

# The Light company

Houston Lighting & Power South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 77485

January 29, 1992

ST-HL-AE-3836

File No.: G26

10CFR50.73

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

South Texas Project Electric Generating Station  
Unit 2

Docket No. STN 50-499

Revision 01 to Licensee Event Report 91-007

Regarding Reactor Trip Caused By Inadvertent

Actuation of a Main Generator Breaker Emergency Trip

Reference: Original LER 91-007 transmitted by letter from William J. Jump to  
Document Control Desk, June 20, 1991 (ST-HL-AE-3795)

Pursuant to 10CFR50.73, Houston Lighting & Power Company (HL&P) submits the attached Licensee Event Report (LER 91-007) regarding a reactor trip caused by inadvertent actuation of a main generator breaker emergency trip. The revision corrects statements in the description of the event, and updates the status of corrective actions. Change bars are provided to highlight the changes. This event did not result in an 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

PLW/amp

Attachment: LER 91-007 Revision 1 (South Texas, Unit 2)

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A Subsidiary of Houston Industries Incorporated

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Houston Lighting & Power Company  
South Texas Project Electric Generating Station

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Revised 10/11/91

L4/NRC/

## LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555 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)

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PAGE (3)

TITLE (4) Reactor Trip Caused By Inadvertent

Actuation of Generator Breaker Emergency Trip

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 NAME	DOCKET NUMBER(S)
0 5	2 2	9 1	1 9 1	0 0 7	0 1	0 1	2 9	9 2		0 5 0 0 0
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (11)							
1			<input checked="" type="checkbox"/> 20.402(b) <input type="checkbox"/> 20.406(a) <input type="checkbox"/> 50.73(a)(2)(iv) <input type="checkbox"/> 73.71(b)							
POWER LEVEL (10)			<input type="checkbox"/> 20.406(a)(1)(i) <input type="checkbox"/> 50.36(a)(1) <input type="checkbox"/> 50.73(a)(2)(v) <input type="checkbox"/> 73.71(c)							
1 0 0			<input type="checkbox"/> 20.406(a)(1)(ii) <input type="checkbox"/> 50.36(a)(2) <input type="checkbox"/> 50.73(a)(2)(vi) <input type="checkbox"/> OTHER (Specify in Abstract Below and in Text, NRC Form 365A)							
			<input type="checkbox"/> 20.406(a)(1)(iii) <input type="checkbox"/> 50.73(a)(2)(i) <input type="checkbox"/> 50.73(a)(2)(vii)(A) <input type="checkbox"/>							
			<input type="checkbox"/> 20.406(a)(1)(iv) <input type="checkbox"/> 50.73(a)(2)(ii) <input type="checkbox"/> 50.73(a)(2)(viii)(B) <input type="checkbox"/>							
			<input type="checkbox"/> 20.406(a)(1)(v) <input type="checkbox"/> 50.73(a)(2)(iii) <input type="checkbox"/> 50.73(a)(2)(ix) <input type="checkbox"/>							

LICENSEE CONTACT FOR THIS LER (12)

NAME

Charles Ayala - Supervising Licensing Engineer

TELEPHONE NUMBER

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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC
B	S B	R V	P 0 9 5	X					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input checked="" type="checkbox"/>	<input type="checkbox"/>				

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

On May 22, 1991, Unit 2 was in mode 1 at 100% power. At approximately 2220 hrs, while waiting in the area of the main generator breaker to unlock a local cabinet for an Electrical Maintenance individual, a non-licensed operator inadvertently actuated the local generator breaker emergency trip pushbutton. The sudden loss of secondary load caused an automatic over temperature delta temperature (OTAT) reactor trip. Pressurizer spray was unable to reduce the pressure before the pressurizer PORVs opened at approximately 2335 psig. Steam generator 2C power-operated relief valve (PORV) failed to open even though the pressure exceeded the lift setpoint. The non-licensed operator responsible for the trip was counselled with regards to paying strict attention to performance of operations activities. The Steam Generator 2C PORV has been repaired. Other switch designs have been reviewed to identify changes that can prevent similar inadvertent actuations.

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LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN: LER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, 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)  0 5 0 0 0 4 9 9	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 1	— 0 0 7	— 0 1	0 2	OF	0 5

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

DESCRIPTION OF EVENT:

On May 22, 1991, Unit 2 was in mode 1 at 100% power. At approximately 2220 hours, a non-licensed operator waiting to unlock a local cabinet for an Electrical Maintenance craftsman inadvertently actuated the local generator breaker emergency trip pushbutton. The sudden loss of secondary load caused an automatic over-temperature delta temperature (OTΔT) reactor trip. The non-licensed operator immediately notified the Control Room of the cause of the breaker trip.

The transient caused RCS pressure to increase. Pressurizer spray valve 2-RC-PCV-0655C had been closed previously and placed in manual control; the available automatic spray valve was not able to reduce the pressure before the pressurizer PORVs opened at approximately 2335 psig. RCS pressure reached approximately 2350 psig.

Main Turbine Governor valves closed when the Generator Breaker was opened. This caused steam generator pressures to increase. Steam generator 2A, 2B, and 2D power-operated relief valves (PORVs) opened as expected at approximately 1225 psig. However, steam generator 2C PORV failed to open even though the lift setpoint pressure was exceeded. Steam generator pressure reached approximately 1285 psig (the lowest steam generator safety relief valve setpoint). The pressure did not exceed the allowable setpoint tolerance, so that none of the steam generator safety relief valves are believed to have opened.

Following the first Unit 2 refueling outage, pressurizer spray valve 2-RC-PCV-0655C began leaking excessively (approximately 10-15% valve position). The scope of the work required to repair the valve and the time available in the existing outage dictated that the rework be postponed until the next refueling outage. A caution tag was placed on the Main Control Board directing that the valve remain closed and in manual control. This contributed to the pressure transient that caused the pressurizer PORVs to open; however, given the magnitude of the transient (100% load rejection), the PORVs would probably have opened regardless of the pressurizer spray valve availability.

All other systems and components operated as expected, and the plant was stabilized in Mode 3. The NRC was notified of the event at 0044 on May 23, 1991.

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LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, 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)  0 5 0 0 0 4 9 9	LER NUMBER (5)			PAGE (3)		
		YEAR 9 1	SEQUENTIAL NUMBER 0 0 7	REVISION NUMBER 0 1			

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

CAUSE OF EVENT:

This event was caused by the following:

1. The non-licensed operator was inattentive while performing his duties.
2. Human error was not considered in design and location of the local generator breaker emergency trip pushbutton.
3. Previous corrective actions taken were not complete. Previous inadvertent actuation events resulted in identification of components that required additional barriers to inadvertent operation. The generator breaker emergency trip pushbutton should have been identified in these evaluations.
4. The cause of the failure of the steam generator PORV to actuate is attributed to iron particulates in the EHC fluid. During troubleshooting and repair of the PORV, an EHC fluid sample showed out-of-specification particulate contamination in each range. According to the vendor, the control valve is sensitive to particulate interference. No other anomalies were found.

ANALYSIS OF EVENT:

This event is reportable pursuant to 10CFR50.73(a)(2)(iv) as a Reactor Protection System actuation. The non-licensed operator was not performing duties associated with the generator breaker emergency trip button. Actuation occurred when he leaned against it.

CORRECTIVE ACTIONS:

The following corrective actions are being taken as a result of this event:

1. The non-licensed operator responsible for the trip was counselled by Plant Operations management on May 23, 1991, with specific instructions regarding paying strict attention to performance of operating activities.
2. The subject external pushbutton has been removed from local panels in both units. Local tripping of the main generator output breaker is still possible from inside the cabinets, but access requires opening a cabinet door to manipulate the trip button.

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LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 600 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

CORRECTIVE ACTIONS: (Cont'd)

3. A list of switches, pushbuttons, breakers, etc., that are considered to be susceptible to inadvertent operation leading to plant trips has been developed. The list addresses such switches, pushbuttons, breakers, etc., that were not identified in a previous review addressed by LER 87-013 (discussed below). Changes will be implemented as soon as possible, but not later than the next refueling outage of Unit 1. Unit 2 changes have been completed.
4. The EHC fluid in the steam generator 2C PORV was flushed, replaced, and verified acceptable by analysis. The PORV has been tested, and was declared operable at 0350 on May 25, 1991.
5. A program to determine the root cause of particulate contamination of steam generator PORV EHC fluid has been completed. The particulate matter found in a sample drawn on May 24 is primarily small iron particles resulting from erosion within the actuator.
6. As a result of the findings the root cause evaluation noted in item 5 above, the following preventive measures have been put in place:
  - a. If the oil is found to be out-of-specification for particulates, the oil will either be changed out or the oil will be purified.
  - b. The in-line filtration will be changed from 10 microns to <5 microns. The change is expected to be implemented by June 30, 1992.
  - c. The PORV's will be stroked monthly to maintain operability (following change in filtration).
  - d. The PORV actuators will be disassembled and inspected at the next available refueling outage for Unit 1 (Fall, 1992). This has been completed for Unit 2.
  - e. PORV samples will be taken monthly (following change in filtration). This is expected to provide adequate time to address the problem if unsatisfactory results are obtained.

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SEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 H. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY

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South Texas, Unit 2

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

ADDITIONAL INFORMATION:

The PORVs are manufactured by Control Component, Inc., with Enertech (formerly Paul-Munroe Hydraulics, Inc.) hydraulic actuators, model number PF89270-500 series.

LER 90-011 for STPEGS Unit 2 addressed a reactor shutdown due to an inoperable steam generator power-operated relief valve. Steam generator 2D PORV became inoperable due to chemical breakdown of the hydraulic fluid in the actuator assembly. The chemical breakdown was caused by a valve bonnet steam leak which resulted in elevated temperature in the valve actuator area and which contributed to moisture intrusion into the hydraulic reservoir.

LER 88-039 for STPEGS Unit 1 addressed an event in which Technical Specification 3.0.3 was entered due to a Maintenance Electrician inadvertently hitting a local trip button with his elbow. This caused loss of power to MCC E1B2 and various Train B components.

LER 89-006 for STPEGS Unit 1 addressed a partial loss of offsite power caused by inadvertent actuation of a generator breaker test switch by an unlicensed operator.

LER 87-013 for STPEGS Unit 1 addressed an event in which a construction engineer inadvertently turned off a disconnect switch providing power to the toxic gas monitors which was located adjacent to one being installed. A corrective action for this event was establishment of a plant operability task force which was to consider use of protective guards or special caution tags to help prevent accidental switch operation.

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