to satisfy the requirements of Specification 4.7.10.

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

At approximately 1300, the Unit 2 unit supervisor (utility, licensed) was reviewing work documents when he discovered the Unit 1 local surveillance logs for January 15, incomplete and lying on a desk adjacent to the Unit 1 unit supervisor's desk.

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.

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B. CAUSE OF EACH COMPONENT OR SYSTEM FAILURE

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

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

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

D. FAILED COMPONENT INFORMATION

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

III. ANALYSIS OF THE EVENT

A. SAFETY SYSTEM RESPONSES THAT OCCURRED

Not applicable - there were no safety system actuations 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 limitations on nominal area temperatures ensure that safety-related equipment within the monitored areas will not be subjected to temperatures that would adversely impact the environmental qualification of that equipment. Exposure to elevated temperatures could reduce the qualified life or design life of the equipment, or degrade the operability of equipment.

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With the exception of Auxiliary and Safeguards Building valve operating areas, Primary plant ventilation exhaust filter room and electrical and controls building chiller area, all rooms required to be monitored are equipped with a Hi temperature alarm in the Control Room. All accessible areas are visited at least twice per shift by auxiliary operators on normal equipment rounds. During the event, no room temperature alarms were received or abnormal conditions reported. It is concluded that the event did not adversely impact the safe operation of CPSES Unit 1 or the health and safety of the public.

IV. CAUSE OF THE EVENT

The cause of the event has been determined to be personnel error resulting from lack of attention to activities being performed. The distractions of other administrative and training functions diverted the unit supervisor's concentration from assignment or auxiliary operator duties and document review.

V. CORRECTIVE ACTIONS

A. IMMEDIATE

Upon discovery of the incompleted local surveillance logs, an auxiliary operator was immediately dispatched to perform the activity. The surveillance was satisfactorily completed at 1411.

B. ACTION TO PREVENT RECURRENCE

Management has emphasized to all operating shift personnel expectations with respect to individual awareness of operating activities, effective prioritization of those activities, and the strict adherence to all requirements of the unit Technical Specifications. Management has required Operations supervisory personnel to assign responsibility for all watch stations, including the sniftly local surveillance log, during the shift turnover meeting. Operations supervisory personnel have also been directed to immediately remove to file completed copies of the local surveillance log.

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VI. PREVIOUS SIMILAR EVENTS

CPSES Licensee Event Reports (LER) 90-005, 90-010, 90-015, 90-024, 90-026, 90-034, 90-040, 90-044, 91-003, 91-007, 91-011, 91-017, 91-028 and 91-030 describe previous events involving Technical Specification surveillance activities. The details of previously reported events are sufficiently different from the event described in LER 91-032 to conclude that previous corrective actions could not be expected to have prevented this event.