

# The Light company

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

October 3, 1996  
ST-HL-AE-5483  
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  
Revision 1 to Licensee Event Report 95-013  
Turbine Trip and Reactor Trip Due to Main Transformer Lockout

Pursuant to 10CFR50.73, South Texas Project submits the attached revision to Unit 1 Licensee Event Report 95-013 regarding a turbine trip and reactor trip due to main transformer lockout. This event did not have an adverse effect on the health and safety of the public.

The purpose of this revision is to provide the apparent cause of the control rod insertion anomaly that occurred during this event. The South Texas Project has been and will continue to work with Westinghouse to determine the root cause, along with short and long term corrective actions. The final root cause and actions will be documented as part of Nuclear Regulatory Bulletin 96-001 correspondence. Changes are indicated by revision bars.

On July 25, 1996, an extension to the due date of this revision to October 10, 1996, was granted by Ms. Linda Smith, Acting Branch Chief, Nuclear Regulatory Commission - Division of Reactor Projects.

If you should have any questions on this matter, please contact Mr. S. M. Head at (512) 972-7136 or me at (512) 972-7800.

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*G. L. Parkey*

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JMP/

Attachment: Revision 1 to LER 95-013 (South Texas, Unit 1)

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

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*11*

Houston Lighting & Power Company  
South Texas Project Electric Generating Station

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EXPIRES 04/30/98

## LICENSEE EVENT REPORT (LER)

(See reverse for required number of  
digits/characters for each block)ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY  
INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE  
INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY.  
FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND  
RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION,  
WASHINGTON, DC 20555-0001, 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)

05000 498

PAGE (3)

1 OF 6

TITLE (4)

Turbine Trip and Reactor Trip Due to Main Transformer Lockout

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
12	18	95	95	-- 013 --	01	10	03	96		
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
1										
POWER LEVEL (10)			100							
			20.2201(b)							
			20.2203(a)(1)							
			20.2203(a)(2)(i)							
			20.2203(a)(2)(ii)							
			20.2203(a)(2)(iii)							
			20.2203(a)(2)(iv)							
			20.2203(a)(3)(i)							
			20.2203(a)(3)(ii)							
			20.2203(a)(3)(iii)							
			20.2203(a)(4)							
			50.73(a)(2)(i)							
			50.73(a)(2)(ii)							
			50.73(a)(2)(iii)							
			50.73(a)(2)(iv)							
			50.73(a)(2)(v)							
			50.73(a)(2)(vii)							
			50.73(a)(2)(viii)							
			50.73(a)(2)(ix)							
			73.71							
			OTHER							
			Specify in Abstract below or in NRC Form 366A							

## LICENSEE CONTACT FOR THIS LER (12)

NAME

Scott M. Head - Sr. Consulting Engineer

TELEPHONE NUMBER (Include Area Code)

(512) 972-7136

## 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
X	AA	ROD	W120	N					

## SUPPLEMENTAL REPORT EXPECTED (14)

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

## ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On December 18, 1995, Unit 1 was in Mode 1 at 100% power. At approximately 0336 hours, a Backup Pilot Wire Monitoring Relay actuated and resulted in a lockout of the Unit 1 main and auxiliary transformers. This event tripped open the generator output breaker, the main turbine, the breakers for all four 13.8 kV auxiliary buses and caused loss of offsite power to the A Train Engineered Safeguards Features Bus. The main turbine trip resulted in a reactor trip. The plant was stabilized in Mode 3. Following the reactor trip, three control rods indicated a rod position of six steps from rod bottom. All other control rods had indication of their rod bottom lights illuminated. Human performance issues identified regarding this event involved compliance with Emergency Operating Procedures, notification timeliness and accuracy, and inappropriate manual starting of Train B and C Standby Diesel Generators. The root cause of the trip was improper maintenance performance that resulted in a pinched wire which grounded the A phase of the backup pilot wire current transformer when the cover was reinstalled during the Unit 1 refueling outage in the Spring of 1995. Root cause determination for the control rod insertion anomaly is subject of an ongoing investigation. Core physics analyses for this condition were performed and determined continued operation of Unit 1 is acceptable until the end of the current operating cycle. Corrective actions include repair of the grounded connection; reinforcement of management's expectations regarding control rod insertion indication, Emergency Operating Procedure usage and accuracy of notifications; training on lessons learned from this event; and procedure enhancements.

LICENSEE EVENT REPORT (LER)  
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

## DESCRIPTION OF EVENT:

On December 18, 1995, Unit 1 was in Mode 1 at 100% power. At approximately 0336 hours, a ground fault occurred on one of the main transmission lines from the South Texas Project Electric Generating Station switchyard. The ground fault cleared when a protective breaker opened in the line. When the transmission line fault cleared, a Backup Pilot Wire Monitoring Relay actuated and resulted in a lockout of the Unit 1 main and auxiliary transformers. This event tripped open the generator output breaker, the main turbine, the breakers for all four 13.8 kV auxiliary buses and caused loss of offsite power to the A Train Engineered Safeguards Features Bus. The main turbine trip resulted in a reactor trip. The loss of electrical power to all Unit 1 auxiliary buses caused a loss of all reactor coolant pumps. The A Train Standby Diesel Generator started and loaded on its Engineered Safeguards Features Bus as expected. All Auxiliary Feedwater Pumps started to supply feedwater to the Steam Generators as expected. Main Feedwater Isolation Valves closed on an expected Feedwater Isolation signal as designed.

The loss of power resulted in loss of indication of voltage and current from offsite power to all Unit 1 auxiliary and standby buses when read from Main Control Board Panel CP010. With only the A Train Standby Diesel Generator running, the B and C Train Standby Diesel Generators were manually started to ensure power was available to all three Engineered Safeguards Features Buses. Subsequently, it was determined that only indication to panel CP010 had been lost and that Trains B and C Engineered Safeguards Features Buses had remained energized from offsite power. The B and C Train Standby Diesel Generators did not load their respective Engineered Safeguards Features Buses and were secured.

During verification that the control rods had fully inserted, it was noted that the digital rod position for control rods F10, C9 and N7 each indicated a rod position of six steps from rod bottom with their respective rod bottom lights not lit. All other control rods had indication of their rod bottom lights illuminated. This condition was considered as all rods fully inserted. Subsequently, during plant stabilization, control rod N7 indicated the fully inserted position.

The partial loss of offsite power caused normal letdown to isolate, which resulted in transfer of Charging Pump suction to the Refueling Water Storage Tank due to a low level in the Volume Control Tank. This provided a source of boration to the Reactor Coolant System. Normal letdown was restored at 0357 hours but the Charging Pump suction remained aligned to the Refueling Water Storage Tank to provide a boration flowpath for maintaining xenon free shutdown margin.

The Main Steam Isolation Valves were closed to limit cooldown. Main Steam Isolation Valve 1B Control Room indication showed the valve was not fully closed. Approximately nine minutes later, the valve indicated fully closed and it was subsequently determined that it had fully closed initially. An adjustment was made to the valve limit switch to correct the indication.

At approximately 0350 hours, the Pressurizer Power Operated Relief Valves automatically cycled three times. Auxiliary spray flow was subsequently used to control pressurizer pressure. Natural circulation of the Reactor Coolant System was verified.



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## DESCRIPTION OF EVENT: (Continued)

The electrical buses supplying power to the Reactor Coolant Pumps were reenergized at approximately 0450 hours. At approximately 0511 hours, Reactor Coolant Pump 1A was restarted followed by Reactor Coolant Pump 1D approximately eleven minutes later. This reestablished forced Reactor Coolant System flow and restored normal pressurizer spray capability.

At approximately 0603 hours, normal offsite power was restored to the A Train Engineered Safety Features Bus and the A Train Standby Diesel Generator was placed in cooldown.

At approximately 0610 hours, a Shutdown Margin verification was performed and Reactor Coolant System boron concentration was determined to be greater than the xenon free required value.

Investigation of the Unit 1 main transformer condition determined that one wire on the backup pilot wire current transformer for the A phase on Main Transformer 1B was pinched between the cover and the seating surface. This condition grounded the current transformer windings to the main transformer casing and, coupled with the line fault on the A phase of the transmission line from the South Texas Project Electric Generating Station, setup the conditions which led to the reactor trip.

Other equipment problems providing operator challenges occurred during this event:

1. The protection circuits did not trip the Startup Feed Pump on low net positive suction head and required manual trip of the pump from the Control Room.
2. Steam Generator Feed Pump #13 could not be placed on its turning gear.
3. The supply breaker to Load Center 12J1 failed during reenergization.
4. The Fire Protection Computer audible alarm continued to sound in the Control Room during this transient until the computer was rebooted.

Human performance issues involving this event were identified:

1. Management expectations regarding compliance with Emergency Operating Procedures were not met. Although control rod position indications received following the reactor trip required emergency boration, this action was not taken.
2. Management notification of the reactor trip was not timely.
3. Accuracy of the notification of this event to the Nuclear Regulatory Commission did not meet expectations.
4. Manually starting Train B and C Standby Diesel Generators was inappropriate.

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## DESCRIPTION OF EVENT: (Continued)

A Human Performance Post-Trip Review Team was formed to investigate and evaluate the human performance issues. This team focused on the sequence of events and procedures used to respond to the transient. The Team determined that reasonable technical decisions were made in handling a complex transient. Some examples were found where procedures and their usage did not meet management's expectations. Actions identified to enhance performance and better define management expectations are listed as Corrected Actions in this report.

## CAUSE OF EVENT:

The cause of this event was a grounded connection on the A phase of the Main Transformer 1B backup current transformer for the HCB differential relay. The condition resulted in the current transformer sensing a differential in line current when the fault in the transmission line from the South Texas Project Electric Generating Station cleared. This differential caused actuation of the Pilot Wire Monitoring Relay.

The root cause of the trip was improper maintenance performance that resulted in a pinched wire which grounded the A phase of the backup pilot wire current transformer when the cover was reinstalled during the Unit 1 refueling outage in the Spring of 1995.

The apparent cause of the incomplete Rod Cluster Control Assembly insertion is fuel assembly thimble tube distortion resulting from high, in-vessel, compressive loading imparted on the assembly skeleton. The problematic distortion is limited to the assembly dashpot area of the thimble tubes, and causes mechanical interference which prevents complete control rod insertion. The South Texas Project has been and will continue to work with Westinghouse to identify the root cause, along with short and long term corrective actions. The final conclusions of this control rod insertion anomaly will be documented in future Nuclear Regulatory Commission Bulletin 96-001 correspondence.

The cause of the failure to emergency borate the reactor was misdiagnosis of the post-trip rod position and the belief by the operating crew that all rods were fully inserted.

## ANALYSIS OF EVENT:

Reactor Trips and Engineered Safeguards Features Actuations are reportable pursuant to 10CFR50.73 (a)(2)(iv). The reactor was brought to an orderly shutdown. All Engineered Safeguards Features functioned as designed. There were no adverse safety or radiological consequences of this event.

Following the reactor trip, the Reactor Coolant System average temperature reached a low of 554 degrees. This was the result of Auxiliary Feedwater being inserted to the Steam Generators to establish natural circulation. The Shutdown Margin remained satisfied during this event, greater than 271 ppm over the minimum required boron concentration.

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## ANALYSIS OF EVENT: (Continued)

The failure of control rods F10, C9 and N7 to fully insert was investigated. These control rods did insert to the six step position from rod bottom (approximately 4 inches) as indicated by digital rod position indication.

Followup testing determined that this condition was repeatable. An additional rod failed to fully insert at core location N-9 stopping at six steps from rod bottom. There were no indications that the rods were having any difficulty during insertion except in the bottom of the guide tube dash pot region. Rod drop traces did not indicate any significant decrease in rod speed until dashpot entry and did not indicate any evidence of loose parts. Rod drop times of the affected rods were consistent with startup testing performed in the Spring of 1995 and well within Technical Specification requirements. The affected rods were manually inserted to rod bottom further supporting there was no indication of loose parts.

Control rods exhibiting this problem were all in high burnup fuel assemblies, approximately 43,000 MWD/MTU. The service life of the affected control rods is six cycles which is approximately half of their design life (15 years).

A safety evaluation for this condition determined that the affected rods were capable of performing their safety function for reactivity control and for shutdown and that there was no impact on Shutdown Margin. This safety evaluation conservatively assumed that all rod control cluster assemblies in the high burnup fuel assemblies, which represents 32 of the total 57 rod control cluster assemblies, would not insert below 12 steps from rod bottom following a reactor trip. Core physics analyses for this condition were performed and determined continued operation of Unit 1 is acceptable until the end of the current operating cycle.

A review of Industry Operating Experience of control rod insertion anomalies indicated several potential causes including foreign material, degraded control rod, corrosion products and guide tube bowing. Root cause determination for the control rod insertion anomaly observed following the Unit 1 reactor trip is subject of an ongoing investigation.

The last occasion of rod drop testing in Unit 1 was successfully completed during the Spring 1995 refueling outage. In addition, all rods demonstrated proper insertion indications during the Unit 1 reactor scram that occurred on August 29, 1995.

## CORRECTIVE ACTIONS:

1. The grounded connection on the A phase of the Main Transformer 1B backup current transformer for the HCB differential relay was repaired.
2. A faulty pressure switch in the loss of suction protection instrumentation on the Startup Feed Pump was found and repaired.
3. Lessons learned from this event were discussed with maintenance personnel involved in the root cause of this event.

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## CORRECTIVE ACTIONS: (Continued)

4. Guidance was issued to reinforce management's expectations regarding control rod insertion indication, Emergency Operating Procedure usage and accuracy of notifications to regulatory agencies. On-Shift Licensed Operators were briefed by management regarding this reinforced guidance prior to assuming shift duties.
5. Training information regarding the lessons learned from this event has been issued to operations and maintenance personnel.
6. Licensed Operator training has been enhanced with special emphasis on procedure usage, reactivity management issues, accuracy of notifications to offsite agencies and expected response to the rod position indication during this event.
7. The South Texas Project has been and will continue to work with Westinghouse to determine the root cause of the control rod insertion anomaly, along with short and long term corrective actions. Further correspondence on this issue will be provided via correspondence to Nuclear Regulatory Commission Bulletin 96-001.
8. The Reactor Trip Response procedure has been revised to provide specific criteria for supporting decision making and diagnosis of conditions.
9. The Emergency Operating Procedures Users Guide has been revised to include specific criteria when alternate step performance can be authorized regarding Emergency Operating Procedures.
10. An effectiveness evaluation of the Event Review process has been completed. No significant problems were identified however, enhancement to the process have been incorporated into the Event Review Team Procedure.

## ADDITIONAL INFORMATION:

One Licensee Event Report had been previously submitted by the South Texas Project to the Nuclear Regulatory Commission within the last three years regarding a reactor scram and partial loss of offsite power due to a main transformer failure. Licensee Event Report 94-007 attributed the cause to the failure of a capacitor within the pilot wire relay.

In response to Nuclear Regulatory Commission Bulletin 96-001, "Control Rod Insertion Problems," the South Texas Project committed to perform additional hot, full flow rod drop testing in Unit 1 during the Spring Refueling Outage. The May 18, 1996 testing resulted in a total of eleven control rods that did not fully insert to rod bottom. The testing results are documented in South Texas Project correspondence ST-HL-AE-5408, dated July 3, 1996.