

DMB

In Reply Refer To:
Dockets: 50-498
50-499
EA 87-240

JAN 19 1988

Houston Lighting & Power Company
ATTN: J. H. Goldberg, Group Vice
President, Nuclear
P.O. Box 1700
Houston, Texas 77001

Gentlemen:

This refers to the enforcement conference conducted in the NRC Region IV office on December 30, 1987, with you and other members of your staff and Region IV staff members to discuss findings of the NRC inspection conducted during the period of November 1-30, 1987, which were documented in NRC Inspection Report 50-498/87-71; 50-499/87-71, dated December 18, 1987.

The topics covered are described in the enclosed meeting summary.

It is our opinion that this meeting was beneficial and provided a better understanding of the concerns identified during the inspection.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter will be placed in the NRC's Public Document Room.

Should you have any questions concerning this letter, we will be pleased to discuss them with you.

Sincerely,

Original Signed By
L. J. Callan

L. J. Callan, Director
Division of Reactor Projects

Enclosure:
Meeting Summary

CC:
Houston Lighting & Power Company
ATTN: M. Wisenberg, Manager
Nuclear Licensing
P.O. Box 1700
Houston, Texas 77001

RIV:DRP/D *EB*
HFBundy:gb
1/14/88

with change attached
C:DRP/D
GLC:stable
1/14/88

EO *AP*
DAPowers
1/15/88

D:DRP *AP*
LJCallan
1/19/88

8801280025 880119
PDR ADOCK 05000498
Q PDR

1E45 111

Houston Lighting & Power Company
ATTN: Gerald E. Vaughn, Vice President
Nuclear Operations
P.O. Box 1700
Houston, Texas 77001

Central Power & Light Company
ATTN: R. L. Range/R. P. Verret
P.O. Box 2121
Corpus Christi, Texas 78403

City Public Service Board
ATTN: R. J. Costello/M. T. Hardt
P.O. Box 1771
San Antonio, Texas 78296

City of Austin
ATTN: M. B. Lee/J. E. Malaski
P.O. Box 1088
Austin, Texas 78767-8814

Texas Radiation Control Program Director

bcc distrib. by RIV:

*DRP

R. D. Martin, RA
Section Chief (DRP/D)

*RIV File

*Lisa Shea, RM/ALF

R. Bachmann, OGC

*P. Kadambi, NRR Project Manager

*DRS

*RRI-OPS

*RRI-CONST.
RPSB-DRSS

*RSTS Operator

*H. Bundy

*R. Taylor

D. Powers

MEETING SUMMARY - DECEMBER 30, 1987

Licensee: Houston Lighting and Power Company (HL&P)
Facility: South Texas Project (STP), Units 1 and 2
Dockets: 50-498 Operating License: NPF-71
 50-499 Construction Permit: CPPR-128

Subject: Enforcement Conference
 Concerning NRC Inspection Findings (NRC Inspection
 Report 50-498/87-71; 50-499/87-71) and Related Concerns

On December 30, 1987, representatives of HL&P met with NRC Region IV and NRR personnel in the NRC office in Arlington, Texas to discuss the findings documented in NRC Inspection Report 50-498/87-71; 50-499/87-71, dated December 18, 1987. Other recent events of mutual concern were also discussed. The attendance list and summary of the licensee presentation are attached. The meeting was held at the request of the NRC, Region IV.

The licensee discussed root causes for selected events, corrective actions taken to preclude recurrence, and results achieved to-date.

The NRC staff expressed particular concern regarding the two events discussed below:

a. Plant Entered Mode 4 on October 31, 1987, with High Head Safety Injection (HHSI) System Valves Shut

The licensee agreed that this was the most serious of the events selected for discussion. There was no direct safety impact because the reactor core has not been operational and no decay heat was present. Accordingly, the major NRC concern was with regard to the evident weaknesses in the licensee operating practices which allowed this condition to continue for 51 hours prior to discovery. Many operators, supervisors and managers had opportunities to question the off-normal valve positions during this period.

b. Pressurizer Pressure-Low Trip Setpoint Was Set Less Conservatively than Technical Specification (TS) Requirement on November 24, 1987

This setpoint error had the effect of rendering all four channels of the safety injection actuation system inoperable. The staff questioned the efficiency of the licensee's procedure review and approval process in allowing the incorrect setpoint to be inserted in the procedure. This setpoint had been changed as result of engineering analysis by the vendor and HL&P had requested the TS change as a result of this analysis. NRC Inspection Report 50-498/87-27 discussed this change as a followup to HL&P Incident Review Committee Item 333. Also NRC Inspection Report 50-498/87-39, Open Item 498/8739-10, identified specific TS setpoint errors for annunciators and suggested further verification of instrument setpoints. Despite these references and subsequent TS audits performed by the licensee, the setpoint error was not corrected prior to entry into Mode 3. Another concern the NRC staff had was the fact that HL&P in Licensee Event Report (LER) 87-017, dated December 21, 1987, failed to recognize the change to Mode 3 with incorrect setpoints as a TS violation. This point was clarified in the meeting.

The NRC staff explained to licensee representatives the enforcement policy. The licensee was commended for his candor in reporting and discussing the above described events.

Attachments:

- A. Enforcement Conference Attendance
- B. Outline of HL&P's Presentation

Attachment A

Enforcement Conference Attendance December 30, 1987

<u>Name</u>	<u>Title</u>	<u>Organization</u>
J. H. Goldberg	Group VP Nuclear	HL&P
G. E. Vaughn	VP Nuclear Operations	HL&P
W. H. Kinsey	Plant Manager, STP	HL&P
M. Wisenburg	Manager, Engineering & Licensing	HL&P
M. A. McBurnett	Manager, Operations Support Licensing	HL&P
L. Joe Callan	Director, Division of Reactor Projects	NRC, RIV
J. L. Milhoan	Director, Division of Reactor Safety	NRC, RIV
A. Bill Beach	Deputy Director, Division or Reactor Projects	NRC, RIV
H. L. Scott	Enforcement Staff	NRC, RIV
G. L. Constable	Chief, Reactor Projects Section D	NRC, RIV
D. M. Hunnicutt	Chief, Test Programs Section	NRC, RIV
M. T. Hardt	Director, Nuclear Division	City Public Service San Antonio
D. R. Carpenter	Senior Inspector-STP	NRC, RIV
H. F. Bundy	Project Engineer	NRC, RIV
N. P. Kadambi	Project Manager	NRC, NRR
J. I. Tapia	Project Engineer (Section A)	NRC, RIV



NRC ENFORCEMENT CONFERENCE

ARLINGTON, TEXAS

DECEMBER 30, 1987

AGENDA

- Introduction — J. H. Goldberg
- Technical Specification Violations — W. H. Kinsey
- Management Initiatives — W. H. Kinsey
- Questions/Answers

EVENT

- Plant entered Mode 4 on 10-31-87 with HHSI system valves isolated.
- Discovered during shift turnover on 11-02-87.
- Immediately opened Train "B" and "C" valves.

ROOT CAUSE

- Poorly planned evolution. Operations Management in effort to verify plant lineup did not understand procedural relationships and operator performing evolution did not understand "big picture."

CORRECTIVE ACTION

- Remedial training for operators and management on compliance with procedures, selection of procedures, proper planning and attention to detail.
- Revise specific involved procedures and review others for similar weakness.
- Enhance shift turnover information on status of Safety Related equipment.
- Simulator training with emphasis on mode changes and accompanying requirements.

EVENT

- Plant staff discovered that Reactor Containment Building (RCB) Atmosphere monitor I-131 channel was not tested in accordance with technical specifications on 09-18-87.
- Grab sampling of RCB initiated and the channel tested within 24 hours.

ROOT CAUSE

- Process for review of last minute technical specification changes and incorporation of technical specifications into surveillance procedures was not rigorous. Management relied on responsible individuals to perform last minute changes without verification.

CORRECTIVE ACTION

- Review technical specification surveillances and LCO numbers, with exception of ESF and RTS setpoints, against surveillances.
- Implementation of future technical specification changes will be performed using a detailed process that incorporates independent verification.

EVENT

- Plant staff discovered Pressurizer Pressure—Low Trip Setpoint was set less conservatively than technical specification requirement on 11-24-87.
- Plant conditions required for function never achieved.
- Instruments recalibrated within 24 hours.

ROOT CAUSE

- Process for review of last minute technical specification changes and incorporation of technical specifications into surveillance procedures was not rigorous. Management relied on responsible individuals to perform last minute changes without verification.

CORRECTIVE ACTION

- Review Engineered Safety Features and Reactor Trip System setpoints against surveillance procedures to ensure no other items were missed.
- Implementation of future technical specification changes will be performed using a detailed process that incorporates independent verification.

EVENT

- Plant staff discovered that the slave relay contact for train "A" containment spray actuation was not tested on 11-24-87.
- Performed test within 24 hours.

ROOT CAUSE

- Superficial review of procedure field change and absence of written interpretation of technical specification requirements.

CORRECTIVE ACTION

- Reviewed trains "B" and "C" to ensure identical error was not made.
- Remedial training for I&C Division Supervision on independent verification of procedure changes and on attention to detail.

EVENT

- Plant staff discovered the 4160 degraded voltage and the degraded voltage coincident with safety injections contacts were not tested on 12-12-87.
- Performed tests within 24 hours

ROOT CAUSE

- Technical preparation and independent review were not rigorous. Absence of written interpretation of technical specification requirements.

CORRECTIVE ACTION

- Established station policy on relay testing.
- Performed two independent reviews of all I&C and electrical surveillance tests for compliance with technical specifications.

EVENT

- Plant staff discovered both toxic gas monitors out of service on 12-06-87.
- Placed control room in recirculation mode and restored monitors to service.

ROOT CAUSE

- Insufficient supervision and training of reactor operator student conducting routine log readings.

CORRECTIVE ACTION

- Conduct Plant Operations and Chemical Operations staffs crew briefings, stressing importance of conducting thorough indoctrination/training for students. Reemphasize responsibility for student actions.
- Reprogram toxic gas monitors such that operators are only required to read computer printouts to perform channel operation checks.
- Review and revise OJT training program for operator rounds.
- Review and revise operator logs for channel check recording requirements.
- Complete technical specification equipment "positive statusing" review.

EVENT

- NRC Resident Inspector informed Plant Manager that, contrary to commitment, "A" train Auxiliary Feedwater cross-connect valve was not tagged closed when plant entered mode 3.

ROOT CAUSE

- Insufficient written guidance and training provided to shift personnel on implementation of "Night Order" assignments.

CORRECTIVE ACTION

- Revise "Night Order" administrative procedure and train shift personnel on changes.

EVENT

- Two fire protection dampers were found to be blocked open with electrical tie wraps and wire. These dampers were designed to be held open with fusible links.
- Fire watches immediately established in affected areas.

ROOT CAUSE

- Unknown. Quality assurance records indicate adequate installation. No evidence can be found of maintenance or in situ testing on the affected dampers following installation.

CORRECTIVE ACTION

- One damper has been restored to full service. Other damper is still inoperative awaiting replacement parts.

MANAGEMENT INITIATIVES

- O COMPLETE OR ONGOING
 - Management briefings with all employees prior to OL
 - Aggressive OER program
 - Attendance at industry meetings
 - Pre-INPO NTOL audit
 - Special assist visit from INPO
 - Operations readiness assessment by Delian
 - Maintenance readiness assessment by Impell
 - Supplemental help in areas with less than desirable experience
 - Review of other operating station programs and procedures
 - Aggressive use of plant procedures during preoperational test program
 - Rigorous Technical Specification verification against plant design
 - Reliability Task Force
 - / Feedwater
 - / Radiation Monitoring
 - / Toxic Gas Monitors
 - / Motor Operated Valves
 - / Seismic Monitors
 - / BOP Design Trip Reduction
 - Technical Specification equipment indication to operator review
 - RPS & ESF equipment "Bump" protection review

MANAGEMENT INITIATIVES

O PLANNED

- Executive management briefings with all supervision and management
- Additional review of recent plant startup events
- Increase emphasis on use of simulator for normal evolution training
- Peer involvement on personnel error investigations
- Root cause determination training for representative Department personnel
- Continued high level management involvement in Station Operation
 - / Plan of Day Meetings
 - / Station Problem Reports