



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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ARLINGTON, TEXAS 76011-8064

March 31, 2000

Mr. C. L. Terry
TXU Electric
Senior Vice President & Principal Nuclear Officer
ATTN: Regulatory Affairs Department
P.O. Box 1002
Glen Rose, Texas 76043

SUBJECT: PLANT PERFORMANCE REVIEW - COMANCHE PEAK STEAM ELECTRIC
STATION

Dear Mr. Terry:

The purpose of this letter is to communicate our assessment of your performance and to inform you of our planned inspections at your facility. On March 2, 2000, we completed a Plant Performance Review (PPR) of Comanche Peak Steam Electric Station. We conduct these reviews to develop an integrated overview of the safety performance of each operating nuclear power plant. We use the results of the PPR in planning and allocating inspection resources and as inputs to our senior management meeting (SMM) process. This PPR evaluated inspection results and safety performance information for the period from January 25, 1999, through February 11, 2000, but emphasized the last 6 months to ensure that our assessment reflected your current performance. Our most recent summary of plant performance at Comanche Peak Steam Electric Station was provided to you in a letter dated September 16, 1999.

The NRC has been developing a revised reactor oversight process that will replace our existing inspection and assessment processes, including the PPR, SMM, and Systematic Assessment of Licensee Performance (SALP). We recently completed a pilot program for the revised reactor oversight process at nine participating sites and are making necessary adjustments based on feedback and lessons learned. We are beginning initial implementation of the revised reactor oversight process industry-wide, including your facility, on April 2, 2000.

This PPR reflects continued process improvements as we make the transition into the revised reactor oversight process. You will notice that the following summary of plant performance is organized differently from our previous performance summaries. Instead of characterizing our assessment results by SALP functional area, we are organizing the results into the strategic arenas embodied in the revised reactor oversight process. Additionally, in assessing your performance we have considered the historical performance indicator data that you submitted in January 2000 in conjunction with the inspection results. The results of this PPR were used to establish the inspection plan in accordance with the new risk-informed inspection program (consisting of baseline and supplemental inspections). Although this letter incorporates some terms and concepts associated with the new oversight process, it does not reflect the much

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broader changes in inspection and assessment that will be evident after we have fully implemented our revised reactor oversight process.

During the last 6 months, both units of Comanche Peak Steam Electric Station operated at or near full power until Unit 1 was shut down for refueling. Although the NRC noted some minor performance issues during this assessment period, Comanche Peak Steam Electric Station continues to operate in a safe manner.

We did not identify any significant performance issues in the reactor safety, radiation safety, or safeguards strategic arenas. We did note that you were challenged during the Unit 1 refueling outage by the failure of an electric hoist and subsequent drop of a reactor coolant pump motor. This was inspected in detail by the resident staff. Based on our assessment, only baseline inspections are planned.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were used during this PPR process to arrive at our integrated view of your performance trends. The PIM for this assessment is grouped by the prior SALP functional areas of operations, maintenance, engineering, and plant support, although the future PIM will be organized along the cornerstones of safety as described in the revised reactor oversight process. The enclosed PIM includes items summarized from inspection reports or other docketed correspondence regarding Comanche Peak Steam Electric Station. We did not document all aspects of licensee programs and performance that may be functioning appropriately. Rather, we only documented issues that we believe warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since our last inspection report was issued but had not yet received full review and consideration. We will make this material publically available as part of the normal issuance of our inspection reports and other correspondence.

Enclosure 2 lists our planned inspections for the period April 2000 through March 2001 at Comanche Peak Steam Electric Station to allow you to resolve scheduling conflicts and personnel availability in advance of our inspector arrival onsite. The inspection schedule for the latter half of the period is more tentative and may be adjusted in the future due to emerging performance issues at Comanche Peak Steam Electric Station or other Region IV facilities. Routine resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at (817) 860-8243.

Sincerely,



Joseph I. Tapia, Chief
Project Branch A
Division of Reactor Projects

TXU Electric

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Docket Nos.: 50-445
50-446
License Nos.: NPF-87
NPF-89

Enclosures:

1. Plant Issues Matrix
2. Inspection Plan

cc w/enclosures:

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TXU Electric

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United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV

COMANCHE PEAK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/02/1999	1999015	Pri: OPS Sec:	Licensee	POS	Pri: 1B Sec: 3B Ter:	Good operator performance during a plant transient. Contract workers erecting scaffolding dropped a scaffold pole on the Unit 1 moisture separator reheater drain tank alternate drain valve and it failed open. Operators responded well by isolating the failed-open valve and reducing main turbine load.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
09/30/1999	1999015	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3B Ter:	Good operator performance during midloop operations. Control room operators performed well during the draindown and midloop operations in Unit 1. Reactor coolant system level was monitored on all available instruments which performed as designed. An additional reactor operator was stationed in the control room to monitor the residual heat removal system. This reduced the burden on the reactor operator and allowed him to concentrate on reactor coolant system level indications. Distractions to the operators were kept to a minimum.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
08/21/1999	1999014	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3B Ter:	Good performance by control room operators. Operators conducted themselves in accordance with procedures, training, and licensee management expectations. Communications were formal, clear, and concise and repeat-backs were observed to be enforced by everyone involved. Operators consistently reviewed alarm reference procedures when unexpected alarms were received. Operators scanned the control boards at the appropriate frequency and operators demonstrated a questioning attitude for unexpected indications. Operating logs were clear and concise. Entry into Technical Specification Limiting Conditions for Operation were properly documented and the duration was appropriately minimized through effective planning and scheduling.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
07/10/1999	1999012	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: 3B Ter:	Operators did not enter 4-hour shutdown action statement for feedwater isolation valve. Operators were generally attentive to the control boards and demonstrated a questioning approach towards routine plant operations. Control room operators did not enter a 4-hour shutdown action statement for a feedwater isolation valve which operated abnormally during a surveillance test. Although the licensee was able to demonstrate operability before the 4-hour allowed outage time would have expired, this demonstrated a departure from the licensee's typically conservative decision making.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
06/24/1999	1999301	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	The six applicants for senior operator licenses passed their examinations. The six applicants for senior operator licenses passed their examinations. Applicants demonstrated effective oversight and adequate communication techniques during the dynamic scenarios.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
05/29/1999	1999011	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: Ter:	Control room operators responded well to the loss of the Unit 2, Train A safeguards bus. Control room operators responded well to the loss of the Unit 2, Train A safeguards bus on May 22. The licensee was unable to determine the root cause of the event.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

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Region IV
 COMANCHE PEAK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/29/1999	1999011	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 2A Ter:	Operators performed the restart of Unit 2 in accordance with applicable procedures. During the restart of Unit 2 following the fourth refueling outage, operators performed the return to full power in accordance with applicable procedures. Restoration and cleanup following the outage was completed in a timely manner, with plant equipment in good material condition and properly aligned for normal power operations.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
05/11/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 3B Sec: Ter:	Plant personnel had a good understanding of the corrective action program. Plant personnel had a good understanding of the corrective action program. While all personnel were cognizant of the reporting requirements, some personnel (e.g., contractor personnel), due to their limited knowledge of the process, used a team approach for reporting deviations through their supervision. The implementation of the manual SmartForm process allowed personnel to report deviations without use of the computerized system.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
05/11/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 5B Sec: Ter:	Corrective action program priorities were appropriate and self-assessments were thorough. Corrective action program priorities were appropriate. Self assessments were thorough and intrusive, and the subsequent corrective actions identified by the audits were either already corrected or properly tracked for resolution.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
05/11/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 5B Sec: Ter:	Noncited violations were properly entered into the corrective action program. Noncited violations were properly entered into the corrective action program and were being resolved in a timely and technically adequate manner.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
05/11/1999	1999008	Pri: OPS Sec:	NRC	STR	Pri: 1C Sec: Ter:	Corrective action program was effective and personnel understood the importance of the program. The corrective action program was found to be effective at identifying, resolving and preventing issues that degrade the quality of plant operations. It was noted that both site personnel and management clearly understood the importance of this program. However, there were some examples where the corrective action program controlling procedures were either lacking in guidance or had inappropriate guidance. In spite of these procedure guidance problems, it was found that issues were being conservatively addressed. No issues were identified, that were not already entered into the corrective action program, that was caused by these procedure guidance problems.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/17/1999	1999007	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Operations response to repeated failures of the SG FRV controls was consistent and minimized transients. Operators responded to repeated failures of the Steam Generator 1-02 feedwater regulating valve control system in a consistent manner that minimized the plant transients. After faulty control cards were replaced, no further failures occurred.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

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Region IV
 COMANCHE PEAK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/17/1999	1999007	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: Ter:	Shutdown for 4th Unit 2 refueling outage and cooldown of surge line were well controlled. The conduct of operations reflected a conservative decision-making policy. Both units were operated by knowledgeable operators using good self-verification and peer-checking techniques and communications. The shutdown for the fourth Unit 2 refueling outage was well controlled and, in contrast with past shutdowns for refueling outages, did not end in a reactor trip. The Unit 2 solid plant cooldown from 350 ° F to Mode 5 (less than 200 ° F) allowed better control of pressurizer surge line cooldown rates and was conducted without error. This was the first time operators conducted this procedure and the lack of errors was attributed to effective self- and peer-verification and training.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/17/1999	1999007	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: Ter:	Delay in drain down to mid-loop was conservative and minimized time in reduced inventory. Mid-loop activities were conducted in accordance with procedures and were uneventful. Pre-evolution briefings were comprehensive. Management demonstrated conservative decision-making when the reactor coolant system drain down was delayed until after shift turnover. This minimized the time spent in a reduced inventory condition.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
03/06/1999	1999003	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	The operations department has become more demanding of engineering's operability determinations. The operations department has become more demanding of support organizations concerning operability determinations on safety-related equipment. This was demonstrated by their questioning attitude toward failure of Channel 3 of the Unit 1 N-16 instrument. This was a noted improvement over past instances of accepting equipment as operable after intermittent failures with no root cause determined.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
02/12/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 3B Ter:	Operators generally performed at high skill and competency levels. Operators generally performed at high skill and competency levels while exhibiting good implementation of human performance skills including three-part communication, self-verification, peer checking, procedure use, and supervisory oversight. Crew briefings by the unit supervisor occasionally did not meet the expected frequency. This performance was consistent between shift and staff crews.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
02/12/1999	1999001	Pri: OPS Sec:	NRC	STR	Pri: 1A Sec: 1B Ter: 3B	The operations training organization continues to sustain a high level of performance. The operations training organization continues to sustain a high level of performance in implementing a Systems Approach to Training for the licensed operator requalification program. The recent implementation of the operations self-assessment data base for tracking lessons learned from evolution debriefs, was an example of how the program continues to improve.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

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Region IV
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/13/1999	1999016-01	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: 3B Ter:	Two errors occurred during fuel handling from a lack of attention-to-detail and poor independent verification The licensee made two separate errors during fuel handling activities: (1) the improper positioning of a thimble plug in the incorrect fuel assembly and (2) a sequence error while reloading the Unit 1 core. Both of these errors were attributed to a lack of attention to detail and ineffective independent verification. In both cases, personnel discovered their own errors, suspended activities, and notified their supervisors. The failure to properly implement the fuel shuffle sequence plan in accordance with plant procedures was a violation of Technical Specification 5.4.1. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. The incorrect placement of the thimble plug and the core reload sequence error were entered into the licensee's corrective action program as SmartForms SMF-1999-002717-00 and SMF-1999-002905-00, respectively.
Dockets Discussed: 05000445 Comanche Peak 1						
11/13/1999	1999016-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: 3B Ter:	Missed surveillance for power operated relief valve actuation circuits. On May 10, 1999, the licensee identified that the power-operated relief valve actuation circuits were not properly tested as required by Technical Specification Surveillance Requirements 4.4.4.1 and 4.4.8.3.1. The missed surveillance was reported in accordance with 10 CFR 50.73(a)(2)(B) in Licensee Event Report 50-445;446/99-001-00. Surveillance procedures were appropriately modified and the untested contacts tested satisfactorily during the next shutdown. Technical Specification 3.4.8.3 required the power-operated relief valves to be operable in Modes 4, 5, and 6 for low temperature overpressure protection and Technical Specification 3.4.4 required the power-operated relief valves to be operable in Modes 1, 2, and 3 for overpressure protection. Due to the location of the untested contacts, the licensee concluded that the power operated relief valves remained operable for Modes 1, 2 and 3 because the untested contact did not preclude manual operation of the relief valves. Although the automatic mode of operation was preferred, there was no Technical Specification restriction to rely on manual operation of these valves while in Modes 1, 2 or 3. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as SmartForm SMF-1999-001289-00.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
10/25/1999	1999018	Pri: MAINT Sec:	Licensee	NEG	Pri: 2A Sec: 3A Ter: 3B	Failure of electric hoist due to improper maintenance and lack-of-attention to detail resulted in an uncontrol Failure of an electric chain hoist while lifting the Unit 1 Reactor Coolant Pump 1-03 motor resulted in the 40 ton motor falling 20 to 30 feet before a chain link randomly lodged between the lower chain block and brass guide bar of the hoist and arrested the fall. Licensee personnel in containment were aggressive in verifying all personnel were clear of the area and that there were no injuries. There were no actual safety consequences as a result of this event. However, had the link not randomly lodged in the hoist, the 40 ton motor would have continued to fall, probably landing on the reactor coolant pump flange and damaging the reactor coolant system piping. Although all the reactor fuel had been moved to the spent fuel pool, a rapid draindown of the refueling cavity could have exposed personnel in containment to high doses of radiation from the exposed core barrel, which was stored in the refueling cavity. The licensee's root cause investigation was thorough, probing, and expedient in determining the root cause of the event. The licensee's investigation team determined that improper maintenance resulted in misalignment between the spindle shaft and the planetary gear assembly in one of the hoist's drive trains. This led to failure of that drive train and, ultimately, failure of the entire hoist. Despite several opportunities, the licensee failed to recognize symptoms of the gear misalignment and correct it prior to this event.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
10/02/1999	1999015	Pri: MAINT Sec:	Self	NEG	Pri: 3A Sec: 3B Ter:	Maintenance work resulted in secondary chemistry excursion. Instrument and control technicians demonstrated poor maintenance practices when they inadvertently backfilled pressure transmitter lines with water contaminated with cleaning fluid. This resulted in a high sodium condition in the Unit 2 condensate system. The technicians were unaware of the requirements in Procedure INC-3016, "Backfilling Process Sensors and Sensing Line," which would have precluded this event. The licensee's root cause investigation was thorough, and probed into the root causes of this event.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/02/1999	1999015	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: Ter:	Good plant housekeeping and material condition. Housekeeping and material condition remained good. Significant improvements were noted in the cleanliness of the station service water intake structure. The inspectors walked down a number of manual containment isolation valves in Unit 2 and found them to be in the proper position and in good condition.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
08/21/1999	1999014	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: 2B Ter: 3A	Plant transient resulted from poor EHC system troubleshooting practices. Troubleshooting activities on the Unit 1 electrohydraulic control system resulted in a 140 MWe transient on the main turbine. The decision to reinstall a known failed component in an operating plant system for troubleshooting purposes was contrary to sound practices and resulted in the main turbine transient. The transient presented multiple complex challenges to control room operators and was a contributing factor in a failure of Unit 1 Main Feedwater Pump 1B. In addition, these failures occurred during peak grid loading, which necessitated operating Unit 1 with abnormal equipment conditions for 30 hours while awaiting for grid conditions to support repair activities.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
08/21/1999	1999014	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: 2B Ter: 3A	Inadequate configuration control of the EHC system. Instrumentation and controls technicians demonstrated a questioning attitude by comparing a new speed sensing card with the old card prior to installation however, a lack of adequate design documentation on the cards and incorrect drawings led to the installation of an incorrectly configured circuit card. This had no adverse impact on plant operations since the new card did not work.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
08/21/1999	1999014-01	Pri: MAINT Sec:	NRC	NCV	Pri: 1C Sec: 2A Ter:	Inadequate storage of nonplant equipment. A number of examples were identified where nonplant equipment was stored inappropriately. One example involved two carts full of batteries secured to containment radiation monitoring equipment conduits that were in violation of Station Administrative Procedures. The licensee immediately corrected the problem and entered the condition in their corrective action program for trending (SmartForm SMF-1999-002079-00). This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy.
Dockets Discussed: 05000445 Comanche Peak 1						
07/10/1999	1999012	Pri: MAINT Sec:	NRC	POS	Pri: 1A Sec: Ter:	Plant material condition and cleanliness continued to be good. Overall, plant cleanliness and material condition continue to be good. The licensee took prompt and effective steps to correct minor housekeeping issues as they arose.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
07/10/1999	1999012	Pri: MAINT Sec:	NRC	POS	Pri: 1A Sec: 1C Ter:	Conduct of maintenance and surveillance activities was good. The conduct of maintenance and surveillance activities was good. Maintenance and surveillance activities conducted were well planned and safely coordinated. Personnel directing surveillance tests were knowledgeable, followed the procedures, and maintained good command and control of the activities. The licensee correctly identified and classified the failure of the Unit 2 charging flow control valve as a maintenance preventable functional failure.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV
 COMANCHE PEAK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/29/1999	1999011	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	The conduct of maintenance and surveillance activities during refueling and startup was good. The conduct of maintenance and surveillance activities was good. Maintenance and surveillance activities conducted during the refueling outage and during plant startup were planned and coordinated safely and proficiently. Personnel directing surveillance tests were knowledgeable, followed the procedures, and maintained good command and control of the activities.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
05/18/1999	1999014-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: 3A Ter:	Missed TS surveillance on steam generator gross activity composite sample A licensee event report (LER 50-445;446/99002) was submitted for missing the Technical Specification surveillance requirement for steam generator gross activity composite determination on May 18, 1999. The missed surveillance was caused by chemistry personnel overlooking the directions contained in Chemistry Shift Orders. The following day, the appropriate samples were taken and steam generator gross activity composite was found to be within specification. This condition was entered in the corrective action program (SmartForm SMF-1999-001339-00). The missed Technical Specification surveillance requirement is a Severity Level IV violation of plant Technical Specification 4.7.1.4 which is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
05/11/1999	1999008-01	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: Ter:	Activity performed as minor maintenance required entry into limiting condition for operation. One minor maintenance activity deviated from the guidance in the controlling maintenance procedure in that the activity was conducted as a minor maintenance activity even though it required entry into a technical specification limiting condition for operation. This failure to follow procedures is being treated as a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V. Violation was entered into licensee's corrective action program as SmartForm SMF-1999-1261.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/17/1999	1999007	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Minimum throttle valve gap was not verified prior to marking/locking following ECCS flow balance. Although emergency core cooling flow balancing was acceptable, a minor problem involving the licensee not verifying the minimum throttle valve gap size prior to ordering the throttle valves locked and marked was identified by the inspector. After checking throttle valve gap size, at least one throttle valve had to be unlocked and readjusted. The flow balancing was reperfomed with no problems.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/17/1999	1999007	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Safety practices and equipment were used, workers were careful to exclude foreign material from systems. Maintenance activities were conducted in accordance with approved procedures and good work practices. Effective communication between work organizations was observed. Personnel protective equipment was used appropriately and effective personnel safety practices were observed. Maintenance workers were careful to exclude foreign material from systems. Some minor problems were noted with the storage of non-plant equipment and foreign material exclusion but all were corrected immediately by the licensee.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/17/1999	1999007	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Surveillance activities were generally conducted well and self checking was noted. Surveillance activities were generally conducted in accordance with approved procedures and were well coordinated. Good self-checking and peer-verification was noted. Communications between personnel conducting surveillances were clear and included formal repeat backs.
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12/25/1999	1999018-01	Pri: ENG Sec:	NRC	NCV	Pri: 4B Sec: 1C Ter: 3B	Inadequate abnormal operating procedures for loss of coolant while shutdown The postulated drop of a reactor coolant pump motor onto reactor coolant piping which would result in a reactor coolant leak in Mode 5 with fuel in the reactor would require at least one containment sump for decay heat removal. No procedural controls were developed to maintain at least one sump available while in Mode 5 during heavy load lifts even though abnormal operating procedures directed operators to shift the residual heat removal system suction to the containment sumps following a postulated loss of reactor coolant. The failure to have procedural controls for an available containment sump in Mode 5 during heavy load lifts is a violation of Technical Specification 5.4.1. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as SmartForm 1999-003178-00.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
12/25/1999	1999018-02	Pri: ENG Sec:	Licensee	NCV	Pri: 4C Sec: 4B Ter: 3B	Failure to translate system requirements into design specifications. On June 17, 1998, the licensee determined that the hydrogen purge system would not function as described in the Final Safety Analysis Report or the Design Basis Document and appropriately wrote Licensee Event Report 98-005-00. The FSAR and DBD state that the system can be operated with containment pressures between 0 and 5 psig. However, at containment pressures above 0 psig, the flow rate through the filter elements would exceed the design limits; therefore, the charcoal adsorber residence stay times required by NRC Regulatory Guide 1.140 and ANSI N509-1976 would not be satisfied. The failure to adequately translate the design requirement for maximum flow rates through the hydrogen purge system into design specifications is a violation of 10 CFR Part 50, Appendix B, Criterion III. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This condition was entered into the licensee's corrective action program as SmartForm SMF-1999-000487-00.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
10/02/1999	1999015	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Good safety evaluation for dual train outage. The licensee's safety evaluation for the Unit 1 dual train component cooling water and emergency diesel generator system outages was clear and concise. Limits established by the evaluation were properly translated into defense-in-depth contingency plans and monitored by plant personnel.
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08/21/1999	1999014	Pri: ENG Sec:	NRC	NEG	Pri: 3B Sec: 4B Ter:	Engineering evaluation of ECCS failed to consider multiple degraded conditions. The inspectors consulted with the NRC Office of Nuclear Reactor Regulation and concluded that the emergency core cooling system remained operable despite the nonconforming condition associated with throttle valve erosion. The licensee took adequate and timely corrective actions to address this condition. Although no violation of regulatory requirements was identified, the licensee failed to consider the degraded throttle valve issue in an operability evaluation associated with pressure locking of motor-operated valves. The licensee's failure to consider synergistic effects of multiple degraded conditions was a departure from past good performance.
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08/21/1999	1999014-03	Pri: ENG Sec:	Licensee	NCV	Pri: 3B Sec: 4B Ter:	Poorly implemented design modifications were identified during the Unit 2 outage. Several poorly implemented design modifications were identified during the fourth Unit 2 refueling outage. The first example involved the installation of expansion joints on steam generator atmospheric relief valves not qualified for the calculated pressure in the design modification. The second involved a nonconforming condition caused by a failure to remove shipping bars prior to the installation of several auxiliary feedwater system check valves. The shipping bar prevented the affected check valves from stroking to their full open position. The third example involved the installation of emergency core cooling throttle valves with the incorrect insert nozzle throat diameter. Appropriate immediate corrective actions were taken and the specific root causes associated with each issue were identified. Poor documentation of communications between vendors and engineering, inconsistent turnover between lead engineers, and tight vendor schedules were found to contribute to the problems. Inadequate work instructions contributed significantly to the installation of nonconforming auxiliary feedwater check valves in the plant. This condition was entered into the licensee's corrective action program (SmartForm SMF/PIR 1999-001103-01-00). This was a Severity Level IV violation of Technical Specification 6.8.1. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy.
Dockets Discussed: 05000446 Comanche Peak 2						
08/21/1999	1999014-04	Pri: ENG Sec:	NRC	NCV	Pri: 3B Sec: Ter:	Design Change did not comply with ANSI/ASME Code N509-1976 requirements. The inspectors identified that the licensee implemented a design change to the control room emergency pressurization system that did not conform to the ANSI/ASME Code N509-1976 requirement that the heat generated from radioactive decay and adsorption of iodine be considered when developing these setpoints. The failure to include appropriate design control measures in Design Change 12503, Revision 0, was a Severity Level IV violation of 10 CFR, Part 50, Appendix B, Section III, "Design Control. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. The licensee's immediate operability evaluation concluded that the design change error did not affect the radiation dose to operators for a postulated design bases accident. The licensee appropriately placed the issue in their corrective action program (SmartForm SMF-1999-001744-00).
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
07/10/1999	1999012	Pri: ENG Sec:	Licensee	POS	Pri: 4B Sec: 4C Ter:	Thorough evaluation of 6.9kV and 480V setpoints prior to placing in TRM revealed nonconservative values. The licensee was thorough in the evaluation of 6.9 kV and 480 volt relay setpoints as these setpoints were transferred from existing Technical Specifications to the Technical Requirements Manual during transition to Improved Technical Specifications. The licensee reviewed the basis for the setpoint data, which revealed several nonconservative values, rather than transferring it directly to the Technical Requirements Manual. Immediate corrective actions taken were appropriate and the remaining corrective actions will be tracked in the licensee's corrective action program.
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06/18/1999	1999010	Pri: ENG Sec:	NRC	NEG	Pri: 4A Sec: Ter:	CCW design calculations did not account for pump degradation, and IN 97-90 review was inadequate. The component cooling water heat exchanger monitoring program and resultant surveillance program comprised an effective method of assuring that the equipment was adequate. However, the design calculations did not provide for a pump degradation margin, nor was it accounted for in the IST surveillance procedure. Additionally, the review of the NRC Information Notice 97-90 was inadequate. The team considered this to be an indication of a poor translation of the design basis into plant procedures during initial facility licensing and the subsequent heat exchanger return valve throttling modification.
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06/18/1999	1999010	Pri: ENG Sec:	NRC	NEG	Pri: 4A Sec: 4B Ter:	Inability to accurately measure CCW flow to set valve positions was a design deficiency. The inability to ensure accurately measured component cooling water flow from the residual heat removal and containment spray heat exchangers to set valve control limit switches represented a design deficiency. The team also identified an inability of the licensee's design and safety evaluation programs to identify and address a potential for electronic interference due to the installation of new equipment. The team concluded this was an isolated problem. Overall, the design modification package for replacing the inverter and battery charger was of good quality.
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06/18/1999	1999010	Pri: ENG Sec:	NRC	NEG	Pri: 4C Sec: Ter:	Lack of rigor, poor safety evaluation and post-modification testing related to modification to cooling water v. The modification to throttle safety-related heat exchanger cooling water return valves was indicative of a lack of sufficient rigor. The team identified findings that related to poor performance of the safety evaluation and the adequacy of post-modification testing.
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06/18/1999	1999010	Pri: ENG Sec:	NRC	NEG	Pri: 4C Sec: Ter:	Significant calculational discrepancies included nonconservative assumptions and failure to update inputs. The licensee had a comprehensive process in place for control of calculations. The calculation for the heat exchanger fouling was an example of the pro-active engineering actions. However, a number of significant calculational discrepancies included use of nonconservative assumptions and the failure to update design inputs in all of the calculations affected by system modifications.
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06/18/1999	1999010	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Engineering became more effective in the control of work and closure of backlog task items. Associated with the 1996 reorganization, the engineering organization apparently became more effective in the control of work and the closure of backlog task items, despite a reduced staff.
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06/18/1999	1999010	Pri: ENG Sec:	NRC	POS	Pri: 5C Sec: Ter:	Corrective action program for CCW was effective, licensee was very aggressive in identifying prematurely cl Implementation of the corrective action program relative to the CCW system, including evaluations, technical reviews, and corrective actions, was effective. The change in philosophical approach from ONE Forms to SmartForms regarding closure of corrective action documents was an administrative enhancement, which reduced the potential for not completing identified corrective actions. Upon discovery of a failure to implement corrective actions after a ONE Form had been prematurely closed, licensee personnel were very aggressive in identifying similar conditions.
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06/18/1999	1999010-01	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	Failure to Correctly Implement a Modification onthe CCW System The failure to correctly implement facility design modification process elements related to conservatism in calculations, validation of uncertainties, instrument loop uncertainties, post-modification testing, and the potential for inducing degradation due to a modification, was a noncited violation of Criterion III of Appendix B to 10 CFR Part 50. The licensee addressed these issues in SmartForms 1999-1326, 1999-1377, 1999-1396, and 1999-1397.
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06/18/1999	1999010-02	Pri: ENG Sec:	NRC	NCV	Pri: 2B	Failure to Perform Required Surveillance Testing of Station Battery The missed surveillance service test for Unit 1 Battery BT1ED2 was a noncited violation of Technical Specification 4.8.2.1.d. However, the surveillance tests conducted were adequate to ensure plant operation under normal, abnormal, and emergency conditions. Enforcement discretion was granted by the Office of Nuclear Reactor Regulation for the inspection team-identified missed BT1ED2 battery surveillance and a plant shutdown was not required (EA 99-197). The attention to detail in scheduling, conducting, and reviewing battery surveillance testing needed improvement to achieve adequate surveillance testing.
Dockets Discussed: 05000445 Comanche Peak 1						
06/18/1999	1999010-03	Pri: ENG Sec:	NRC	NCV	Pri: 4C	Failure to Perform Temporary Modification Evaluations and Required Walkdowns Generally, temporary modifications were controlled in accordance with the governing procedures. There was one identified instance in which licensee personnel failed to document authorization and implementation of a change to a temporary modification. The team observed that the temporary modification extension and justification process appeared to be ineffective, in that, the review failed to recognize that the changes to the temporary modification itself occurred, which might have impacted the original evaluation. In addition, the team identified a failure by licensee personnel to perform walkdowns at the specified frequency to verify that temporary modifications were correctly installed. Both of these conditions were examples of a noncited violation of Criterion V of Appendix B to 10 CFR Part 50. The licensee initiated SmartForms 1999-1321 and 1999-1384 to address these issues.
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05/29/1999	1999011	Pri: ENG Sec:	NRC	POS	Pri: 4B	System engineering provided good support by promptly evaluating an Accumulator 2-04 leak. Safety Injection Accumulator 2-04 developed a small intersystem leak. System engineering provided good support to safe plant operation by promptly evaluating the impact of the leakage and identifying the source. The troubleshooting plan was thorough and appropriately documented per plant procedures.
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05/11/1999	1999008	Pri: ENG Sec:	NRC	NEG	Pri: 4C	Tracking repeated fuse failures was hampered by licensee's policy on fuse replacement. Although a large number of work activities were identified for loose or hot fuse clips, an effective thermography surveillance testing program was identifying and correcting fuse problems before failures occurred. Proper plant configuration was maintained by effectively controlling failed fuse replacement. However, tracking repeated electrical fuse failures was reduced by the licensee's policy on replacement.
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05/11/1999	1999008-02	Pri: ENG Sec:	Licensee	NCV	Pri: 4B	Failure to identify and correct 6.9kV and 480V circuit breakers and motor operators problems was an NCV. Failures of 6.9 kV and 480V circuit breakers were not promptly identified and corrected and were the first and second examples of a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI. A licensee-identified failure to promptly identify and correct a motor-operated valve problem identified by industry update information was a third example of a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI. Subsequent corrective actions were prioritized properly. This violation was entered into the licensee's corrective action program as SmartForms SMF-1999-268, SMF-1999-1259, and SMF-1999-1291.
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04/17/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4C	Licensee review of AFW was performed with adequate degree of confidence The licensee review of the Auxiliary Feedwater System was performed in such a way that an adequate degree of confidence existed that deficient surveillance procedures for testing of system safety-related logic circuits had been properly identified and the surveillance procedures had been adequately revised.
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04/17/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	Industry Operating Experience Report program adequately addressed Generic Letter 96-01 issues. Based on a sample of Generic Letter 96-01 deficiencies identified by other licensees, the licensee's Industry Operating Experience Report Review Program adequately addressed these deficiencies.
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03/06/1999	1999003	Pri: ENG Sec:	NRC	NEG	Pri: 4C Sec: Ter:	Previously identified degraded conditions were not considered in current operability determinations. The licensee failed to include important information about degraded emergency core cooling system performance in their motor-operated valve pressure locking issue operability review. As a result, engineers improperly concluded that the emergency core cooling system hot-leg injection mode was still operational following a design basis loss-of-coolant accident. The licensee had no formal process for ensuring that existing degraded conditions identified in the past were considered in current operability evaluations.
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03/06/1999	1999003	Pri: ENG Sec:	NRC	NEG	Pri: 4C Sec: Ter:	Justification for continued operation was based partially on unsupported engineering judgement. The licensee's justification for continued plant operation, which addressed an adverse condition associated with emergency core cooling throttle valve erosion, partially relied on a Westinghouse topical submittal which had been withdrawn from the NRC in October 1998. The submittal, which proposed the elimination of the emergency core cooling system hot-leg recirculation mode following a loss-of-coolant accident, had been withdrawn because it was technically incorrect in assuming that the core barrel-to-vessel gap was sufficient to allow flow under all conditions. As a result, the licensee's justification for continued operation was based partially on unsupported engineering judgement.
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02/18/1999	1998009	Pri: ENG Sec:	NRC	NEG	Pri: 4A Sec: Ter:	A generator load rejection occurred which should have been beyond the capability to sustain operation. On January 3, 1999, a significant main generator load rejection occurred which should have been beyond the capability of Unit 2 to remain in operation. This was attributed to the large capacity of the steam dumps which also caused reactor coolant system overcooling following reactor trips. The propensity for reactor coolant system overcooling has sensitized operators toward rapidly securing the turbine-driven auxiliary feedwater pump following a reactor trip to prevent an inadvertent safety injection from occurring. Modifications to the steam dumps were being considered.
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01/21/2000	2000002	Pri: PLTSUP Sec:	NRC	WK	Pri: 1C Sec: 4A Ter:	Design Weakness in Security System. A weakness in the design of the security system allowed an individual security officer to grant unescorted access to individuals without the knowledge of any other security officer or plant employee. This weakness was corrected during the inspection.
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01/21/2000	2000002-01	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: 3B Ter:	Unescorted Access Authorization Granted Prior to Completion of Required Plant Access Training and Testin A violation of the security plan and a security procedure was identified for granting an employee unescorted protected area access prior to the employee successfully completing plant access and fitness-for-duty training and testing. This Severity Level IV violation is being treated as a noncited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This violation was entered into the licensees corrective action program as Smart Form SMF-1999-000698-00.
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10/02/1999	1999015	Pri: PLTSUP Sec:	Licensee	NEG	Pri: 3B Sec: Ter:	Weaknesses in contractor radiation worker training program. Three examples of poor radiological practices involved contract employees and situations which were covered by the licensee's radiation worker training program. This was indicative of weaknesses in the radiation worker training program for contractors.
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10/02/1999	1999015	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Licensee exercised Y2K contingency plan. Technical Support Center staff performance during the "Y2K" emergency drill was good. The licensee simulated a partial loss of the plant's telephone system. Personnel responded well and were able to reestablish the required lines of communications. The concept of a "Y2K Center" to deal with year 2000 specific transition problems was a good initiative.
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10/02/1999	1999015	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: Ter:	Quality assurance department effective in identifying performance trends. Two examples of poor radiological practices were identified by the licensee's quality assurance organization during routine observations and evaluations, which was indicative of a good questioning attitude and their effectiveness in identifying performance issues.
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10/02/1999	1999015-01	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 3A Sec: 3B Ter:	Radiological Controls Practices Not in Accordance with Plant Procedures Several examples of poor radiological control practices were observed by the inspectors and the licensee during the Unit 1 refueling outage. In one example, an individual failed to contact radiation protection technicians when he observed erratic indications on his electronic dosimeter. In two other instances, personnel failed to follow the requirements of Station Administration Manual STA-656, "Radiation Work Control." Failure to follow this procedure was a violation of Technical Specification 5.4.1. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. These examples are included in the licensee's corrective action program as Smart Forms SMF-1999-2502 and SMF-1999-2530.
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10/02/1999	1999015-02	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 3A Sec: Ter:	Failure to Post the Station Service Water Tunnel as a Radiation Area The licensee improperly released the station service water tunnel from the radiologically controlled area based on inadequate radiation surveys. Although this did not result in any significant unmonitored dose to individuals working in the area nor did it exceed the posting requirements of 10 CFR 20.1902, the failure to properly post the tunnel in accordance with licensee procedures for approximately 8 months was a violation of Technical Specification 5.4.1. This Severity Level IV violation is being treated as a noncited violation, consistent with Appendix C of the NRC Enforcement Policy. This condition was entered into the licensee's corrective action program as Smart Form SMF-1999-1850.
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07/23/1999	1999013	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Implementing procedure not consistent with emergency plan for minimum EOF staffing. A licensee emergency plan implementing procedure concerning the activation and operation of the emergency operations facility was not consistent with the emergency plan in that it stated that the facility could be considered activated with only three key personnel present while the plan required six.
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07/23/1999	1999013	Pri: PLTSUP Sec:	NRC	STR	Pri: 1C Sec: 3A Ter:	Overall emergency response performance was good and TSC engineering support was noteworthy. Overall, performance was good. The control room, technical support center, operations support center, and emergency operations facility successfully implemented key emergency plan functions including emergency classifications, notifications, protective action recommendations, and dose assessment. Engineering analysis and support from the technical support center was noteworthy.
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07/21/1999	1999013	Pri: PLTSUP Sec:	Licensee	NEG	Pri: 1C Sec: Ter:	One EOF notification with updated PARs was unnecessarily delayed due to facility briefing and concurrence One notification from the emergency operations facility, which contained updated protective action recommendations, was unnecessarily delayed due to a facility briefing and obtaining the Texas Bureau of Radiation Controls concurrence prior to the notification.
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07/21/1999	1999013	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: 5A Ter:	Control room post-exercise critique did not include normal conduct of operations or basic operator knowledge The licensee's post-exercise facility debriefs and the management critique were generally thorough, open, and self critical. However, in the control room simulator, the licensee did not discuss issues concerning normal conduct of operations or basic operator knowledge even though these areas could affect emergency response efforts.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
07/10/1999	1999012	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3B Sec: Ter:	Radiation workers lack of knowledge of PM-7 portal monitor operation. Radiation workers demonstrated a lack of knowledge on the operation of the PM-7 portal monitor. As a direct result, approximately 20 radiation workers did not recognize an actual alarming condition when an individual who recently had a radio-chemical treatment for medical reasons caused all the PM-7 portal monitors to alarm as out of service, an expected alarm condition for high radiation background.
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07/10/1999	1999012	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Transfer of resin to high-integrity container performed by knowledgeable personnel. Personnel involved in the transfer of spent resin to a high-integrity container for shipment offsite were knowledgeable of the procedure and the expected dose rates during the process. Radiation protection technicians were effective in maintaining the dose ALARA during the evolution.
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06/18/1999	1999010-04	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Failure to Assure Safe Shutdown Capability A design basis fire in the cable spreading room had the potential to cause the spurious opening of the RHR system hot-leg isolation valves and the licensee's alternative shutdown capability for the cable spreading room was not capable of mitigating the resulting transient. Therefore, the licensee was not in compliance with its fire protection program because the ability to safely shut down the plant was challenged in the event a design basis fire occurred in the cable spreading room. Operating License Section 2.G requires the licensee to implement and maintain in effect all provisions of the approved fire protection program as described in the Final Safety Analysis Report and this occurrence was considered a violation of Operating License, Section 2.G. However, discretion is being exercised after consultation with the Office of Enforcement pursuant to Section VII.B.6 of the Enforcement Policy and a violation is not being cited on the basis of the licensee's timely and effective corrective action pursuant to the guidance in Enforcement Guidance Memorandum 98-02, Revision 1 (EA 99-203). The licensee had identified the necessary corrective actions in SmartForm 1998-2203, which was being closed. This closed LER 50-445/98007-00 and -01.
Dockets Discussed: 05000445 Comanche Peak 1						
04/23/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Effective in-place filter maintenance and testing program was implemented. An effective maintenance and testing program was implemented for the in-place filter and laboratory charcoal testing of the engineered-safety-feature ventilation filter systems.
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04/23/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Liquid and gaseous effluent rad monitors were operable and maintained. The liquid and gaseous effluent radiation monitors were operable and properly maintained, tested, and calibrated in accordance with Offsite Dose Calculation Manual requirements. Effluent radiation monitor alarm set points were properly calculated and installed.
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04/23/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 3B Sec: Ter:	Training and qualification programs for the chemistry, radiation protection, and radwaste staff were proper. Training and qualification programs for the chemistry technical staff, radiation protection technical support staff, and radwaste plant equipment operators were properly implemented. The chemistry, radiation protection, and radwaste operations departments maintained well trained, qualified, and experienced staffs for conducting sampling, analyses, processing, and release operations for radioactive waste effluents.
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04/23/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 5C Ter:	Licensee's assessment program for radwaste effluent program was good. The licensee's assessment program of the radioactive waste effluent program was good. The auditors assigned to perform the assessment of the radioactive waste effluent program were well qualified to perform the radioactive waste effluent program evaluations. The annual nuclear overview evaluations provided management with a good perspective to assess the radioactive waste effluent program. The contractor laboratories used to perform surveillance testing of the engineered-safety-related ventilation filter systems and the radioactive waste effluent samples were properly evaluated.
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04/23/1999	1999009	Pri: PLTSUP Sec:	NRC	STR	Pri: 1C Sec: Ter:	An excellent liquid and gaseous radwaste management program was implemented. An excellent liquid and gaseous radioactive waste effluent management program was implemented. The processing, sampling, and analyses of radioactive liquid and gaseous waste effluents and the approval and performance of waste discharges were conducted in accordance with Offsite Dose Calculation Manual requirements. Excellent performance was noted in the reduction of liquid effluent volume, gamma radionuclide curies released, and offsite dose. Since 1993, the volume of liquid radioactive waste discharged was reduced approximately 80 percent, and the curie amount of radioactive liquid effluent mixed fission and activation products released showed a 74 percent reduction resulting in a dose reduction of approximately 99.6 percent. Since 1994, the gaseous effluent activity released decreased approximately 99.4 percent.
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04/17/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 1A Sec: Ter:	Management conservative decisions minimized radiation worker dose. Licensee management demonstrated conservative decision-making when they pre-approved various radiation worker limitations and temporary shielding that increased the duration of the outage but minimized radiation worker dose. Overall, radiation protection personnel conducted effective radiation and contamination surveys. The planned dose for the Unit 2 refueling outage was 190 person-rem. Actual dose received was 101.7 person-rem which was approximately 40 person-rem less than the last Unit 2 refueling outage.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/09/1999	1999006-02	Pri: PLTSUP Sec:	NRC	NCV	Pri: 3A Sec: 3C Ter:	Failure to perform complete radiological evaluations on temporary shielding packages. A violation of Technical Specification 6.8.1 was identified for failure to perform complete radiological exposure evaluations on three separate temporary shielding packages as required by a radiation protection program procedure. This Severity Level IV violation is being treated as a non-cited violation, consistent with Appendix C of the NRC Enforcement Policy. This violation was placed in the licensee's corrective action program as SMART Form SMF-1999-000813-00.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/02/1999	1999006	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3A Sec: 3C Ter:	RP failed to evaluate rad levels and post hot spots in accordance with expectations. Radiation protection personnel failed to evaluate radiation levels and post hot spots in accordance with expectations.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/02/1999	1999006	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3B Sec: Ter:	Rad workers did not respond to continuous air monitor alarms. On two occasions, radiation workers, in a high traffic area of containment, did not respond to continuous air monitor audible and visual alert/fault alarms in accordance with management expectations.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/02/1999	1999006	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	ALARA program was acceptably implemented. The ALARA program was acceptably implemented. ALARA considerations were properly incorporated into the outage schedule and were generally well implemented. Radiological work packages were effectively planned, and ALARA personnel were involved during the implementation stage. Lessons learned from past similar work were incorporated into the radiological work packages. Station and task activity doses were tracked and trended by the ALARA staff. The Unit 2 refueling outage dose as of March 31, 1999, was approximately 36 person-rem. Effective chemistry shutdown plans and controls were implemented. Appropriate radiation protection instrumentation, protective clothing, and consumable supplies were available to support radiological work.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV
COMANCHE PEAK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/02/1999	1999006	Pri: PLTSUP Sec:	NRC	POS	Pri: 3B Sec: Ter:	Contract RP technician training program was effectively implemented. The contract radiation protection technician training program was effectively implemented. Radiation protection management was involved in the development of the contract radiation protection technician training program and qualification task topics. Qualification tasks included all the tasks assigned to contract senior radiation protection technicians. Contract senior radiation protection technicians met the technical experience requirement of Technical Specification 6.3.1.b and the training requirements delineated in station procedures.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
04/02/1999	1999006-01	Pri: PLTSUP Sec:	NRC	NCV	Pri: 3A Sec: 3C Ter:	Failure to perform radiological surveys. A violation of 10 CFR 20.1501(a) was identified for failure to evaluate the airborne concentrations and potential radiological hazards that could be present in the spent fuel pool work area on the 860-foot elevation of the fuel building. This is the first example of a Severity Level IV violation that is being treated as a non-cited violation, consistent with Appendix C of the NRC Enforcement Policy. A second violation of 10 CFR 20.1501(a) was identified for failure to ensure the radioactive airborne quality from Steam Generators 1 and 4 portable ventilation units. These violations were placed in the licensee's corrective action program as SMART Form SMF-1999-000808-00. A third violation of 10 CFR 20.1501(a) was identified for failure to evaluate the airborne concentrations and potential radiological hazards that could be present inside Steam Generator 3. This violation was placed in the licensee's corrective action program as SMART Form SMF-1999-000818-00.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
03/06/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1A Sec: Ter:	Plant cleanliness remains very good, despite extensive work in the Unit 2 turbine building. Plant cleanliness remains very good, despite extensive work in the Unit 2 turbine building and outage preparations in all areas of Unit 2. Extensive scaffolding was erected in support of the outage but was not observed to interfere with safety-related equipment.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
03/06/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3B Ter:	The inspectors observed good radiological practices being implemented by plant personnel. The inspectors observed good radiological practices being implemented by plant personnel. Workers were familiar with their radiological work permit requirements. The inspectors accompanied licensee personnel into the Unit 2 containment during power operations and observed good contamination controls and ALARA practices.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
03/06/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3B Ter:	Security drills conducted were appropriately monitored and controlled. The scenarios were challenging. The inspector found that the security drills conducted were appropriately monitored and controlled. The scenarios were challenging and maximized the opportunity to identify weaknesses.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
03/06/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3B Ter:	Plant personnel were quick to respond to a report of a grass fire on plant property. Plant personnel were quick to respond to a report of a grass fire on plant property. Although no structures or safety-related equipment were threatened by the fire, high winds and dry conditions aggravated the situation. The plant fire brigade performed well in extinguishing the fire.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV

COMANCHE PEAK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/26/1999	1999005	Pri: PLTSUP Sec:	NRC	NEG	Pri: 4C Sec: Ter:	Licensee failed to request renewal of its QA program within 30 days of expiration. Due to tracking system errors, the licensee failed to request renewal of its quality assurance program within 30 days of expiration. The NRC expedited its quality assurance program renewal so the licensee could continue radioactive shipping activities.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
02/26/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 2A Sec: Ter:	Housekeeping throughout the radiological controlled areas was very good. Housekeeping throughout the radiological controlled areas was very good.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
02/26/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 5B Ter:	Comprehensive audits and corrective actions were effective for the solid radwaste program. Comprehensive audits performed by qualified personnel effectively evaluated the solid radioactive waste management and radioactive waste/material transportation programs. The corrective action process was effectively used to identify problems, perform evaluations and assessments, and implement prompt corrective actions.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
02/26/1999	1999005	Pri: PLTSUP Sec:	NRC	STR	Pri: 1A Sec: 1C Ter:	Solid radwaste management and transportation programs implemented well. The solid radioactive waste management and radioactive waste/material transportation programs were implemented well. Waste stream sampling and analysis met regulatory requirements. Solid radioactive waste was properly classified and characterized for shipment and disposal. Shipping papers contained the required information, and packages were properly surveyed and labeled. The process of preparing for shipment a high integrity container with exposure rates up to 23 rem/hr was conducted very proficiently keeping radiation exposures ALARA.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						
02/26/1999	1999005-01	Pri: PLTSUP Sec:	NRC	NCV	Pri: 3B Sec: Ter:	Failure to perform required training for two radwaste quality control inspectors. A violation of 49 CFR 172.704 was identified involving the failure of two radwaste quality control inspectors to receive function specific training every three years. This violation is in the licensee's corrective action program as SMART Form 1999-000371. This Severity Level IV Violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy.
Dockets Discussed: 05000445 Comanche Peak 1						
01/29/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1A Sec: 5A Ter:	Comprehensive audits effectively evaluated the radiological environmental monitoring program. Comprehensive audits, performed by qualified personnel, effectively evaluated the radiological environmental monitoring program. The corrective action process was effectively used to identify problems, perform evaluations and assessments, and implement prompt corrective actions.
Dockets Discussed: 05000445 Comanche Peak 1 05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region IV

COMANCHE PEAK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/29/1999	1999004	Pri: PLTSUP Sec:	NRC	STR	Pri: 1A Sec: 1C Ter:	An excellent radiological environmental monitoring program was implemented. An excellent radiological environmental monitoring program was implemented in accordance with the Technical Specifications and the Offsite Dose Calculation Manual requirements. A well trained, experienced, and qualified staff were responsible for implementing the radiological environmental monitoring program. In 1997, no environmental air samples were missed indicating that the air sampling program was effectively implemented. Sample collection, shipment, and analyses report records were meticulously maintained. An effective meteorological monitoring program was in place. The meteorological towers were properly maintained with all instrumentation calibrated at the proper frequencies. Data recovery was greater than 90 percent in 1997 and 1998.
Dockets Discussed:						
05000445 Comanche Peak 1						
05000446 Comanche Peak 2						

United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

By Primary Functional Area

Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
E EI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

COMANCHE PEAK
Inspection / Activity Plan
04/02/2000 - 03/31/2001

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates Start	Planned Dates End	Inspection Type
	RPBA17	- DRILL, EXERCISE AND EVENT EVALUATION	2				
1, 2	IP 7111406	Drill Evaluation		2	04/02/2000	07/08/2000	Baseline Inspections
	RPBA13	- TEMPORARY PLANT MODIFICATIONS	2				
1, 2	IP 7111123	Temporary Plant Modifications		2	04/02/2000	03/31/2001	Baseline Inspections
	EMB	- 50.59	2				
1, 2	IP 7111102	Evaluation of Changes, Tests, or Experiments		1	04/24/2000	04/27/2000	Baseline Inspections
	PSB-RP1	- EFFLUENTS	3				
1, 2	IP 7112201	Radioactive Gaseous and Liquid Effluent Treatment and Monitoring Systems		2	05/01/2000	05/05/2000	Baseline Inspections
	PBA-TI	- TI-144, PI DATA REVIEW	1				
1, 2	IP 2515/144	Performance Indicator Data Collecting and Reporting Process Review		1	05/14/2000	08/05/2000	Safety Issues
	PSB-RP7	- ENVIRONMENTAL MONITORING	1				
1, 2	IP 7112203	Radiological Environmental Monitoring Program		1	05/15/2000	05/19/2000	Baseline Inspections
	PSB-RP2	- RAD MATERIAL PROCESSING/SHIPPING	1				
1, 2	IP 7112202	Radioactive Material Processing and Transportation		1	06/26/2000	06/30/2000	Baseline Inspections
	PSB-RP3	- RAD MONITORING INSTR	1				
1, 2	IP 7112103	Radiation Monitoring Instrumentation		1	06/26/2000	06/30/2000	Baseline Inspections
	RPBA21	- EQUIPMENT ALIGNMENTS	2				
1, 2	IP 7111104	Equipment Alignment		2	07/09/2000	08/19/2000	Baseline Inspections
	PSB-EP1	- A&N, ERO, PI&R, EAL/EP, PIV	2				
1, 2	IP 7111402	Alert and Notification System Testing		2	07/17/2000	07/21/2000	Baseline Inspections
1, 2	IP 7111403	Emergency Response Organization Augmentation Testing		2	07/17/2000	07/21/2000	Baseline Inspections
1, 2	IP 7111404	Emergency Action Level and Emergency Plan Changes		2	07/17/2000	07/21/2000	Baseline Inspections
1, 2	IP 7111405	Correction of Emergency Preparedness Weaknesses and Deficiencies		2	07/17/2000	07/21/2000	Baseline Inspections
1, 2	IP 71151	Performance Indicator Verification		2	07/17/2000	07/21/2000	Baseline Inspections
	OB-PIR	- PIR INSPECT	5				
1, 2	IP 71152	Identification and Resolution of Problems		3	07/31/2000	08/04/2000	Baseline Inspections
	EMB	- MAINT RULE IMPLEMENTATION	1				
1, 2	IP 7111112B	Maintenance Rule Implementation		1	08/28/2000	09/01/2000	Baseline Inspections
	PSB-RP4	- ALARA PLANNING/CONTROL 1	1				
1, 2	IP 7112102	ALARA Planning and Controls		1	09/25/2000	09/29/2000	Baseline Inspections
	EMB	- ISI	1				
1, 2	IP 7111108	Inservice Inspection Activities		1	10/02/2000	10/06/2000	Baseline Inspections
	EMB	- SSD&PC BAGMAN	1				
1, 2	IP 7111121	Safety System Design and Performance Capability		1	10/02/2000	10/06/2000	Baseline Inspections
	RPBA25	- ADVERSE WEATHER	2				
1, 2	IP 7111101	Adverse Weather Protection		2	10/08/2000	01/13/2001	Baseline Inspections

This report does not include INPO and OUTAGE activities.
This report shows only on-site and announced inspection procedures.

COMANCHE PEAK
Inspection / Activity Plan
04/02/2000 - 03/31/2001

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates		Inspection Type
					Start	End	
	PSB-RP5	- ACCESS TO RAD SIGN AREAS AND PIV	1				
1,2	IP 7112101	Access Control to Radiologically Significant Areas		1	10/09/2000	10/13/2000	Baseline Inspections
1,2	IP 71151	Performance Indicator Verification		1	10/09/2000	10/13/2000	Baseline Inspections
	PSB-S1	- ACCESS AUTH/CONTROL, SEC PLAN, AND PIV	1				
1,2	IP 7113001	Access Authorization Program (Behavior Observation Only)		1	10/23/2000	10/27/2000	Baseline Inspections
1,2	IP 7113002	Access Control (Search of Personnel, Packages, and Vehicles: Identification ar		1	10/23/2000	10/27/2000	Baseline Inspections
1,2	IP 7113004	Security Plan Changes		1	10/23/2000	10/27/2000	Baseline Inspections
1,2	IP 71151	Performance Indicator Verification		1	10/23/2000	10/27/2000	Baseline Inspections
	EMB	- SSD&PC	7				
1,2	IP 7111121	Safety System Design and Performance Capability		4	10/30/2000	11/17/2000	Baseline Inspections
	PSB-RP6	- ALARA PLANNING/CONTROL 2	2				
1,2	IP 7112102	ALARA Planning and Controls		2	12/18/2000	12/22/2000	Baseline Inspections
	RPBA22	- EQUIPMENT ALIGNMENTS	2				
1,2	IP 7111104	Equipment Alignment		2	01/14/2001	02/24/2001	Baseline Inspections
	RPBA20	- DRILL, EXERCISE AND EVENT EVALUATION	2				
1,2	IP 7111406	Drill Evaluation		2	01/14/2001	03/31/2001	Baseline Inspections
	OB-RQ	- REQUAL INSP	3				
1,2	IP 7111111B	Licensed Operator Requalification		2	02/12/2001	02/16/2001	Baseline Inspections
	EMB	- HEAT SINK PERF	1				
1,2	IP 7111107B	Heat Sink Performance		1	03/26/2001	03/30/2001	Baseline Inspections