

The Light company

Houston Lighting & Power South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 77483

May 11, 1993
ST-HL-AE-4434
File No.: G02.04
10CFR2.201

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

South Texas Project
Units 1 and 2
Docket Nos. STN 50-498; STN 50-499
Supplemental Reply to Notice of Violation 9235-02
Regarding Failure to Promptly Identify
and Correct Conditions Adverse to Quality

Reference 1): Correspondence from W. H. Kinsey, Jr. (HL&P) to NRC
Document Control Desk, dated April 2, 1993
(ST-HL-AE-4388)

Reference 2): Correspondence from A. Bill Beach (NRC) to
William T. Cottle (HL&P), dated April 29, 1993
(ST-AE-HL-93393)

In Reference 1), Houston Lighting & Power (HL&P) committed to provide a supplemental report on the Notice of Violation because evaluation of the failure to take prompt corrective actions to resolve a recurring deficiency identified in essential chiller 21A was not complete. The evaluation is now complete and the results have been included in the Attachment, annotated by change bars.

As confirmed in Reference 2), HL&P committed by telephone to provide additional information concerning the third example of Violation 9235-02, Auxiliary Feedwater Pump 24 overspeed trip mechanism. The additional information is also included in the Attachment, annotated by change bars.

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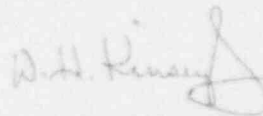
Project Manager on Behalf of the Participants in the South Texas Project

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Finally, justification for our position that foreign material on the SDG fuel oil strainer does not represent a condition adverse to quality has been added and annotated with change bars.

If there are any questions regarding these matters, please contact Mr. A. W. Harrison at (512) 972-7298 or me at (512) 972-7921.



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

JTC/sr

Attachment: Supplemental Reply to Notice of Violation 9235-02

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SUPPLEMENTAL REPLY TO NOTICE OF VIOLATION 9235-02

I. Statement of Violation:

Criterion XVI to 10 CFR 50, Appendix B, requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material, and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. Procedure OPGP03-ZX-0002, Revision 0, "Corrective Action Program," Section 4.1, Station Problem Report Instruction, requires that, "any person at STPEGS who identifies or becomes aware of a Condition Adverse to Quality (CAQ) or Significant Condition Adverse to Quality (SCAQ) SHALL promptly document the occurrence using an SPR Form." Four examples of violating these requirements are stated below:

1. Contrary to the above, a station problem report was not promptly initiated to document the foreign material (rust like particles) found on the Emergency Diesel Generator 23 fuel oil strainers on December 4, 1992. This nonconforming condition was identified during the performance of Service Request DO-186915 to replace the strainers.
2. Contrary to the above, prompt corrective actions were not initiated to correct equipment deficiencies with Essential Chiller 21A. Plant Equivalency Change CH-178119 was initiated in June 1992 to correct a condition which permitted the upper oil reservoir to migrate to the lower reservoir, requiring the essential chiller to be declared inoperable in accordance with Technical Specification 3.7.14. On December 9, 1992, the Essential Chiller 21A was declared inoperable because the essential chiller did not have sufficient indicated oil level showing in the upper reservoir. Plant Equivalency Change CH-178119 had not been initiated and no date had been established for implementing the plant equivalency change.
3. Contrary to the above, as of December 17, 1992, the licensee had not identified the cause for the repetitive problems with Auxiliary Feedwater Turbine 24 overspeed trip mechanism and had taken no corrective actions to preclude the recurrence of the problem.

I. Statement of Violation: (cont'd)

4. Contrary to the above, the corrective action taken to a violation documented in NRC Inspection Report 50-498/91-11; 50-499/91-11 involving individuals working more than 72 hours in any 7-day period, was not adequate to preclude repetition. During the inspection, four individuals were identified to have exceeded 72 hours worked in a 7-day period without plant manager approval. One occurrence involved an instrumentation and controls technician, with three additional occurrences involving electrical maintenance personnel.

These four examples constitute one Severity Level IV violation. (Supplement I) (498;499/9235-02)

II. Houston Lighting & Power Position:

HL&P concurs that the cited violation occurred, but does not agree that the fuel oil strainer example represents a condition adverse to quality. The fuel oil system is designed and maintained to minimize water and sediment in the fuel oil. Periodic drainage of water accumulation, the use of high quality fuel, and keeping the fuel oil tanks full assures that internal corrosion and algae growth will be minimal. Fuel oil is sampled periodically and verified that particulate contamination is within limits. However, there are six filters or strainers in the system between the Auxiliary Fuel Oil Storage Tank (in the yard) and the fuel injectors on the diesel engine to assure that the fuel is clean. The solids found on the strainer elements in question had built up slowly over a two-year period of normal operation. Therefore, since it is normal for the strainer to collect trace amounts of solids from the fuel and the strainers were performing their function, this does not represent a condition adverse to quality.

III. Reason for Violation:

The cause of the second example, essential chiller 21A modifications was a lack of sensitivity to the significance of the chiller modifications in establishing implementation priority.

The cause of the third example, Auxiliary Feedwater Pump 24 overspeed trip mechanism, was that the system engineer did not consider the various failures as indicators of a different and larger problem. The evaluation was not given high enough priority to completely investigate and resolve the real problem.

III. Reason for Violation: (cont'd)

The fourth example, the adverse trend involving overtime exceedance, was caused by a lack of training on the detailed requirements of the Administrative Technical Specification governing overtime. Most of the exceedances occurred because personnel assumed that the requirement was based on a fixed seven-day schedule instead of a rolling seven-day time period.

IV. Corrective Actions:

The modifications noted in the Inspection Report have been implemented for essential chillers in both Units except for changing the evaporator pressure switch setpoint on chiller 21C. This is scheduled to be completed prior to the end of the Unit 2 refueling outage.

Throughout the conduct of operational readiness reviews that HL&P has implemented for startup of Unit 1 from the current forced outage, Operations and Engineering personnel have been reevaluating the potential safety impact of open Service Requests, design modifications, temporary modifications, and other engineering backlog items on equipment operability, safe plant operation, and operator work-arounds. The evaluations and the presentations made before the Senior Management Panel have been educational regarding increasing sensitivity to the significance to safe operations of modifications and other work. This process will continue in preparation for the startup of Unit 2. HL&P will continue to emphasize with Operations, Maintenance, and Engineering personnel the identification and effective corrective action for plant equipment problems.

The physical corrective actions involved with the third example, Auxiliary Feedwater Pump 24 overspeed trip mechanism, included cleaning the trip reset plunger and changing from Mobil Vaprotec Light oil to Mobil DTE 797, which is compatible with Vaprotec. The generic corrective actions are described in the next paragraph.

The generic implications of the equipment condition have also been considered. The program to analyze and trend equipment history to identify repetitive component degradations and failures will be upgraded to provide for more prompt and effective action to prevent recurrence. (Corrective action will commence by April 15, 1993, and will be completed by December 15, 1993.) Additionally, training will be conducted to increase personnel awareness of the definition of non-conforming conditions and the necessity of prompt corrective action. Appropriate plant procedures will be revised to include specific examples of non-conforming conditions and

IV. Corrective Actions: (cont'd)

specific instructions for dealing with non-conforming Service Requests. The Service Request Form will be revised to ensure the clear indication of a non-conforming condition. (Completion Date: June 30, 1993).

To correct the fourth example, a memo was issued to Maintenance Department Personnel to reemphasize the STPEGS Overtime Policy. The Overtime Exceedance Policy (OPGP02-ZA-0060) will be replaced by OPGP03-ZA-0116 to clearly define management expectations regarding compliance with Administrative Technical Specification requirements. Training will be conducted on the new procedure. (Completion Date: June 10, 1993.)

V. Date of Full Compliance:

HL&P will be in full compliance on December 15, 1993. In the interim, the necessity for initiating an SPR to fully investigate apparent adverse trends in equipment condition will be emphasized to station personnel.