



Log # TXX-94299  
File # 10200  
Ref. # 50.73(a)(2)(i)

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  
MISSED TECHNICAL SPECIFICATION SURVEILLANCE  
LICENSEE EVENT REPORT 446/94-016-00

Gentlemen:

Enclosed is Licensee Event Report (LER) 94-016-00 for Comanche Peak Steam Electric Station Unit 2, "Missed Refueling Machine Auxiliary Monorail Hoist Surveillance Due to Personnel Error."

Sincerely,

A handwritten signature in cursive script, appearing to read 'C. L. Terry'.

C. L. Terry

ES:tg  
ENCLOSURE

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

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PDR ADOCK 05000446  
S PDR

P. O. Box 1002 Glen Rose, Texas 76043

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NRC FORM 366		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED OMB NO.3150-0104 EXPIRES: 4/30/92	
<b>LICENSEE EVENT REPORT (LER)</b>					
Facility Name (1) <b>COMANCHE PEAK-UNIT 2</b>				Docket Number (2) <b>0510010446</b>	
Title (4) <b>MISSIED REFUELING MACHINE AUXILIARY MONORAIL HOIST SURVEILLANCE DUE TO PERSONNEL ERROR</b>				Page (3) <b>1 OF 5</b>	
Event Date (5)      LER Number (6)      Report Date (7)      Other Facilities Involved (8)					
Month	Day	Year	Year	Sequential Number	Revision Number
10	16	94	94	0116	00
			Month	Day	Year
			11	14	94
Operating Mode (9) <b>6</b>			Facility Names <b>N/A</b>		
Power Level (10) <b>01010</b>			Docket Numbers <b>0510010111</b>		
This report is submitted pursuant to the requirements of 10 CFR § 42.49 (Check one or more of the following) (11)					
20.402(b)		20.405(c)		50.73(a)(2)(iv)	
20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)	
20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)	
20.405(a)(1)(iii)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)		50.73(a)(2)(iii)		50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)	
Licensee Contact For This LER (12)					
Name <b>Rafael Flores, Shift Operations Manager</b>				Area Code      Telephone Number <b>817-897-5590</b>	
Complete One Line For Each Component Failure Described in This Report (13)					
Cause	System	Component	Manufacturer	Reportable To NPRDS	
Supplemental Report Expected (14)					
<input type="checkbox"/> Yes (if yes, complete Expected Submission Date)					<input checked="" type="checkbox"/> No
					Expected Submission Date (15)
					Month      Day      Year
Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)					
<p>On October 16, 1994, with the reactor vessel head removed, control rod drive shafts were being unlatched from the control rods in preparation for core offloading. This evolution involves the use of a load indicator in line with the refueling machine auxiliary hoist. During this process, some difficulty was experienced due to the size of the load indicator. A decision was made by the Fuel Handling Supervisor to change the load indicator to a smaller one which had been staged in the area. This smaller indicator had been properly calibrated but had not been load tested within the previous 100 hours as required by Technical Specification (TS) 4.9.6.2.</p> <p>During subsequent shift relief, it was discovered by one of the oncoming Fuel Handling Supervisors that the TS surveillance (load test) had not been performed on this second indicator. The Fuel Handling Supervisor directing operations in Containment was immediately notified to cease the control rod unlatching evolution. This was done and the second indicator was replaced by the original indicator prior to continuing operations.</p> <p>The root cause of this event was personnel error. Corrective actions included counseling of the personnel involved.</p>					

# 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	0151010141416	Year	Sequential Number	Revision Number			
		94	0116	00	2	OF	5

Text (if more space is required, use additional NRC Form 366A's) (12)

## 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 October 16, 1994, Comanche Peak Steam Electric Station (CPSES) Unit 2 was in Mode 6, Refueling, with the Reactor Coolant System (RCS)(EIIS:(AB)) at a temperature of approximately 100 degrees Fahrenheit and atmospheric pressure.

### 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 directly to the event.

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

On October 16, 1994, with the reactor vessel head (EIIS:(AC)) removed, control rod drive shafts (EIIS:(AC)) were being unlatched from the control rods (EIIS:(ROD)(AA)) in preparation for core offloading. This evolution involves the use of a load indicator in line with the refueling machine (EIIS:(FHM)(DB)) auxiliary monorail hoist. At approximately 3:00 a.m. CDT, some difficulty was experienced when the unlatching tool would not disengage from one of the drive shafts. An attempt was then made to remove the drive shaft and stow it but there was insufficient clearance to do this due to the physical size of the indicator. The decision was then made by the Fuel Handling Supervisor (utility, licensed) to change the indicator to a smaller one that had been staged in the area. This smaller indicator had been properly calibrated and load tested to 200, 400, 600, 800 and 1,000 pounds on September 1, 1994 prior to the start of outage operation but had not been load tested within the previous 100 hours as required by Technical Specification (TS) 4.9.6.2.

From this time until approximately 7:00 a.m., control rod unlatching verification was performed using this second load indicator. At 7:00 a.m., October 16, 1994, an oncoming Fuel Handling Supervisor (utility, licensed) was told of the load indicator changeout during the pre-shift brief. He then questioned whether the new load indicator had been tested

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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Facility Name (1)

Docket Number (2)

LER Number (6)

Page (3)

COMANCHE PEAK-UNIT 2

015101010141416

Year

Sequential  
NumberRevision  
Number

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OF

5

Text (If more space is required, use additional NRC Form 356A's) (12)

in accordance with the TS surveillance. When informed that it had not, he immediately notified the Fuel Handling Supervisor directing operations in Containment to discontinue rod unlatching operations in accordance with the action requirement of Technical Specification 3.9.6. This was done and the second indicator was replaced with the original indicator prior to resuming operations.

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

At 7:00 a.m., on October 16, 1994, an oncoming Fuel Handling Supervisor discovered, during a pre-shift brief, that the load indicator had been changed out but that the load test surveillance had not been performed on the second indicator.

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 failed components with multiple functions that affected this event.

D. FAILED COMPONENT INFORMATION

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

NRC FORM 366A		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED OMB NO 3150-0104 EXPIRES: 4/30/92	
<b>LICENSEE EVENT REPORT (LER)</b> <b>TEXT CONTINUATION</b>				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	015101010416	Year	Sequential Number	Revision Number	
		94	0116	00	4 OF 5

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

### III. 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 - there were no safety systems which were rendered inoperable due to a failure.

#### C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

Operability requirements for the refueling machine auxiliary monorail hoist ensure that: 1) the auxiliary monorail hoist will be used for latching, unlatching, and movement of control rod drive shafts; 2) the auxiliary monorail hoist has sufficient load capacity to latch, unlatch and move the control rod drive shafts; and 3) the core internals and reactor vessel are protected from excessive lifting force in the event they are inadvertently engaged during lifting operations.

During the entire evolution of unlatching the control rod drive shafts load indication never reached higher than 475 pounds. This is well below the 600 pound limit allowed by TS 3.9.6.b. and although the load indicator had not been load tested within 100 hours prior to unlatching the drive shafts, it had been satisfactorily tested prior to refueling operations.

Based on these factors, this event did not adversely affect the safe operation of CPSES Unit 2, or the health and safety of the public.

### IV. CAUSE OF THE EVENT

#### ROOT CAUSE

Personnel error. The Fuel Handling Supervisor did not re-verify that the TS surveillance had been accomplished on the replacement load indicator. This is considered an isolated case.

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Facility Name (1)	Pocket Number (2)	LER Number (6)			Page (3)	
COMANCHE PEAK-UNIT 2	0 5 0 0 0 4 4 6	Year	Sequential Number	Revision Number		
		9 4	- 0 1 6	- 0 0	5	OF 5

Text (if more space is required, use additional NRC Form 386A's) (17)

## V. CORRECTIVE ACTIONS

### A. IMMEDIATE CORRECTIVE ACTIONS

The untested load indicator was replaced with the appropriate one.

### B. CORRECTIVE ACTIONS TO PREVENT RECURRENCE

#### ROOT CAUSE

Personnel error.

#### CORRECTIVE ACTION

The Fuel Handling Supervisors were counseled in their need to pay more attention to detail. The Fuel Handling Coordinator/Technical Specification Surveillance Coordinator conducted a session with the Fuel Handling Supervisors which involved a review of Technical Specifications.

## VI. PREVIOUS SIMILAR EVENTS

CPSES Licensee Event Report (LER) 91-028 involved the missed surveillance of TS 4.9.6.2. However, the circumstances surrounding the event were significantly different from those described above. Therefore, this is considered an isolated case.