

The Light company

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

May 19, 1993
ST-HL-AE-4454
File No.: G02.04
10CFR2.201

Director, Office of Enforcement
U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

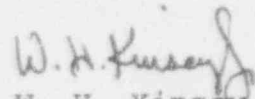
South Texas Project
Units 1 and 2
Docket Nos. STN 50-498; STN 50-499
Reply to Notice of Violation and
Proposed Imposition of Civil Penalty
Inspection Reports 92-29, 92-32, and 93-03;
Enforcement Action 93-023

Houston Lighting & Power Company (HL&P) has reviewed the Notice of Violation and Proposed Imposition of Civil Penalty dated April 19, 1993, and submits the attached reply.

HL&P does not intend to protest the proposed civil penalty. An electronic wire transfer has been made, payable to the Treasurer of the United States, for this civil penalty.

Your concern relating to the identification of additional personnel performance issues during inspection 93-11 is addressed in Section V.A of the reply to this Notice of Violation.

If you have any questions, please contact C. A. Ayala at (512) 972-8628 or me at (512) 972-7921.


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

DNB/sr

Attachments: 1. Affidavit
2. Reply to Notice of Violation and Proposed Imposition of Civil Penalty EA 93-023

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

JEH

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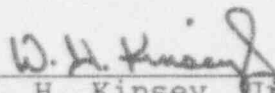
U.S. Nuclear Regulatory Comm.
Attn: Document Control Desk
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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

In the Matter)	
)	
Houston Lighting & Power)	Docket Nos. 50-498
Company, et al.,)	50-499
)	
South Texas Project)	
Units 1 and 2)	

AFFIDAVIT

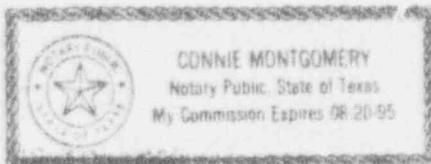
I, W. H. Kinsey, Jr., being duly sworn, hereby depose and say that I am Vice President, Nuclear Generation, of Houston Lighting & Power Company; that I am duly authorized to sign and file with the Nuclear Regulatory Commission the attached Reply to Notice of Violation and Proposed Imposition of Civil Penalty (NRC Inspection Reports 92-29, 92-32 and 93-03; Enforcement Action 93-023); that I am familiar with the content thereof; and that the matters set forth therein are true and correct to the best of my knowledge and belief.

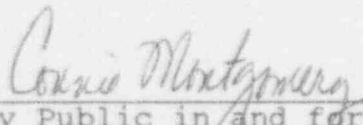


W. H. Kinsey, Jr.
Vice President,
Nuclear Generation

STATE OF TEXAS)

Subscribed and sworn to before me, a Notary Public in and for the State of Texas, this 19 day of May, 1993.





Notary Public in and for the
State of Texas

Reply to Notice of Violation and Proposed
Imposition of Civil Penalty EA 93-023

I. Statement of Violation:

Technical Specification 6.8.1.a requires that written procedures shall be established, implemented, and maintained for those activities recommended in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, February 1978. RG 1.33, Appendix A, Item 1.d recommends operating procedures for procedure adherence.

STP Procedure OPGP03-ZA-0010, Revision 15, "Plant Procedure Adherence and Implementation and Independent Verification," Step 4.2.1, states, "For performance of procedures which require manipulation of plant equipment, prior to performing any step or group of steps of a procedure, the individual performing that step SHALL first implement the seven step Self Verification program..."

The Self Verification program is defined in the procedure and requires that an employee stop and think about the task, locate the device to be operated, touch the device, verify the correct device, anticipate the expected and unexpected responses and the actions to be taken, manipulate the component, and observe for expected and unexpected responses.

Step 4.2.1.2 of the Self Verification program states "LOCATE device to be operated" and includes the following directions: a) Ensure you are on the correct UNIT; b) Ensure you are on the correct TRAIN; and c) Ensure you are on the correct DEVICE.

Contrary to the above, from September 28, 1992, through January 9, 1993, licensee personnel did not verify the correct device, did not ensure they were on the correct unit, did not ensure they were on the correct train or otherwise complete the self-verification program required by procedure OPGP03-ZA-0010 in the following eight instances:

- A. On September 28, 1992, Equipment Clearance Order 1-92-8030 was issued to allow chemical cleaning of Condenser Waterbox 12N. Seven of 64 Waterbox outlet bolts for Condenser Waterbox 12S were removed before water leakage revealed that work was being conducted on the wrong component.
- B. On October 12, 1992, work specified by Work Package 116446-EP01 for Essential Cooling Water Pipe Support EW-1107-HL5006 was performed on Essential Cooling Water Pipe Support EW-1128-HL5003.

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I. Statement of Violation: (Cont'd)

- C. On October 19, 1992, an underfrequency trip actuating device operational test was performed on Reactor Coolant Pump 2A whereas work permission had only been given to perform the test on Reactor Coolant Pump 2C.
- D. On October 29, 1992, a local leak rate test was performed on Containment Isolation Valves CV0033A, B, and C whereas the procedure was written for performing the test on Containment Isolation Valves CV0034A, B, and C.
- E. On November 2, 1992, while performing Procedure OPSP02-SI-0964, "Accumulator C Pressure Group 3 ACOT (P-0964)," a technician incorrectly lifted wire TB-J from terminal 7 and wire TB-J from terminal 8 when the procedure called for lifting wire TB-J from terminal 10 and wire TB-J from terminal 11.
- F. On November 5, 1992, during final review of Unit 1 Qualified Display Parameter System work packages, it was determined that Service Requests AM-164610 and AM-164611 were performed in Unit 1 on October 30, 1992, whereas the service requests were written for and intended to be performed in Unit 2.
- G. On November 7, 1992, Service Request 173475 was written to repair a steam leak on Heater Drip System Valve N2HDLC7222 whereas the leak was actually on valve N2HDLC7223; this resulted in repairs being made to the leaking valve but not the valve identified on the service request.
- H. On January 9, 1993, a technician failed to implement the seven step self verification program while attempting to adjust the high neutron flux setpoint for channel N-0041 from 84.5 to 109 percent. As a consequence, the setpoint was erroneously set at 99 percent.

These violations represent a Severity Level III problem and a Civil Penalty of \$25,000.

II. Houston Lighting & Power Position:

HL&P concurs that the cited violation occurred.

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III. Reason for Violation:

- A. Personal accountability issues, such as self-verification and attention to detail, have not been adequately implemented.
- B. Programmatic support of workers did not provide fully effective barriers to personal performance errors; specifically, clarity of written guidance, adequacy of oral briefings and instructions, adequacy of equipment design and labeling, and the repeated assignment of the same individuals for critical tasks.

IV. Corrective Actions:

A. Corrective Actions to Address Personal Accountability Issues:

- 1. The Plant Manager met with crew leaders and planning supervisors to discuss expectations and receive recommendations on corrective actions. The Maintenance Manager suspended field activities to discuss wrong unit/train/component events with craft personnel. Crews met to formulate suggestions for improvement. A plant bulletin on "Attention to Detail" was issued. The Group Vice President, Nuclear briefed the Maintenance, Operations, and Engineering Departments on lessons learned.
- 2. Human Performance Review Boards have been established to review selected human performance events and determine the causal factors of these events.
- 3. Supervisors and managers are stressing self verification and attention to detail in routine meetings. In addition, actions are being taken to identify and remove barriers to supervisor time in the work place.
- 4. Personnel on dedicated work teams are being rotated to minimize desensitization from performing the same task repeatedly.

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IV. Corrective Actions: (Cont'd)

5. The self verification program will be enhanced to reflect the current INPO "STAR" process. This enhancement will be implemented by July 31, 1993.
6. The Plant Manager has instituted a Plant Manager's Forum with line personnel to discuss issues such as human performance expectations and employee identified problem areas.
7. The Deputy Plant Manager will discuss management's expectations regarding personal accountability with each first line supervisor in Maintenance. These discussions are currently in progress.
8. The Plant Manager (or Deputy Plant Manager) will conduct a discussion with the employee and their first line supervisor following human performance related events.

B. Corrective Actions to Address Programmatic Support:

1. Unit identification placards were installed at the main access points. The Service Request checklist was modified to include barriers to reduce wrong unit/train/component errors. Existing work packages were stamped with a unit designator. New work packages have the unit number included in key locations. Work packages have been modified to remove extraneous information, include discrete verification steps prior to starting work, and streamline the precaution and prerequisite sections.
2. A video tape on self verification has been presented in crew meetings.
3. An Augmented Work Control program has been implemented for critical activities.

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IV. Corrective Actions: (Cont'd)

4. Self verification techniques are being reinforced through the use of signs, posters, hard hat stickers, etc. Supervisors are stressing self verifications principles and the need to be mentally prepared in pre-job briefings.
5. A Surveillance Enhancement Program has been initiated. Current plans for 1993 are to develop an enhanced sitewide surveillance procedure writer's guide that incorporates good human factors practices and site procedure performance policies; and to upgrade approximately 51 high priority procedures. These procedures will consist of those that have caused or are similar to those that have caused problems in the past. The remaining procedures are scheduled for completion by December 1996.
6. The plant labeling program is being upgraded. It is anticipated that approval of the project scope, award of contract and project staffing will be completed by December 31, 1993; with labeling activities starting in January 1994. The labeling upgrade project will be substantially complete by December 31, 1996.
7. A new shift schedule will be implemented by the end of the current Unit 2 refueling outage in an effort to improve overall morale and minimize distractions.
8. The results of an Organizational Interface Assessment have been evaluated for issues that affect human performance. HL&P has established a senior management steering committee to address the recommendations in the assessment and develop and oversee implementation of a plan of action for each recommendation.
9. A new goal and action plan on human performance have been added to the Master Operating Plan.

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V. Additional Information:

- A. Four additional examples of personnel error were noted by the NRC at the exit conference (Inspection 93-11) on April 12, 1993. HL&P has determined that additional corrective action beyond that previously discussed, is not warranted. HL&P believes that the corrective actions stated in Section IV of this response, once fully implemented, will be effective in precluding the recurrence of similar problems.

HL&P recognizes, however, that it must continue to seek the most effective methods to implement its goals of human performance improvement. Recent efforts toward this end include:

1. The addition of personnel experienced in human performance issues.
 2. The identification of a Human Performance Coordinator with a specific goal of helping line departments improve human performance.
 3. Initiatives, such as setting aside one day a week where station meetings are minimized, aimed at getting management and supervision into the field and in contact with station personnel.
- B. An additional personnel error event occurred on April 20, 1993, when a Safety Injection Pump motor oil reservoir was over filled. Corrective actions as a result of this event include:
1. Plant Management instituted a Human Performance Improvement Day where virtually all field activities were suspended to allow station personnel dedicated time to identify methods to improve human performance. Plant wide meetings were conducted to discuss human performance and solicit suggestions. An action plan has been developed that incorporates these suggestions.
 2. Plant Management has directed station personnel to limit hours worked to no more than sixty hours per week and to allow at least two consecutive days off after each work period. Exceptions to this direction require management approval.

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VI. Date of Full Compliance:

HL&P is in full compliance.