

Log # TXX-95256
File # 10200
Ref. # 10CFR50.73(a)(2)

September 29, 1995

C. Lance Terry
Group Vice President

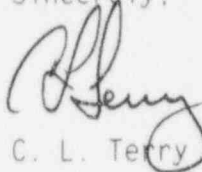
U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES) - UNIT 2
DOCKET NOS. 50-446
CONDITION PROHIBITED BY CPSES TECHNICAL SPECIFICATION
LICENSEE EVENT REPORT 446/95-002-00

Gentlemen:

Enclosed is Licensee Event Report 95-002-00 for Comanche Peak Steam Electric Station Unit 2. "Invalid Technical Specification Surveillance Due to Reading the Incorrect Instrument."

Sincerely,



C. L. Terry

EAS:cc
Enclosure

cc: Mr. L. J. Callan, Region IV
Mr. D. F. Kirsch, Region IV
Mr. T. J. Polich, NRR
Resident Inspectors, CPSES

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NRC FORM 366 (4-95)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/98
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)		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 6 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.

FACILITY NAME (1) COMANCHE PEAK STEAM ELECTRIC STATION 2	DOCKET NUMBER (2) 05000446	PAGE (3) 1 OF 4
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TITLE (4)
 INVALID TECHNICAL SPECIFICATION SURVEILLANCE DUE TO READING THE INCORRECT INSTRUMENT

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 NUMBER
09	02	95	95	-- 002 --	00	10	02	95	CPSSES 1	05000445
									FACILITY NAME	DOCKET NUMBER
									N/A	05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
		20.2201(b)		20.2203(a)(2)(v)		x	50.73(a)(2)(i)		50.73(a)(2)(viii)	
POWER LEVEL (10)	100	20.2203(a)(1)		20.2203(a)(3)(f)			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	TELEPHONE NUMBER (Include Area Code)
DAVE KROSS, SHIFT OPERATIONS MANAGER	817/897-8603

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)	X	NO					

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

Technical Specification (T.S.) 4.3.3.3.a. requires that each accident monitoring instrumentation channel be demonstrated OPERABLE at least once per 31 days by performance of a CHANNEL CHECK.

On September 2, 1995, while preparing to perform this surveillance on the subcooling monitors, a reactor operator (utility, licensed) reviewed the results of the most recent such surveillance and discovered that the results were incorrect; i.e., instead of subcooling monitor readings, core exit thermocouple readings had been recorded.

Subsequent investigation revealed that this surveillance had been similarly misread eight (8) times total (inclusive of both Units 1&2) since commercial operation.

Since the previously missed surveillance had been on Unit 1 and since the periodicity for completion of this surveillance had not elapsed, immediate corrective action consisted of performing the surveillance on Unit 1. Other corrective actions included re-emphasis of management's expectations with regard to log taking.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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		YEAR	SEQUENTIAL	REVISION	
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

I. DESCRIPTION OF THE REPORTABLE EVENT

A. REPORTABLE EVENT CLASSIFICATION

Any operation prohibited by Technical Specification (T.S.).

B. PLANT OPERATING CONDITIONS BEFORE THE EVENT

At the time of discovery, September 2, 1995, Comanche Peak Unit 2 was in MODE 1 operating at 100% power. This surveillance is required in plant operating MODES 1,2 or 3. The plants were in one of these MODES during the times of the other invalid surveillances.

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

At approximately 2230 on September 2, 1995, a reactor operator (utility, licensed) prepared to perform T.S. surveillance 4.3.3.3.a. for the Unit 2 accident instrumentation subcooling monitors. This consisted of recording and comparing meter readings on both subcooling monitors (TI-3611-1 and TI-3612-1). As he was unfamiliar with the surveillance, he checked the previously performed surveillance, which had been performed on August 27, 1995 for Unit 1. In so doing, he noted that the recorded data was incorrect; i.e., core exit thermocouple readings, which are on the other half of the same meter and have similar tag numbers (TI-3611-2 and TI-3612-2), had been recorded instead of the required subcooling margin readings. This surveillance is a CHANNEL CHECK and the acceptance criteria is the differential between the two channels. Since the incorrectly logged core exit thermocouples met this difference, the error was not noted upon review.

As a result of the above discovery, records of this surveillance for both Units 1 & 2 since commercial operations were reviewed. A total of eight (8) similarly misrecorded surveillances were discovered. These occurred on: 1/16/93, 2/13/93, 3/20/93, 7/3/93, 7/31/93, 9/4/93, 2/11/95 and 8/5/95.

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

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

While preparing to perform the surveillance, the operator reviewed past logs and, in so doing, discovered the error.

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

N/A

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

N/A

D. FAILED COMPONENT INFORMATION

N/A

III. ANALYSIS OF THE EVENT

A. SAFETY SYSTEM RESPONSES THAT OCCURRED

There were no safety system responses to this event.

B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY

N/A

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TEXT CONTINUATION

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

C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

Subcooling margin monitors in conjunction with the core exit thermocouples (CET) and the Reactor Vessel Level Indicating System (RVLIS) provides capability to monitor the approach to, existence of and recovery from inadequate core cooling (ICC). The CETs were recorded during these invalid surveillances and found to be well within the criterion and subsequent valid surveillances confirmed instrument operability of the subcooling monitors and no degradation of hardware. It is considered that the health and safety of the public was unaffected by these occurrences.

IV. CAUSE OF THE EVENT

- A. Procedure less than adequate - The noun name on the form (SUBCOOLING MARGIN) does not match the name on the instrument label (RCS SAT MARGIN).
- B. Other intended or required verification not performed - Personnel performing the surveillance did not verify complete instrument number prior to making log entry.

V. CORRECTIVE ACTIONS

IMMEDIATE

Since the periodicity for completion of the previous surveillance (Unit 1) had not elapsed, the surveillance was performed on that Unit satisfactorily.

ACTIONS TO PREVENT RECURRENCE

The surveillance procedure will be revised and management's expectations with regard to proper log taking has been re-emphasized. Human factors need to be considered and acceptance criteria enhanced in re-formatting the form.

VI. PREVIOUS SIMILAR EVENTS

Of the eleven other missed surveillances since January 1, 1993, four resulted from improper review of documents, four resulted from misinterpretation of procedural steps or notes, two resulted from improper scheduling and one occurred as a result of not properly tracking time when in an ACTION STATEMENT. None resulted from incorrect instrument data recording.