

The Light company

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

November 11, 1992

ST-HL-AE-4253

File No.: G02.04

10CFR2.201

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

South Texas Project

Unit 1 & 2

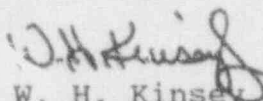
Docket TN 50-498, STN 50-499

Reply to Notice of Violation 9226-01

Regarding Failure to Notify NRC of Inadvertent ESF
Actuation within Required Time Frame

Houston Lighting & Power Company (HL&P) has reviewed Notice of Violation 9226-01 dated October 16, 1992, and submits the attached reply.

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


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

CAA/ag

Attachments: 1) Reply to Notice of Violation 9226-01
2) Licensee Event Report 92-009 (Unit 1)

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A Subsidiary of Houston Industries Incorporated

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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

In the Matter)

Houston Lighting & Power)
Company, et al.,)

Docket Nos. 50-498
50-499

South Texas Project)
Unit 1 and 2)

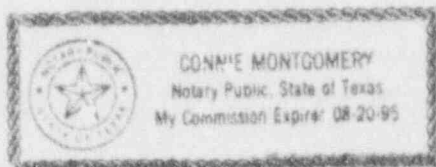
AFFIDAVIT

W. H. Kinsey, Jr., being duly sworn, hereby deposes and says that he is Vice President, Nuclear Generation, of Houston Lighting & Power Company; that he is duly authorized to sign and file with the Nuclear Regulatory Commission the attached reply to the NRC Notice of Violation 9226-01; that he is familiar with the content thereof; and that the matters set forth therein are true and correct to the best of his knowledge and belief.

W. H. Kinsey, Jr.
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 11 day of November, 1992.



Connie Montgomery
Notary Public in and for the
State of Texas

I. Statement of Violation:

Failure to Satisfy Reporting Requirements

10 CFR 50.72(b)(2)(ii) requires that any event or condition that results in a manual or automatic actuation of any engineered safety feature (ESF), that is not the result from nor part of a preplanned sequence during testing or reactor operation, be reported to NRC as soon as practical and, in all cases, within 4 hours of the occurrence.

Contrary to the above, on August 1, 1992, an inadvertent manual actuation of Auxiliary Feedwater Pump 13 occurred but was not reported to NRC within 4 hours.

This is a Severity Level IV violation. (Supplement 1)
(40 CFR 499/9226-01)

II. Houston Lighting & Power Position:

HL&P concurs that the cited violation occurred. This event is documented in Licensee Event Report 92-009 for Unit 1 (attached).

III. Reason for Violation:

At the time of occurrence of the actuation, the operations personnel were aware that an unplanned ESF actuation was reportable, however, they did not realize that manual starting the AFW pump would be an "actuation". The existing Operations Policy on reportability of pre-planned ESF actuations specified that manual ESF actuations are reportable if the actuation is in response to a real or perceived plant condition. This event does not fit either of these conditions. The policy did not specifically address a manual component start which was not in response to a real plant condition, and it did not define "actuation" further. As such an inadvertent manual start of the AFW pump during a surveillance test was not considered an "actuation" and was not initially considered reportable.

The event was also reviewed by the Nuclear Licensing Department two days later, however, the reportability was not recognized until three days after the event. The event was then reviewed again and determined to be reportable since the existing 10CFR50 rules and NUREG 1022 indicated that an actuation, whether manual or automatic, which was not part of a preplanned test sequence, was reportable.

IV: Corrective Actions to Prevent Recurrence:

LER 92-009 includes corrective actions to prevent recurrence of the actuation as well as the delay in NRC notification (refer to "Corrective Actions" section of the attached). In addition to those actions, the following will contribute to prevention of recurrence:

1. 10CFR50.72 and 50.73 have been revised to eliminate reporting of certain invalid ESF actuations. The rule change discussion provided clarifications on the meaning of valid and invalid actuations which are more explicit and clear than previous NRC guidance on reportable actuations. This rule change has been incorporated into the STPEGS Reporting Manual and an Operations Policy change has been made to provide clear direction to operations personnel on reporting of ESF component starts. The policy also further defines which components are considered possible sources of reportable ESF actuations at STPEGS. This new reportability guidance will also be incorporated in the next initial licensed operator training class, currently scheduled for the Spring of 1993. The next requalification cycle of licensed operator training will include this guidance by February 26, 1993.
2. HL&P will assemble previous NRC and STPEGS reportability documents and consolidate this guidance and historical information into a user-friendly, readily available form, such as a Reporting Manual Addendum, for quick reference by operations crews. This will be assembled and ready for use by January 20, 1993.

V. Date of Full Compliance:

HL&P is in full compliance at this time.

The Light company

Houston Lighting & Power

South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 77483

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August 31, 1992
ST-HL-AE-4190
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 92-009
Manual ESF Actuation of an
Auxiliary Feedwater Pump Contrary to Procedure

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Licensee Event Report 92-009 regarding a manual Engineered Safety Feature (ESF) actuation of an Auxiliary Feedwater (AFW) pump contrary to procedure. 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
William J. Jump
General Manager,
Nuclear Licensing

JMP/ag

Attachment: LER 92-009 (South Texas, Unit 1)

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Houston Lighting & Power Company
South Texas Project Electric Generating Station

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File No.: G26
Page 2

CC:

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Texas Department of Health
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Austin, TX 78756-3189

Revised 10/11/91

L4/NRC/

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN FOR 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 1

DOCKET NUMBER (2)

050004981 OF 04

PAGE (3)

TITLE (4)

Manual ESF Actuation of an Auxiliary Feedwater Pump Contrary to Procedure

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)

050004981

050004981

OPERATING MODE (9)

1

20.402(b)

20.405(c)

50.73(a)(2)(i)

73.71(b)

POWER LEVEL (10)

11010

20.405(a)(1)(i)

50.36(a)(1)

50.73(a)(2)(i)

73.71(c)

20.405(a)(1)(ii)

50.36(a)(2)

50.73(a)(2)(ii)

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)(iii)(A)

20.405(a)(1)(iv)

50.73(a)(2)(ii)

50.73(a)(2)(iii)(B)

20.405(a)(1)(v)

50.73(a)(2)(iii)

50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER (12)

TELEPHONE NUMBER

NAME

AREA CODE

Charles Ayala - Supervising Licensing Engineer

511297121-181618

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

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 - approximately fifteen single-space typewritten lines) (16)

On August 1, 1992, Unit 1 was in Mode 1 at 100% power. Testing of the Solid State Protection System (SSPS) actuation train "C" slave relays was in progress. At approximately 2049 hours, the operator performing the Auxiliary Feedwater (AFW) portion of the test misread a procedure step which directed him to verify that the #13 AFW pump did not start following a relay actuation. Rather than verify the pump did not start, the operator turned the control switch on in an attempt to verify that the pump would not start. The #13 AFW pump started and discharged into "C" Steam Generator. The operator quickly realized the error and stopped the pump. The cause of this event was inattention to detail, in that the operator misread the test procedure. Corrective actions include revising the SSPS Actuation Train Slave Relay Test procedures to provide more distinction between steps which verify equipment startup and steps which require an attempted component startup and including this event into the Licensed Operator Regualification training. Additionally, other surveillance procedures were identified to ensure that equipment actuations are clearly defined and a plan of action was developed to enhance these procedures.

LER\92231001.U1

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-630), 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)

DOCKET NUMBER (2)

LER NUMBER (3)

PAGE (3)

South Texas, Unit 1

0 5 0 0 0 4 9 8 9 2 - 0 0 9 - 0 0 0 2 OF 0 4

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

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DESCRIPTION OF EVENT:

On August 1, 1992, Unit 1 was in Mode 1 at 100% power. Unit 1 operators were performing the SSPS Actuation Train C Slave Relay Test. The Auxiliary Feedwater portion of this test requires the operator to depress and hold control switch S-238 in PUSH TO TEST. The next step requires the operator to verify that AFW Pump 13 did not start, then release the control switch and verify return to normal. The operator performing the step read the step to say that he was to verify that AFW pump 13 will not start. He then attempted to manually start AFW Pump 13 to verify that it would not start. However, the pump started and momentarily discharged into "C" Steam Generator. The operator quickly realized the error and stopped the pump.

The Shift Supervisor and the Duty Operations Manager discussed this event and determined that it was not reportable because the AFW pump was started during a surveillance test. The operators did not think that a manual start of a pump was an "actuation" as specified in 10CFR50.72(b)(2)(ii) for these conditions. Therefore, the event was not initially reported to the NRC. The event was also reviewed by the Nuclear Licensing Department two days later, however the reportability of the event was not recognized until the reportability status was questioned by the Deputy Plant Manager who brought it to the attention of the NRC Resident Inspector three days after the event. It was subsequently reviewed again by Licensing and determined that the event was reportable because the manual AFW pump start was not part of the preplanned test sequence. A notification was made to the NRC at 1306 hours on August 4, 1992.

CAUSE OF EVENT:

The cause of this event was inattention to detail, in that the operator misread the test procedure. A contributing cause was a weak procedure. The procedure being performed involved the actuation of a variety of equipment. After actuating certain relays, the operator only verifies that equipment status has or has not changed. However, after actuating other relays, the operator is required to attempt a manual start of equipment. The procedure is weak in that the wording of the different actuation verification steps are very similar. The only difference is that the word "does" or "did" is substituted for the word "will".

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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 (P-630), 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)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	0500049892	009	000	03	OF 04

TEXT (If more space is required, use additional NRC Form 305A's) (17)

ATTACHMENT 2
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PAGE 5 OF 6

Although plant personnel were aware that ESF actuations are reportable, they did not consider manually starting the AFW pump an "actuation". It was thought that an "actuation" was an automatic component start or a manual component start in response to a real or perceived plant condition.

ANALYSIS OF EVENT:

The manual actuation of an Engineered Safety Feature is reportable pursuant to 10CFR50.73(a)(2)(iv). There were no adverse radiological or safety consequences as a result of this event. The AFW pump functioned as designed and no significant feedwater transients occurred.

CORRECTIVE ACTIONS:

1. A memorandum was issued by the Plant Manager to define STP policy on the reporting of unplanned ESF actuations. This policy was provided to appropriate Operations personnel and reviewed by appropriate Licensing personnel. The Operations Policy, "Preplanned ESF Actuations", has been clarified to more clearly define what constitutes an "actuation".
2. This event will be included in Licensed Operator Regualification Training, to emphasize the need for caution when performing surveillance testing. This action will be completed by February 26, 1993.
3. The operator who performed the slave relay test has been counseled concerning attention to detail.
4. The SSPS Actuation Train A(B,C) Slave Relay Test Procedures have been changed to provide more distinction between the step which verifies AFW is not running and steps which require an attempted component startup.
5. Other surveillance procedures have been identified where actuation checks are not clearly defined. A plan of action has been developed to enhance these procedures.
6. An Unplanned ESF Actuation Task Force has been initiated to evaluate plant activities to reduce the number of unplanned ESF actuations.

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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 (P-630), 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)

DOCKET NUMBER (2)

LER NUMBER (6)

PAGE (3)

South Texas, Unit 1

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TEXT (If more space is required, use additional NRC Form 365A (1/7))

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ST-HL-AE-4253
PAGE 6 OF 6ADDITIONAL INFORMATION:

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

- Unit 2 LER 89-011; Inadvertent SI and Reactor Trip when a licensed operator skipped two steps in the plant heatup procedure.
- Unit 1 LER 90-001; ESF actuation due to a loss of power when a Maintenance Technician incorrectly lifted a power lead during a modification.
- Unit 1 LER 90-016; Reactor Trip due to inattention to decreasing margin to Over-temperature Delta T trip setpoint during power ascension.
- Unit 1 LER 91-004; Lockout of Standby Bus B when relay was improperly installed. Attributed to inadequate attention to work performance methods.
- Unit 1 LER 91-021; Reactor Trip when maintenance electrician touched the wrong contact while performing a continuity check.
- Unit 1 LER 92-007; Fuel Handling Building HVAC actuation when a technician entered the wrong value into radiation monitoring module RM-23A.

The generic issue of procedural deficiency has been addressed in response to a recent event which was reported as LER 92-005, entitled "Unplanned ESF Actuation Due to a Component Cooling Water Pump Start Due to Inadequate Procedure". HL&P performed an evaluation to determine which plant procedures need to be reviewed for insufficient procedural steps to operate plant equipment. It is HL&P's intent to ensure that safety related equipment manipulations are governed by written guidance. The evaluation will also consider procedures for non-safety related equipment which would impact safety related equipment.

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