

The Light company

Houston Lighting & Power

South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 77483

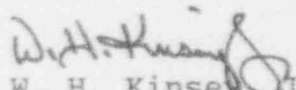
March 19, 1993
ST-HL-AE-4372
File No.: G26
10CFR50.73

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

South Texas Project
Unit 2
Docket No. STN 50-499
Licensee Event Report 93-006
Technical Specification Violation due to Train A
LHSI Cold Leg Injection Motor Operated Valve
Being Inoperable for Greater Than 72 Hours

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Unit 2 Licensee Event Report 93-006 regarding a Technical Specification violation due to Train A Low Head Safety Injection (LHSI) cold leg injection Motor Operated Valve (MOV) being inoperable for greater than 72 hours. This event did not have an adverse effect on the health and safety of the public.

If you should have any questions on this matter, please contact Mr. J. M. Pinzon at (512) 972-8027 or me at (512) 972-7921.


W. H. Kinsey, Jr.
Vice President,
Nuclear Generation

JMP/ag

Attachment: LER 93-006 (South Texas, Unit 2)

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Houston Lighting & Power Company
South Texas Project Electric Generating Station
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U.S. Nuclear Regulatory Comm.
Attn: Document Control Desk
Washington, D.C. 20555

LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNRB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)
South Texas, Unit 2

DOCKET NUMBER (2)

05000

499

PAGE (3)

1 OF 07

TITLE (4)
Technical Specification Violation due to Train A LHSI Cold Leg Injection
Motor Operated Valve Being Inoperable for Greater Than 72 Hours

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)										
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER									
0	2	1	9	3	9	3	0	0	6	0	0	0	3	1	9	9	3		05000
									FACILITY NAME		DOCKET NUMBER								
											05000								

OPERATING MODE (9)	4	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
POWER LEVEL (10)	0	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(vii)(A)	OTHER
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(vii)(B)	(Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)
NAME
Jairo Pinzon - Senior Engineer

TELEPHONE NUMBER (include Area Code)

(5 1 2) 9 7 2 - 8 0 2 7

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)									
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES	(If yes, complete expected submission date)	NO	X				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On February 17, 1993, Unit 2 was in Mode 4 at 0% power. After a recent Motor Operated Valve (MOV) failure, review of completed work packages on a Low Head Safety Injection (LHSI)/Residual Heat Removal (RHR) cold leg injection valve (MOV-0031A) was conducted. It was determined that on April 9, 1989, MOV-0031A could not be operated from the control room handswitch and was not repaired until November 8, 1990 (a period of 19 months). This valve is required to be capable of being closed hours after a Loss of Coolant Accident (LOCA) to establish hot leg recirculation. The cause for this Technical Specification violation was a misinterpretation of the requirement for hot leg recirculation capability. Corrective actions include discussing this event in Licensed Operator Regualification Training and performing a review of work packages on key systems to identify any additional cases of improper operability determinations. Additionally, HL&P will evaluate the adequacy of the current programmatic controls regarding operability determinations.

LER\93062002.U2

REQUIRED NUMBER OF DIGITS/CHARACTERS
FOR EACH BLOCK

BLOCK NUMBER	NUMBER OF DIGITS/CHARACTERS	TITLE
1	UP TO 46	FACILITY NAME
2	8 TOTAL 3 IN ADDITION TO 05000	DOCKET NUMBER
3	VARIES	PAGE NUMBER
4	UP TO 76	TITLE
5	6 TOTAL 2 PER BLOCK	EVENT DATE
6	7 TOTAL 2 FOR YEAR 3 FOR SEQUENTIAL NUMBER 2 FOR REVISION NUMBER	LER NUMBER
7	6 TOTAL 2 PER BLOCK	REPORT DATE
8	UP TO 18 -- FACILITY NAME 8 TOTAL -- DOCKET NUMBER 3 IN ADDITION TO 05000	OTHER FACILITIES INVOLVED
9	1	OPERATING MODE
10	3	POWER LEVEL
11	1 CHECK BOX THAT APPLIES	REQUIREMENTS OF 10 CFR
12	UP TO 50 FOR NAME 14 FOR TELEPHONE	LICENSEE CONTACT
13	CAUSE VARIES 2 FOR SYSTEM 4 FOR COMPONENT 4 FOR MANUFACTURER NPRDS VARIES	EACH COMPONENT FAILURE
14	1 CHECK BOX THAT APPLIES	SUPPLEMENTAL REPORT EXPECTED
15	6 TOTAL 2 PER BLOCK	EXPECTED SUBMISSION DATE

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FOR EACH BLOCK

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14	1 CHECK BOX THAT APPLIES	SUPPLEMENTAL REPORT EXPECTED
15	6 TOTAL 2 PER BLOCK	EXPECTED SUBMISSION DATE

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)		DOCKET NUMBER (2)		LER NUMBER (6)			PAGE (3)
South Texas, Unit 2		05000 499		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	02 OF 07
				93	006	00	

TEXT (If more space is required, use additional copies of NRC Form 366A). (57)

DESCRIPTION OF EVENT:

On February 17, 1993, Unit 2 was in Mode 4 at 0% power. After a recent Motor Operated Valve (MOV) failure, review of completed work packages on the Low Head Safety Injection (LHSI)/Residual Heat Removal (RHR) cold leg injection valve (MOV-0031A) was conducted. It was determined that the valve had been inoperable during previous Mode 1 through 4 operation. On April 9, 1989, MOV-0031A could not be operated from the control room handswitch and was not repaired until November 8, 1990 (a period of 19 months). The operation of Unit 2 while MOV-0031A was inoperable constituted a Technical Specification violation.

On April 9, 1989, Unit 2 was in Mode 4 with a Reactor Coolant System (RCS) heatup in progress. After cooling down the 2A RHR pump and securing it, the operators attempted unsuccessfully to open MOV-0031A with the control room handswitch. After determining that the valve would not open electrically, it was deenergized and manually opened. Electrical Maintenance personnel tested the motor insulation resistance and reported it as satisfactory although the motor and motor overloads were hot to the touch. A work package to troubleshoot this problem was initiated and RCS heatup and eventual plant startup to full power operation was continued. The normal condition for this valve in Mode 1 through 3 is to be open with power removed from the actuator. Since this condition was met it was therefore deemed to be in compliance with the station procedures and Technical Specifications. However, it disabled the A Train LHSI hot leg recirculation capability.

On November 20, 1989, Unit 2 was shut down for a planned outage to inspect Bottom Mounted Instrumentation. MOV-0031A was placed in the Operability Tracking Log (OTL) and work to troubleshoot the motor for MOV-0031A was commenced in accordance with the previously initiated work package. This work was considered not to be a mode ascension restraint. Electrical Maintenance personnel determined that the motor was shorted. The work document described the condition of the motor on MOV-0031A as shorted and that it required replacement. It could not be ascertained whether the electricians reported this condition directly to the Shift Supervisor.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 2	05000 499	9 3	- 0 0 6 -	0 0	03 OF 07

TEXT (If more space is required, use additional copies of NRC Form 365A) (17)

DESCRIPTION OF EVENT: (Con't)

On November 27, 1989, Train A Safety Injection components were declared operable after all preventive and corrective maintenance were thought to be complete. However, the work package and a preventative maintenance activity, (both activities were for maintenance on MOV-0031A) were listed as "work not started" on the OTL. On January 12, 1990, Unit 2 completed all outage activities and commenced reactor heatup and startup to full power operation. MOV-0031A condition was again considered to be in compliance with Technical Specifications (the valve was open with power removed from the actuator).

On September 29, 1990, Unit 2 was shutdown for its first refueling outage. The motor replacement for MOV-0031A was completed on November 8, 1990, and the valve was returned to an operable status.

CAUSE OF EVENT:

The cause of this event was use of a far too narrow interpretation of the operability requirements for the capability to establish hot leg recirculation with the LHSI subsystem following a Loss of Coolant Accident (LOCA). A contributing cause was inadequate programmatic controls for operability determinations. The Technical Specifications do not mention the requirement for hot leg recirculation; however, this information is documented in the Updated Final Safety Analysis Report and the Licensed Operator Training Program.

MOV-0031A has suffered several failures during the life of both units. A failure that occurred in January 1988, in Unit 1 during startup, was attributed to frequent cycling of the motor. A failure that occurred in July 1988, in Unit 2 during Hot Functional Testing, had no apparent cause. A second failure in Unit 2 occurred in August 1988 and was attributed to motor bearing failure. A root cause of the 1989 failure (the subject of this LER) could not be determined. No failures occurred in 1990, 1991, or 1992. A failure that occurred on February 1993 in Unit 2 was attributed to grease lock in the spring pack resulting in mechanical binding of the valve.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)		DOCKET NUMBER (2)		LER NUMBER (6)			PAGE (3)
South Texas, Unit 2		05000 499		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	04 OF 07
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

ANALYSIS OF EVENT:

The Emergency Core Cooling System (ECCS) is designed to meet the acceptance criteria as stated in 10CFR50.46 for breaks up to and including the double ended severance of a reactor coolant pipe. The Safety Injection System is based on a three train design with each train being able to supply 100 percent of minimum ECCS flow. Each train consists of a High Head Safety Injection (HHSI) and LHSI pump, each capable of providing sufficient flow to prevent boron precipitation. Therefore, the STP ECCS system has six flow paths available for hot leg recirculation.

During the cold leg injection and recirculation phase following a LOCA, the flow path from the Train A LHSI pump would be through the normally open MOV-0031A to the RCS loop A cold leg. Approximately 13 hours after a LOCA, the operator aligns at least one, but no more than two Safety Injection Systems to pump borated water to the RCS hot legs using both the HHSI and LHSI pumps. This may be accomplished by closing MOV-0008 and opening MOV-0006 to align the HHSI pump and closing MOV-0031 and opening MOV-0019 to align the LHSI pump in the respective train. This arrangement ensures long term core cooling using subcooled water to terminate any potential boil-off and to provide a flushing flow through the core to preclude potential boron precipitation.

The basis for the three ECCS trains is that flow from one safety injection train is assumed lost through the break. The second safety injection train is not available due to a single failure. This leaves the third train of Safety Injection to successfully inject to the core. Assuming that Train A is the only train providing flow, hot leg recirculation flow would normally be provided by both the LHSI and HHSI pumps.

With MOV-0031A inoperable, flow to the hot leg would be provided by only the HHSI pump in Train A. However, analyses performed by Westinghouse has shown that flow for the HHSI is sufficient to prevent boil-off and boron precipitation. Therefore, sufficient hot leg recirculation flow would be maintained and the hot leg recirculation function satisfied. Since the safety function is satisfied, no adverse consequences would occur as a result of this condition.

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LICENSEE EVENT REPORT (LER)
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FACILITY NAME (1)		DOCKET NUMBER (2)		LER NUMBER (5)			PAGE (3)
South Texas, Unit 2		05000 499		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	05 OF 07
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

ANALYSIS OF EVENT: (Con't)

During the time period that MOV-0031A was inoperable, a limited number of train outages (72-hour action statements) occurred that removed the B or C train of ECCS from service. During these time periods, the ability to mitigate a design basis accident was lost due to single failure considerations. However, implicit in the existence of a Technical Specification action statement is the fact that the single failure criterion is not satisfied for the limited period of time specified. Therefore, there was no additional risk imposed by the MOV-31 inoperability than already experienced while the plant was in an action statement.

During this event, MOV-0031A was inoperable for greater than the 72 hours allowed by Technical Specification 3.5.2. Therefore, this event is reportable pursuant to 10CFR50.73(a)(2)(i)(B).

CORRECTIVE ACTIONS:

1. HL&P will review outstanding OTLs and work documents on Unit 1, in effect or in progress, prior to startup from the current outage to ensure current operability determinations are adequate.
2. MOV-0031A in Unit 2 has been changed from torqued closed to limit closed. This will prevent hard seating of the valve and reduce the possibility for thermal binding, and wedging of the valve stem bearing block. Additionally, this change eliminates the control function of the spring pack. The same modification will be made on the MOV-0031B and MOV-0031C by the end of the current Unit 2 refueling outage. The Unit 1 valves were modified to be limit closed in the last refueling outage.
3. This event will be included in Licensed Operators Regualification Training. This action will be completed by August 10, 1993.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)		DOCKET NUMBER (2)		LER NUMBER (6)			PAGE (3)
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South Texas, Unit 2		05000 499					OF
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TEXT (If more space is required, use additional copies of NRC Form 365A) (17)

ADDITIONAL ACTIONS AND PROGRAM ENHANCEMENTS:

1. The Unit 2 spring pack on MOV-0031A was cleaned and reassembled. The spring pack on MOV-0031A, MOV-0031B, and MOV-0031C will be replaced with a spring pack which has grease relief paths by the end of the current refueling outage. These grease relief paths will be installed or verified installed for Unit 1 in the next refueling outage. It is acceptable to delay this action since the valves are set limit closed and as a result, spring pack condition will not affect valve performance.
2. HL&P will perform a review of prior Operability Tracking Logs and sample key safety related service requests to determine if any additional cases of improper operability determinations exist for either Unit. This review will be completed by June 1, 1993.
3. HL&P will perform an evaluation of the database for open, closed and voided safety related work packages on key safety related systems in both Units to identify other issues that represent recurrent less than satisfactory equipment performance. This evaluation will be completed by June 1, 1993. Corrective actions will be developed as necessary.
4. HL&P will evaluate enhancements for the current programmatic controls regarding operability determinations. This evaluation will be completed by March 30, 1993. Revisions to the operability determination process will be made based on this evaluation, as appropriate.
5. HL&P will develop a plan to revise the process for identification, trending and correction of repeat equipment problems. This plan will be developed by June 17, 1993.

LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 77-4), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
South Texas, Unit 2	05000 499	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	07 OF 07
		9 3	- 0 0 6 -	0 0	

TEXT (If more space is required, use additional copies of NRC Form 365A) (17)

ADDITIONAL INFORMATION:

The transition from April 9, 1989, to present includes many significant changes in the overall station programs for work identification, work management, operability review, problem identification, and corrective action determination. The most significant changes are:

- In the area of operability review, proceduralized criteria and structure has been added to the process.
- In the area of out-of-service equipment, the current process has a more definite criteria for when an Operability Tracking Log entry is required and criteria for when an entry can be removed and explicit approval requirements.

Overall, as addressed above, the programs in place currently provide the Shift Supervisor with structure, requirements, and guidance that was not available to the Shift Supervisors on April 9, 1989. In addition, the unit was in initial startup in April 1989, since that time, operations personnel have gained significant experience in performing their evaluations as evidenced by the fact that the February 10, 1993 failure of MOV-0031A resulted in a declaration of inoperability of MOV-0031A.

The issue of frequent valve cycles was unique to hot functional and startup testing. These valves are not subject to frequent cycles during normal operations or accident conditions.

The MOV-31 series valves in each unit are in the Motor Operated Valve Actuator Test (MOVAT) program which will prevent improper set up of the actuator.

The motor operated valve model number is SB-1-60 and is manufactured by Limitorque.

There have been no similar events reported to the NRC regarding a Technical Specification violation due to LHSI cold leg injection Motor Operated Valve being inoperable for greater than 72 hours.