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

June 11, 1991
ST-HL-AE-3787
File No.: G26
10CFR50.73

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

South Texas Project Electric Generating Station
Unit 1
Docket No. STN 50-498
Licensee Event Report 91-016
Failure to Perform A Surveillance Test Due to Personnel Error

Pursuant to 10CFR50.73, Houston Lighting & Power Company (HL&P) submits the attached Licensee Event Report (LER 91-016) regarding failure to perform a surveillance test due to personnel error. This event did not have any adverse impact on the health and safety of the public.

If you should have any questions on this matter, please contact Mr. C. A. Ayala at (512) 972-8628 or me at (512) 972-7205.

William J. Jump
William J. Jump
Manager,
Nuclear Licensing

SDP/amp

Attachment: LER 91-016 (South Texas, Unit 1)

cc:

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LA/NRC/

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
South Texas, Unit 1	0 5 0 0 0 4 9 8	1 OF 0 5

TITLE (4)
Failure to Perform a Surveillance Test Due to Personnel Error

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

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

OPERATING MODE (9)	1											
POWER LEVEL (10)	1 0 0		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)			
			20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)			
			20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
			20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)					
			20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)					
			20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)					

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Charles Ayala - Supervising Licensing Engineer	AREA CODE 5 1 2 9 7 2 - 8 6 2 8

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
A											

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

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

On May 13, 1991, at approximately 2230 hours, Unit 1 was in Mode 1 at 100 percent power. It was discovered that the Technical Specification 3/4.7.1.4 requirements for determining the specific activity of the secondary coolant system had not been performed within the required surveillance interval. This is a violation of Technical Specification 3/4.7.1.4 and is reportable pursuant to 10CFR50.73(a)(2)(i)(B). Steam generator blowdown radiation monitor data was checked, and it was verified that secondary activity had not exceeded normal values or the Technical Specification limit during this period. The cause of this event was failure to ensure testing was performed before exceeding the surveillance interval. Corrective actions included issuance of special orders, and changing procedure and Laboratory schedules to improve visibility and increase awareness of surveillance times.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	0 5 0 0 0 4 9 8	9 1	— 0 1 4	— 0 0	0 2 OF 0 5

TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION OF EVENT:

At approximately 2230 hours on May 13, 1991, Unit 1 was in Mode 1 at 100 percent power. The Unit 1 Chemical Technician Supervisor became aware that the Technical Specification 3/4.7.1.4 requirement for determining gross activity on the secondary system had not been completed within its allowed surveillance. The required samples were immediately collected and analyzed. The Radiation Monitoring System data was reviewed to ensure that the steam generator blowdown monitors did not record any exceedance of the .01 uCi/gm limit during the period in question. No abnormal trends were noted. The surveillance exceeded the specified surveillance interval, including the maximum allowable time extension, by 55 minutes. Therefore, this event is a violation of Technical Specification 3/4.7.1.4 and is reportable pursuant to 10CFR50.73(a)(2)(i)(B). The NRC was notified at 1059 hours on May 14, 1991.

At approximately 0530 hours on May 13, 1991 the Chemistry Technician Supervisor directed the technician assigned to the Radiochemistry Laboratory to draw samples and perform plant procedure OPSP07-CD-0001 which fulfills the requirements of TS 3/4.7.1.4. During preparation to collect the samples at the Secondary Chemistry Laboratory, the technician discovered that the supply of Marinelli beakers normally used for sampling was exhausted. Since it was close to shift turnover, the radiochemistry laboratory technician did not start the surveillance and documented in the surveillance section of the shift turnover sheet that the procedure had not been started. No feedback was given to the supervisor that the task was not in progress. Based on the direction given the technician, the off-going supervisor assumed that the surveillance had been started and documented this on the shift turnover. The task was not signed off as complete on the Chemical Technician Supervisor and Secondary Laboratory Sample schedules which contained the requirement to collect and analyze the samples.

At approximately 0600, the night shift supervisor was relieved by a senior chemical technician acting as Chemical Technician Supervisor (CTS). The day Shift Radiochemistry Laboratory technician received turnover and proceeded with the scheduled items for the Radiochemistry Laboratory. The daily schedule for the Radiochemistry Laboratory did not list the subject surveillance task as a requirement. The verbal turnover did not include discussion of performing the surveillance, and the acting supervisor did not recognize during normal log review that the surveillance had not yet been performed.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	0 5 0 0 0 4 9 8	9 1	0 1 6	0 0	0 3 OF 0 5

TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION OF EVENT: (cont'd)

At approximately 1800 hours the acting supervisor turned over to the same individual he had relieved twelve hours earlier. No information was communicated about the status of the incomplete surveillance test during this turnover. Although the surveillance was not signed off as complete on the daily schedules, the oncoming supervisor incorrectly assumed the test had been completed based on the communication with the technician prior to the morning shift turnover and that the surveillance package was still in the Radiochemistry Laboratory awaiting review. At approximately 2200 hours, the supervisor went to the Radiochemistry Laboratory to pick up the surveillance package. After he was unable to find the started surveillance package and after review of the appropriate logs and records, the supervisor determined that the surveillance test had not been performed. The supervisor then immediately performed the surveillance. The supervisor verified that the 72 hour time limit and allowable time extension had expired and informed management. The supervisor obtained trend data on the S/G blowdown radiation monitors which identified that the Technical Specification limit of .01 uCi/gm had not been exceeded during the time period. The surveillance was completed satisfactorily at 0225 hours on May 14, 1991.

CAUSE OF OCCURRENCE:

The cause of this event was failure to ensure testing was performed before exceeding the surveillance interval. The root causes for this occurrence were:

- Personnel error by the Chemistry Technician Supervisor in the assumption that the surveillance test had been completed as requested.
- Less than adequate administrative controls governing performance and turnover of scheduled surveillances.
- Inadequate communication on the part of shift personnel.

ANALYSIS OF EVENT:

The limitations on secondary coolant system specific activity ensure that the resultant offsite radiation dose will be limited to a small fraction of 10CFR100 dose guideline values in the event of a steam line rupture. Failure to perform a Technical Specification required surveillance within the specified interval is reportable pursuant to 10CFR50.73(a)(2)(i)(B). The surveillance for Technical Specification 3/4.7.1.4 is required to be performed within a 72-hour interval. The surveillance was performed 90 hours and 55 minutes after the previous samples. This exceeded the allowable time extension by 55 minutes. The steam generator blowdown radiation monitor data was verified to ensure that secondary activity had not exceeded normal values or the Technical Specification limit during this period. There was no adverse impact on the health and safety of the public.

CORRECTIVE ACTIONS:

The following corrective actions have been taken as a result of this event:

1. Checks were performed on the steam generator blowdown radiation monitors to verify that the trend data values had not exceeded the Technical Specification limits during this time period. The required samples for determining gross activity on the secondary system were collected and analyzed and found to be satisfactory.

2. Special Orders have been issued by the Chemical Operations and Analysis Division relative to completion/turnover controls of surveillance tests. The Special Orders prohibit turnover beyond the assigned shift of scheduled surveillances with a test interval of less than 7 days without approval of Chamical Operations and Analysis Management. In addition, the Radiochemistry Laboratory sample schedule was revised to add performance of 0PSP07-CD-0001 as a requirement.

3. This issue has been reviewed with the individuals involved. In addition, a directive has been issued to chemistry personnel reinforcing the priorities for performance, communication, and documentation of surveillance tests relative to other responsibilities.

4. The Chemical Operations & Analysis Shift relief and Turnover Procedure (0PCP01-ZA-0004) was changed to require the Chemical Technician Supervisor to verify completion of surveillances scheduled for the shift, or to initiate immediate actions to ensure completion.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	0 5 0 0 0 4 9 8	9 1	— 0 1 6	— 0 0	0 5 OF 0 5

TEXT (If more space is required, use additional NRC Form 366A's) (17)

CORRECTIVE ACTIONS: (cont'd)

5. Chemical Technician Supervisor turnover sheets have been changed to include the date/time a surveillance was last performed and the date/time the next surveillance is due.

6. The scheduling of surveillance tests site wide have been reviewed, and with the above corrective actions in place, adequate measures exist to prevent recurrence of this event.

ADDITIONAL INFORMATION:

The following similar events have occurred at STPEGS.

LER 88-064 - Failure To Perform the Weekly Battery Surveillance Test on Battery E1D11

LER 89-007 - Failure To Perform A Surveillance Test Due To Personnel Error

LER 89-024 - Failure To Perform A Required Accumulator Boron Sample

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