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TXX -11109

Ref. # 10CFR50.73(a)(2)(vii)(D)

September 8, 2011

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

SUBJECT: COMANCHE PEAK NUCLEAR POWER PLANT (CPNPP)
DOCKET NO. 50-446
HUMAN ERROR RESULTING IN INOPERABILITY OF
ALL SAFETY INJECTION ACCUMULATORS
LICENSEE EVENT REPORT 446 / 11-004-00

Dear Sir or Madam:

Enclosed is Licensee Event Report (LER) 446/11-004-00, " Human Error Resulting in Inoperability of All Safety Injection Accumulators," for Comanche Peak Nuclear Power Plant (CPNPP) Unit 2.

This communication contains no licensing basis commitments regarding CPNPP Units 1 and 2.

Should you have any questions, please contact Gary Merka at (254) 897-6613.

Sincerely,

Luminant Generation Company LLC

Rafael Flores

By: _____
Mitch L. Lucas
Site Vice President

Enclosure

c - E. E. Collins, Region IV
B. K. Singal, NRR
Resident Inspectors, Comanche Peak

IE22
NRR

NRC FORM 366 (10-2010) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES:10/31/2013

Estimated burden per response to comp ly with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to i ndustry. Send comments regarding burden estimate to the Records and FOIA/Priv acy Service Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor , and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
Comanche Peak Nuclear Power Plant (CPNPP) Unit 2	**05000** 446	1 OF 4

4. TITLE
Human Error Resulting in Inoperability of All Safety Injection Accumulators

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
07	11	2011	2011	004	00	09	09	2011	FACILITY NAME	DOCKET NUMBER **05000**

9. OPERATING MODE
1

10. POWER LEVEL
100

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (*Check all that apply*)

☐ 20.2201(b)	☐ 20.2203(a)(3)(i)	☐ 50.73(a)(2)(i)(C)	☒ 50.73(a)(2)(vii)
☐ 20.2201(d)	☐ 20.2203(a)(3)(ii)	☐ 50.73(a)(2)(ii)(A)	☐ 50.73(a)(2)(viii)(A)
☐ 20.2203(a)(1)	☐ 20.2203(a)(4)	☐ 50.73(a)(2)(ii)(B)	☐ 50.73(a)(2)(viii)(B)
☐ 20.2203(a)(2)(i)	☐ 50.36(c)(1)(i)(A)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(ix)(A)
☐ 20.2203(a)(2)(ii)	☐ 50.36(c)(1)(ii)(A)	☐ 50.73(a)(2)(iv)(A)	☐ 50.73(a)(2)(x)
☐ 20.2203(a)(2)(iii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(v)(A)	☐ 73.71(a)(4)
☐ 20.2203(a)(2)(iv)	☐ 50.46(a)(3)(ii)	☐ 50.73(a)(2)(v)(B)	☐ 73.71(a)(5)
☐ 20.2203(a)(2)(v)	☐ 50.73(a)(2)(i)(A)	☐ 50.73(a)(2)(v)(C)	☐ OTHER
☐ 20.2203(a)(2)(vi)	☐ 50.73(a)(2)(i)(B)	☐ 50.73(a)(2)(v)(D)	VOLUNTARY LER

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME	TELEPHONE NUMBER (*Include Area Code*)
Timothy A. Hope, Nuclear Licensing Manager	254-897-6370

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED
☐ YES (*If yes, complete 15. EXPECTED SUBMISSION DATE*) ☒ NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

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

Technical Specification (TS) Surveillance Requirement (SR) 3.5.1.5 requires that power be removed from the accumulator isolation valve motor operators when RCS pressure is above 1000 psig. On July 11, 2011, at approximately 1035 CDT, with Unit 2 in Mode 1 (Power Operations) at 100 percent power, TS 3.0.3 was entered when power was restored to all Safety Injection (SI) accumulator isolation valves while the Reactor Coolant System (RCS) pressure was at approximately 2235 psig. This condition resulted when a non-licensed operator who had been directed to operate equipment for Unit 1, which was being cooled down and depressurized in preparation for a mid-cycle outage, erroneously operated Unit 2 equipment. The incorrect operation of equipment on the wrong Unit was immediately recognized by the Unit 1 Reactor Operator and reported to the Unit 2 Reactor Operator. The Unit 2 Unit Supervisor declared all four Unit 2 SI Accumulators inoperable and entered TS 3.0.3. The Unit 2 Unit Supervisor directed a second non-licensed operator to re-open the breakers providing power to the Unit 2 SI Accumulator isolation valve motor operators and TS 3.0.3 was exited at 1115.

The condition was caused by a personnel error. Corrective actions include reinforcement of station expectations regarding use of error reduction tools and issuance of an "Operations Human Performance Event Communication" regarding this event to all station managers and supervisors.

All times in this report are approximate and Central Daylight Time unless noted otherwise.

I. DESCRIPTION OF THE REPORTABLE EVENT

A. REPORTABLE EVENT CLASSIFICATION:

10CFR50.73(a)(2)(vii)(D) "Any event where a single cause or condition caused two independent trains to become inoperable in a single system designed to mitigate the consequences of an accident".

B. PLANT CONDITION PRIOR TO EVENT:

On July 11, 2011, CPNPP Unit 1 was in Mode 3 while CPNPP Unit 2 was in Mode 1 operating at 100% 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 July 11, 2011, at 0600 hours, CPNPP Unit 1 initiated a mid cycle outage to repair secondary system equipment. Tasks were being performed to secure the turbine and secondary systems and cool down and depressurize the Unit 1 Reactor Coolant system to Mode 4. At approximately 0930 hours on July 11, 2011, a qualified NEO (Utility, Non-licensed) was directed to perform System Operating Procedure, SOP-202A, "Unit 1 Safety Injection (SI) Accumulators", step 5.2.C, to close the 480 volt AC breakers [EIIS:(BKR)] providing power to the four Unit 1 Safety Injection (SI) Accumulator Injection Valve motor operators [EIIS:(BQ)(ISV)]. The NEO was provided a current revision copy of the Unit 1 procedure, SOP-202A, for in-hand use during the activities. The NEO then traveled to the Operations tool staging area on elevation 832 ft in the Unit 2 Safeguards Building to obtain the component locking tabs required by the procedure. From this location, the NEO traveled to the Unit 2 Train A Emergency Switchgear room on elevation 810 ft. where he located the incorrect (Unit 2) SI Accumulator Injection Valve motor operator circuit breakers and contacted the Unit 1 Reactor Operator (RO) (Utility, Licensed) via the plant page system. The Unit 1 RO then verbally confirmed the procedure identity and step to be performed. Believing he was located in the Unit 1 Safeguards Building, the NEO then repeated back/confirmed the Unit 1 procedure and step identity as correct. When the NEO received the approval to proceed from the Unit 1 RO, he then performed the SOP-202A procedural step on the Unit 2 Emergency Switchgear Train A and B breakers believing that he was performing the activities on Unit 1 equipment. After completing the procedure step, the NEO contacted the Unit 1 RO and the Unit 1 RO then attempted to close the four Unit 1 SI Accumulator Injection Valves. When no indications of valve position change were received, the Unit 1 RO asked the NEO to verify which Unit he was working in and the NEO realized he had performed the steps on the Unit 2 Emergency Switchgear breakers containing similar tag numbers, rather than the correct Unit 1 breakers.

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

The personnel error was discovered when the expected indications were not received when the Unit 1 Reactor Operator (RO) attempted to close the Unit 1 Safety Injection (SI) Accumulator Injection Valves using the Unit 1 Control Room handswitches.

II. COMPONENT OR SYSTEM FAILURES

A. CAUSE OF EACH COMPONENT OR SYSTEM FAILURE

Not applicable - No component failures were identified during this event.

B. FAILURE MODE, MECHANISM, AND EFFECTS OF EACH FAILED COMPONENT

Not applicable - No component failures were identified during this event.

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

Not applicable - No component failures were identified during this event.

D. FAILED COMPONENT INFORMATION

Not applicable - No component failures were identified during this event.

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

The four (4) Unit 2 Safety Injection accumulators were inoperable from 1035 CDT to 1115 CDT on July 11, 2011.

C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

Power is required to be removed from the Safety Injection Accumulator Isolation Valve motor operators when RCS pressure is greater than 1000 psig per Technical Specification surveillance requirement (SR) 3.5.1.5. The valves were always fully open and could not be closed due to the key-lock switch in the Control Room being in the OFF position and the P-11 interlock which automatically opens the valves whenever Pressurizer pressure is greater than 1960 psig. If an event had occurred, the Accumulators would have been available to perform their safety function. Consequently, this event resulted in no actual safety consequences and there were no safety system functional failures associated with this event.

IV. CAUSE OF THE EVENT

The cause of this event was the failure of the worker to utilize the expected error prevention tools based upon the incorrect assumption that the Operator was in the correct Unit.

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

V. CORRECTIVE ACTIONS

The CPNPP Unit 2 Unit Supervisor declared all four (4) Unit 2 Safety Injection accumulators inoperable and entered TS 3.5.1, Condition D and LCO 3.0.3 at 1035 CDT on July 11, 2011. The Unit 2 Safety Injection (SI) Accumulator Isolation Valve motor operator breakers were re-opened to restore compliance with TS 3.5.1. LCO 3.0.3 was exited at 1115 on July 11, 2011.

The Unit 1 Control Room Operators reduced the RCS cool down and depressurization rate and directed a different, qualified NEO to close the Safety Injection (SI) Accumulator Isolation Valve motor operator breakers for Unit 1 prior to resuming the Unit 1 RCS cool down and depressurization.

The NEO originally assigned to perform the activity was removed from assigned plant operation activities. A performance enhancement plan has been developed and is being conducted for the operator in question to reinforce station expectations regarding usage of error reduction tools.

On July 12, 2011, the Director, Operations, issued an "Operations Human Performance Event Communication" to the Station Managers and Supervisors for communication and awareness of the event among all departments.

VI. PREVIOUS SIMILAR EVENTS

There have been no previous similar reportable events at CPNPP in the last three years.