



TUELECTRIC

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May 1, 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 NO. 50-145
OPERATION PROHIBITED BY THE PLANTS TECHNICAL SPECIFICATION
LICENSEE EVENT REPORT 92-007-00

Gentlemen:

Enclosed is Licensee Event Report 92-007-00 for Comanche Peak Steam Electric Station Unit 1, "Personnel Error Leading to the Failure to Perform a Technical Specification Condition Surveillance Within a Specified Time Limits."

Sincerely,

William J. Cahill, Jr.

JET/tg
Enclosure

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

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9205050241 920501
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NRC FORM 366		U.S. NUCLEAR REGULATORY COMMISSION				APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92				
LICENSEE EVENT REPORT (LER)						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) COMANCHE PEAK - UNIT 1						Docket Number (2) 01510101014145		Page (3) 1 OF 015		
Title (4) PERSONNEL ERROR LEADING TO THE FAILURE TO PERFORM A TECHNICAL SPECIFICATION CONDITIONAL SURVEILLANCE WITHIN THE SPECIFIED TIME LIMITS										
Event Date (5)			ER Number (6)		Report Date (7)			Other Facilities Involved (8)		
Month	Day	Year	Year	Sequential Number	Revison Number	Month	Day	Year	Facility Names	Docket Numbers
04	01	92	92	007	010	05	01	92	N/A	015101010111
								N/A		015101010111
Operating Mode (9) 1 This report is submitted pursuant to the requirements of 10 CFR 6: (Check one or more of the following) (11)										
Power Level (10) 01514		<input type="checkbox"/> 20.402(b)		<input type="checkbox"/> 20.405(c)		<input type="checkbox"/> 50.73(a)(2)(iv)		<input type="checkbox"/> 73.71(b)		
		<input type="checkbox"/> 20.405(a)(1)(i)		<input type="checkbox"/> 50.36(c)(1)		<input type="checkbox"/> 50.73(a)(2)(v)		<input type="checkbox"/> 73.71(c)		
		<input type="checkbox"/> 20.405(a)(1)(ii)		<input type="checkbox"/> 50.36(c)(2)		<input type="checkbox"/> 50.73(a)(2)(vi)		<input type="checkbox"/> Other (Specify in Abstract below and in Text, NRC Form 366A)		
		<input checked="" type="checkbox"/> 20.405(a)(1)(iii)		<input type="checkbox"/> 50.73(a)(2)(i)		<input type="checkbox"/> 50.73(a)(2)(vii)(A)				
		<input type="checkbox"/> 20.405(a)(1)(iv)		<input type="checkbox"/> 50.73(a)(2)(ii)		<input type="checkbox"/> 50.73(a)(2)(vii)(B)				
		<input type="checkbox"/> 20.405(a)(1)(v)		<input type="checkbox"/> 50.73(a)(2)(iii)		<input type="checkbox"/> 50.73(a)(2)(x)				
Licensee Contact For This LER (12)										
Name D.E. BUSCHBAUM						Telephone Number COMPLIANCE SUPERVISOR				
						Area Code 117		Number 819171-1511		
Complete One Line For Each Component Failure Described in this Report (13)										
Cause	System	Component	Manufacturer	Reportable To NPROS	Cause	System	Component	Manufacturer	Reportable To NPROS	
Supplemental Report Expected (14)								Expected Submission Date (15)		
<input type="checkbox"/> Yes (If yes, complete Expected Submission Date)				<input checked="" type="checkbox"/> No				Month	Day	Year
Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)										
<p>On April 1, 1992, the Train E Diesel Generator was declared inoperable to allow performance of scheduled preventive maintenance. The related Technical Specification requires that two independent circuits between the offsite transmission network and the onsite Class 1E distribution system be determined to be operable by verifying correct breaker alignment within one hour and at least once per 8 hours thereafter. The initial surveillance was performed successfully, but the next surveillance was not performed within the specified time limits. The cause of the event was determined to be personnel error. Corrective actions include individual counseling, procedure enhancement, and development of a standardized tracking device for conditional surveillances.</p>										

NRC FORM 366A		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92	
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)	
COMANCHE PEAK - UNIT 1		01510101415		912 - 01017 - 01012	
Text (If more space is required, use additional NRC Form 366A's) (17)		Year	Sequential Number	Revision Number	Page (3)
					OF 015
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 April 1, 1992, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 1, Power Operation, with the reactor operating at 54 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					
On April 1, 1992, at approximately 0645 CST, the Train B Diesel Generator (EIS:(DG)(EK)) was declared inoperable to allow the performance of scheduled preventive maintenance.					
D. NARRATIVE SUMMARY OF THE EVENT, INCLUDING DATES AND APPROXIMATE TIMES					
CPSES Technical Specification 3.8.1.1 prescribes the action to be taken upon declaring a diesel generator inoperable - two independent circuits between the offsite transmission network and the onsite Class 1E distribution system (EIS:(EB)) must be determined to be operable by verifying correct breaker (EIS:(52)(EB)) alignments within one hour and at least once per 8 hours thereafter. On April 1, 1992, at approximately 0650, the required surveillance was initially performed, and should have been reperformed by 1450. Contrary to that requirement, the surveillance was not completed again until 1703, exceeding the specified time interval.					

<p>NRC FORM 366A</p> <p style="text-align: center;">LICENSEE EVENT REPORT (LER) TEXT CONTINUATION</p>	<p style="text-align: center;">U.S. NUCLEAR REGULATORY COMMISSION</p> <p style="text-align: right;">APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92</p> <p style="font-size: small;">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 (3150-01-1), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.</p>																			
<p>Facility Name (1)</p> <p>COMANCHE PEAK - UNIT 1</p>	<p>Docket Number (2)</p> <p>01510101415</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="3" style="text-align: center;">LER Number (6)</th> <th colspan="3" style="text-align: center;">Page (3)</th> </tr> <tr> <th style="font-size: x-small;">Year</th> <th style="font-size: x-small;">Sequential Number</th> <th style="font-size: x-small;">Revision Number</th> <th style="font-size: x-small;">Page</th> <th style="font-size: x-small;">Of</th> <th style="font-size: x-small;">Pages</th> </tr> <tr> <td style="text-align: center;">92</td> <td style="text-align: center;">- 0107</td> <td style="text-align: center;">- C10</td> <td style="text-align: center;">013</td> <td style="text-align: center;">OF</td> <td style="text-align: center;">015</td> </tr> </table>	LER Number (6)			Page (3)			Year	Sequential Number	Revision Number	Page	Of	Pages	92	- 0107	- C10	013	OF	015
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Year	Sequential Number	Revision Number	Page	Of	Pages															
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Year (If more space is required, use additional NRC Form 366A's) (17)

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

At approximately 1355, while reviewing the "Limiting Condition for Operation Action Requirement Log," the Unit 1 Shift Technical Advisor observed that the surveillance requirement of Technical Specification 3.8.1.1 was overdue.

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. 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 responses as a result of this event.

B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY

Not applicable - there were no safety systems or associated components rendered inoperable as a result of this event.

NRC FORM 366A LICENSE EVENT REPORT (LER) TEXT CONTINUATION	U.S. NUCLEAR REGULATORY COMMISSION APPROVED OME 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.																
Facility Name (1) COMANCHE PEAK - UNIT 1	Ticket Number (2) 0151010141415912	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="3">LER Number (6)</th> <th colspan="2">Page (3)</th> </tr> <tr> <th>Year</th> <th>Sequential Number</th> <th>Revision Number</th> <th></th> <th></th> </tr> <tr> <td style="text-align: center;">-</td> <td style="text-align: center;">01017</td> <td style="text-align: center;">-</td> <td style="text-align: center;">010</td> <td style="text-align: center;">014 OF 015</td> </tr> </table>	LER Number (6)			Page (3)		Year	Sequential Number	Revision Number			-	01017	-	010	014 OF 015
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Year	Sequential Number	Revision Number															
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C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

The action requirements specified in the Technical Specifications for periods when one of the diesel generators is inoperable is intended to provide assurance that restrictions upon continued facility operation is commensurate with the level of degradation. Increasing the surveillance frequency to 8 hours ensures that a sufficient number of power supplies are available when one diesel generator is inoperable for maintenance. The Class 1E onsite distribution system remained energized for the duration of the event, and successful verification of the correct breaker alignments demonstrates that the required independent circuits between the offsite transmission network and the onsite class 1E distribution system remained operable at all times. 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

Root Cause No. 1: Supervisory oversight was less than adequate. The administrative procedure defining the controls for documenting and tracking action required as a result of the failure to meet a Technical Specification Limiting Condition for Operation assigns responsibility to Control Room supervisory personnel for advising all affected personnel of conditional surveillance requirements. Contrary to that requirement, the Unit 1 Unit Supervisor (utility, licensed) failed to advise the appropriate operating personnel of the special condition surveillance requirement.

Root Cause No. 2: The Unit Supervisor permitted the distractions of other Control Room administrative duties to interfere with the timely completion of the conditional surveillance requirement.

V. CORRECTIVE ACTIONS

A. IMMEDIATE

Upon discovery of the overdue surveillance, the Reactor Operator (utility, licensed) was directed to perform the related test procedure, and the surveillance was successfully completed at 1703.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

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B. ACTION TO PREVENT RECURRENCE

Individual counseling has been administered, and a memo will be generated to advise operating personnel of the event and the resulting lessons learned.

A review will be performed of the administrative functions performed in the Control Room, and time management training will be administered to Control Room supervisory personnel to enhance skills at setting priorities.

The governing Operations Department administrative procedure will be changed to require a Control Room briefing whenever plant conditions result in the requirement for performance of a conditional surveillance. This provides a routine for directing the performance of conditional surveillances and ensures that the appropriate Control Room personnel are aware of the Technical Specification requirements. The Control Room briefing may be replaced in the future if an alternative method is determined to be more desirable.

The governing administrative procedure will be changed to standardize the method used to track the scheduling of conditional surveillances. A conditional surveillance tracking board has been developed and installed in the Control Room and contains information related to the requirement including the time that the next surveillance is due. The board also includes a bank of timers that can be set to audibly alert the operator of an approaching surveillance deadline. This tracking device may be replaced in the future if an alternative method is determined to be more desirable.

VII. PREVIOUS SIMILAR EVENTS

LER 90-010-00 describes the failure to perform a special condition surveillance on the cooling water reservoir level after increasing the frequency due to high level following excessive rainfall. The failure was caused by a personnel error resulting from responsible personnel becoming involved in other duties. Corrective action was not sufficient to prevent recurrence of a failure to perform a conditional surveillance because of ineffective implementation.