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January 4, 1993

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. 50-445
OPERATION PROHIBITED BY THE PLANTS TECHNICAL SPECIFICATION
LICENSEE EVENT REPORT 92-026-00

Gentlemen:

Enclosed is Licensee Event Report 92-026-00 for Comanche Peak Steam Electric Station Unit 1, "Missed Diesel Generator Fuel Oil Surveillance Due to Personnel Error".

Sincerely,

William J. Cahill, Jr.
William J. Cahill, Jr.

By: *Roger D. Walker*
Roger D. Walker
Manager of Regulatory Affairs
for NEO

OB/tg
Enclosure

c - Mr. J. L. Milhoan, Region IV
Resident Inspectors, CPSES (2)

9301070222 930104
PDR ADOCK 05000445
S PDR

400 N. Olive Street L.B. 81 Dallas, Texas 75201

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Enclosure to
TXX-92641

NRC FORM 300				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-590), 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) <div style="text-align: center;">COMANCHE PEAK-UNIT 1</div>																		DocId: Number (2) <div style="text-align: center;">05000445</div>						Page (3) <div style="text-align: center;">1 OF 106</div>								
Title (4) <div style="text-align: center;">MISSED DIESEL GENERATOR FUEL OIL SURVEILLANCE DUE TO PERSONNEL ERROR</div>																																
Event Date (5)			LER Number (8)				Report Date (7)			Other Facilities Involved (9)																						
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Name(s)						DocId: Number(s)																	
1	2	0	3	9	2	9	2	-	0	2	6	-	0	0	0	1	0	4	9	3	N/A						05000445					
Operating Mode (6)			This report is submitted pursuant to the requirements of 10 CFR 50. (Check one or more of the following) (11)																													
Power Level (10)			20.405(a)				20.405(b)				50.73(a)(2)(iv)				73.71(b)																	
0			20.405(a)(1)(i)				50.90(c)(1)				50.73(a)(2)(v)				73.71(c)																	
0			20.405(a)(1)(ii)				50.90(c)(2)				50.73(a)(2)(vi)				Other (Specify in Abstract below and in Text, NRC Form 300A)																	
0			20.405(a)(1)(iii)				<input checked="" type="checkbox"/> 50.73(a)(2)(i)				50.73(a)(2)(vii)(A)																					
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			20.405(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)																					
Licensee Contact For This LER (12)																																
Name																		Area Code						Telephone Number								
D. J. REIMER, MANAGER, SYSTEM ENGINEERING																		817						897-5584								
Complete One Line For Each Component Failure Described in This Report (13)																																
Cause	System	Component	Manufacturer	Responsible To NPPDS		Cause	System	Component	Manufacturer	Responsible To NPPDS																						
				N																												
Supplemental Report Expected (14)												Expected Submission Date (15)		Month		Day		Year														
<input type="checkbox"/> Yes (If yes, complete Expected Submission Date)												<input checked="" type="checkbox"/> No																				
Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																																
<p>On December 3, 1992, it was discovered that the monthly surveillance to check for and remove water in the Train B Diesel Generator Fuel Oil Storage Tank had not been performed prior to exceeding the allowable grace period which expired on November 28, 1992. The plant was in Mode 6 with Train B satisfying the one Diesel Generator required operable requirement.</p> <p>The cause of the event has been determined to be personnel error in failing to monitor the status of routine surveillances during the outage. Corrective actions included immediate performance of the surveillance upon discovery, lessons learned, and application of surveillance monitoring techniques used during normal plant operation to outages.</p>																																

NRC FORM 306A		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)		Page (3)	
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Text (If more space is required, use additional NRC Form 306A'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 December 3, 1992, Comanche Peak Steam Electric Station (CPSES) Unit 1 was in Mode 6, Refueling, with the Reactor Coolant System (RCS)(EIS:(AB)) at a temperature of approximately 85 degrees Fahrenheit and depressurized, with the reactor head (EIS:(RCT)(AB)) removed.

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 October 16, 1992, the Mechanical Maintenance (MM) Department Scheduler (utility, non-licensed) contacted the CPSES Refueling Outage (Outage) Scheduler (utility, non-licensed) to inform him that both the Train A and Train B Diesel Generator Fuel Oil Storage Tank (DGFOST) surveillances were required by November 15, 1992, and November 21, 1992, respectively. The MM Scheduler asked that these surveillances be incorporated into the outage schedule. The Outage Scheduler misunderstood, and only scheduled the Train A DGFOST surveillance into the outage schedule. On November 15, 1992, the Train A DGFOST surveillance was performed.

On December 3, 1992, the Surveillance Test Coordinator (utility, non-licensed) and the MM Scheduler, while reviewing the surveillance activity schedule, noticed that the Train B DGFOST surveillance work order was past the violation date. The Train B DGFOST surveillance had not been performed. The missed surveillance was then documented in accordance with the appropriate plant procedure.

At 1930 on December 3, 1992, the Train B DGFOST surveillance was satisfactorily performed.

<p>NRC FORM 906A</p> <p>U.S. NUCLEAR REGULATORY COMMISSION</p> <p>LICENSEE EVENT REPORT (LER)</p> <p>TEXT CONTINUATION</p>		<p>APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92</p> <p>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</p>	
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<p>E. <u>THE METHOD OF DISCOVERY OF EACH COMPONENT OR SYSTEM FAILURE, OR PROCEDURAL OR PERSONNEL ERROR</u></p> <p>On December 3, 1992, the Surveillance Test Coordinator, while reviewing the surveillance activity schedule in preparation for entry into Mode 5, discovered that the Train B DGFOST surveillance had not been performed. Independently, but about the same time, the MM Scheduler was reviewing the upcoming outage schedule and noted the surveillance to be in violation. The missed surveillance was immediately documented and the surveillance performed.</p> <p>II. <u>COMPONENT OR SYSTEM FAILURES</u></p> <p>A. <u>FAILURE MODE, MECHANISM, AND EFFECT OF EACH FAILED COMPONENT</u></p> <p>Not applicable - there were no component failures associated with this event.</p> <p>B. <u>CAUSE OF EACH COMPONENT OR SYSTEM FAILURE</u></p> <p>No applicable - there were no component failures associated with this event.</p> <p>C. <u>SYSTEMS OR SECONDARY FUNCTIONS THAT WERE AFFECTED BY FAILURE OF COMPONENTS WITH MULTIPLE FUNCTIONS</u></p> <p>Not applicable - there were no failed components with multiple functions that affected this event.</p> <p>D. <u>FAILED COMPONENT INFORMATION</u></p> <p>Not applicable - there were no component failures associated with this event.</p> <p>III. <u>ANALYSIS OF THE EVENT</u></p> <p>A. <u>SAFETY SYSTEM RESPONSES THAT OCCURRED</u></p> <p>Not applicable - there were no safety system actuations associated with this event.</p> <p>B. <u>DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY</u></p> <p>Not applicable - there were no safety systems which were rendered inoperable due to a failure.</p>			

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<p>C. <u>SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT</u></p> <p>Operability of the minimum specified Alternating Current (AC) and Direct Current power sources and associated distribution systems during shutdown and refueling ensures that 1) the facility can be maintained in the shutdown or refueling condition for extended time periods, and 2) sufficient instrumentation and control capability is available for monitoring and maintaining the unit status.</p> <p>In this event both the Train A and Train B Diesel Generators (DG) (EIS:(DG)(EK)) were inoperable from November 29, 1992, to December 3, 1992. Maintenance had been performed on the Train A DG, and was inoperable and in post work testing during this time. At 0000 on November 29, 1992, the Train B DG became administratively inoperable due to the DGFOST surveillance not being performed. The Train B DGFOST was satisfactorily completed 1930 on December 3, 1992. The Train B DG, although administratively inoperable, was confirmed by passing the surveillance to have been OPERABLE, and could have been relied upon to perform its safety function.</p> <p>During this event all offsite AC sources were available. Furthermore, CPSES Unit 1 was in the final stages of refueling. The last fuel assembly was loaded into the core at 1047 on November 28, 1992. The decay heat remaining in the core was small compared to the water inventory available for cooling (greater than 23 feet above the core).</p> <p>Based on the above, this event did not adversely affect the safe operation of CPSES Unit 1 or the health and safety of the public.</p>					
<p>IV. <u>CAUSE OF THE EVENT</u></p> <p><u>ROOT CAUSE</u></p> <p>Root cause of the event was personnel error. The Train A and Train B DGFOST surveillances are a 31-day surveillance activity. These surveillance activities are automatically scheduled during normal plant operation and are staggered two weeks apart, alternating between Train A and Train B. However, during an outage, these surveillance activities are manually scheduled by the Outage Scheduler when notified by the MM Scheduler. In this event, a communication problem occurred between the MM Scheduler and the Outage Scheduler when scheduling the Train A and Train B DGFOST surveillances. The Outage Scheduler misunderstood, and only scheduled the Train A DGFOST into the outage schedule.</p>					

NRC FORM 366A LICENSEE EVENT REPORT (LER) TEXT CONTINUATION		U.S. NUCLEAR REGULATORY COMMISSION 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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COMANCHE PEAK-UNIT 1	05000445	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 10%;">Year</th> <th style="width: 10%;">Sequential Number</th> <th style="width: 10%;">Revision Number</th> </tr> <tr> <td>92</td> <td>026</td> <td>00</td> </tr> </table>	Year	Sequential Number	Revision Number	92	026	00	05 OF 06
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92	026	00							

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

CONTRIBUTING FACTOR

Due to a significant increase in work load, and reassignment of several personnel including the Surveillance Test Coordinator to support outage activities, surveillance activities were not adequately monitored during the outage. The Surveillance Test Coordinator and the MM (Department) Surveillance Coordinator periodically review the surveillance activity schedule to insure surveillance compliance. Furthermore, during normal plant operations, surveillance activities are monitored by Management on a daily basis (the required surveillances are listed in the managers daily information package); however, during an outage, surveillance activities are not presented as part of the Outage Package.

V. CORRECTIVE ACTIONS

A. CORRECTIVE ACTIONS TO PREVENT RECURRENCE

ROOT CAUSE

Personnel error.

CORRECTIVE ACTION

Responsible Work Organizations should review this event for "Lessons Learned". Emphasis should be placed on the use of good communication skills, as well as considering the work load and reassignment of work activities for Surveillance Coordinator and Schedulers, during an outage.

CONTRIBUTING FACTOR

Surveillance activities were not adequately monitored during the outage during the outage.

CORRECTIVE ACTION

1. An outage lessons learned will re-emphasize the management expectation that surveillances warrant the highest priority, and adequate outage staffing to support surveillance monitoring is required.
2. Specific actions for surveillance monitoring used during normal plant operations will be applied to outages. These actions had been implemented as a result of previous missed surveillances.

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VI. PREVIOUS SIMILAR EVENTS							
<p>Licensee Event Report (LER) 92-010-00 described how CPSES Plant Management established a Task Team to implement a surveillance improvement project to correct problems experienced with surveillance test compliance. The Task Team's emphasis was to standardize cognizant departments in the implementation of the surveillance test program and to implement aggressive methods for enforcing self-checking by the Surveillance Coordinators and second checking of activities involving surveillance test compliance. These corrective actions have been effective during normal plant operations. The application of non-outage surveillance listings and monitoring techniques to outage situations should prevent recurrence of this event.</p>							
VII. ADDITIONAL INFORMATION							
<p>The times listed in the report are approximate and Central Daylight Time.</p>							