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Ref. # 10CFR50.73(a)(2)(i)(B)

August 17, 2010

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

SUBJECT: COMANCHE PEAK NUCLEAR POWER PLANT (CPNPP)
DOCKET NO. 50-445 and 50-446
INADEQUATE SURVEILLANCE TEST PROCEDURE
RESULTING IN FAILURE TO MEET TS REQUIREMENTS
LICENSEE EVENT REPORT 445 / 10-003-00

Dear Sir or Madam:

Enclosed is Licensee Event Report (LER) 445/10-003-00, " Inadequate Surveillance Test Procedure Resulting In Failure To Meet TS Requirements," for Comanche Peak Nuclear Power Plant (CPNPP) Units 1 and 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: Fred W Madden
Fred W. Madden
Director, Oversight & Regulatory Affairs

Enclosure

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

IE22
NRR

NRC FORM 366 (9-2007) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES: 8/31/2010

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), 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 Unit 1	**05000** 445	1 OF 4

4. TITLE

Inadequate Surveillance Test Procedure Resulting in Failure to Meet TS Requirements

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	DOCUMENT NUMBER
									CPNPP Unit 2	**05000 446**
06	18	2010	2010	**003**	00	08	17	2010	FACILITY NAME	DOCUMENT 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
11	16	2010

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

On June 18, 2010, during performance of the Component Design Bases Inspection, the NRC inspectors determined that surveillance test procedure (STP) OPT-216, "Remote Shutdown Operability Test" may not be adequate to meet the Technical Specification (TS) Surveillance Requirement (SR). TS SR 3.0.3 was entered for the affected components and risk assessments were completed which supported continued operability until such time as the STP could be verified to adequately implement the testing requirements to meet the SR or the affected components could be adequately tested.

The cause of this event is still being determined and a supplemental report providing this information will be submitted by November 16, 2010.

There have been no previous similar occurrences of failure to meet TS SRs due to inadequate STPs in the past three years.

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

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

I. DESCRIPTION OF THE REPORTABLE EVENT

A. REPORTABLE EVENT CLASSIFICATION

10CFR50.73(a)(2)(i)(B) "Any operation or condition which was prohibited by the plant's Technical Specifications"

B. PLANT CONDITION PRIOR TO EVENT

On June 18, 2010, CPNPP Unit 1 and Unit 2 were both 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

CPNPP TS SR 3.3.4.2 requires verification every 18 months that each required Hot Shutdown Panel power and control circuit and transfer switch is capable of performing the intended function. Contrary to this requirement, the existing surveillance test procedure (STP) may not adequately verify that capability.

On June 18, 2010, during performance of the Component Design Bases Inspection, the NRC inspectors determined that surveillance test procedure (STP) OPT-216, "Remote Shutdown Operability Test" may not be adequate to meet the Technical Specification (TS) Surveillance Requirement (SR). The STP provided a method to test the transfer of functional control from the Control Room (CR) to the Hot Shutdown Panel (HSP), but may not have provided assurance that a circuit fault affecting control from the HSP would be identified. Engineering personnel (Utility, Non-Licensed) reported the condition to CR personnel (Utility, Licensed) and both units entered TS SR 3.0.3 for the affected components and risk assessments were completed which supported continued operability.

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

On June 18, 2010, during performance of the Component Design Bases Inspection, the NRC inspectors determined that surveillance test procedure (STP) OPT-216, "Remote Shutdown Operability Test" may not be adequate to meet the Technical Specification (TS) Surveillance Requirement (SR).

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

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 current method provided in the STP to test the transfer of functional control from the Control Room (CR) to the Hot Shutdown Panel (HSP) has been utilized since the initial licensing of Unit 1 in 1990 and Unit 2 in 1993.

C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

As of the date of this report, engineering reviews have determined that no undetected failures would have existed and the STPs are adequate. However, these reviews are currently ongoing.

IV. CAUSE OF THE EVENT

The cause of this event is still being determined and a supplemental report providing this information will be submitted by November 16, 2010.

V. CORRECTIVE ACTIONS

Engineering personnel reported the condition to CR personnel and both units entered TS SR 3.0.3 for the affected components. Risk assessments were completed within 24 hours which supported continued operability. Further corrective actions, if any, will be determined upon completion of the ongoing engineering reviews.

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

VI. PREVIOUS SIMILAR EVENTS

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