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

August 7, 1992
ST-HL-AE-4171
File No.: G26
10CFR50.73

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

South Texas Project
Unit 1
Docket No. STN 50-498
Licensee Event Report 92-007
Unplanned ESF Actuation of the
Fuel Handling Building HVAC System

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Licensee Event Report 92-007 regarding an unplanned Engineered Safety Feature (ESF) actuation of the Fuel Handling Building Heating, Ventilating and Air Conditioning (HVAC) system. This event did not have 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
General Manager,
Nuclear Licensing

JMP/ag

Attachment: LER 92-007 (South Texas, Unit 1)

11003

IE22

cc:

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Revised 10/11/91

L4/NRC/

NRC FORM 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

ESTIMATED BURDEN PER 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.

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 3

TITLE (4) Unplanned ESF Actuation of the Fuel Handling Building HVAC System

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

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)					
1		20.402(b)		20.405(c)	X	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0 9 5	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)		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
	AREA CODE
Charles Ayala - Supervising Licensing Engineer	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	

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 July 10, 1992, at approximately 0917 hours Unit 1 was in Mode 1 at 95 percent power. An unplanned Engineered Safety Features (ESF) actuation occurred during the performance of the Spent Fuel Pool Exhaust Monitor surveillance test. Instrumentation and Control (I&C) Technicians were performing the surveillance test as required by Technical Specifications. An erroneous value was entered into the RM-23A module. With the erroneous value being present when the conversion factor was subsequently entered, the RM-23A immediately processed the data and prematurely actuated the Fuel Handling Building isolation equipment. The cause of the event is attributed to lack of attention to detail and not using effective self-verification methods. Corrective actions included restarting the surveillance test without further incident, and providing the technician involved with a written reminder under the STPEGS Constructive Discipline Program. HL&P will also perform an evaluation to determine which procedures need to be revised to ensure a dual verification is performed for those actions where incorrect data entry errors could cause ESF actuations.

DESCRIPTION OF EVENT:

On July 10, 1992 at approximately 0917 hours, Unit 1 was in Mode 1 at 95 percent power. An unplanned Engineered Safety Features (ESF) actuation occurred during the performance of surveillance test on the Spent Fuel Pool Exhaust Monitor, RT-8036. The erroneous value of 1.52E-3 was entered into the RM-23A module. The value that should have been entered was 1.52E+3. The difference between the "+" (plus) and "-" (minus) was not detected at that time. The second procedural step following the erroneous entry was the entry of a conversion factor. When the conversion factor was entered, the RM-23A module processed the information and initiated an actuation of Fuel Handling Building (FHB) Heating, Ventilating, and Air Conditioning (HVAC) System isolation equipment. This caused the ESF actuation to occur prior to the planned ESF actuation. Control Room Operators acknowledged the ESF actuation as an unplanned event and halted performance of the surveillance test. The FHB equipment was then reset to conditions required for the surveillance test to continue. The surveillance test was then continued and completed without further incident. All ESF equipment actuated as designed. The NRC was notified of the unplanned ESF actuation at approximately 1047 hours.

CAUSE OF EVENT:

The cause of the vent is attributed to lack of attention to detail and the non-use of effective self-verification methods. The individual involved had become desensitized to the importance of the task due to the repetitious nature of performing this routine surveillance test.

ANALYSIS OF EVENT:

The unplanned actuation of an Engineered Safety Feature is reportable pursuant to 10CFR50.73(a)(2)(iv). All ESF equipment actuated as expected and there was no threat to the safety of the public or plant personnel or equipment.

CORRECTIVE ACTIONS:

1. The surveillance test was halted and equipment was reset to conditions prior to the actuation. The surveillance test was restarted and completed without further incidence.

2. The Technician involved received a written reminder under the STPEGS Constructive Discipline Program.

3. HL&P will perform an evaluation to determine which procedures need to be revised to ensure a dual verification is performed for those actions where incorrect data entries could cause ESF actuations. The evaluation will be completed by October 1, 1992. Additional corrective action will be developed as necessary.

ADDITIONAL INFORMATION:

Previous events involving ESF actuations that have been reported within the last three years, which were attributed to lack of attention to detail were:

- Unit 2 LER 89-011; Inadvertent Safety Injection and Reactor Trip System Actuation Due to personnel error
- Unit 1 LER 89-013; Unplanned ESF Actuation of the Fuel Handling Building HVAC Due to personnel error
- Unit 1 LER 90-001; ESF Actuation Due to Loss of Power to a Radiation Monitor Relay
- Unit 2 LER 90-010; Inadvertent ESF Actuation Due to Incorrect Connection of Test Equipment
- Unit 2 LER 90-014; Inadvertent ESF Actuation Due to Improper Use of Test Equipment
- Unit 1 LER 91-004; Partial Loss of Offsite Power Actuation During Routine Maintenance