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NRC STAFF PROPOSES FINES TOTALING $175,000 IN THREE HOUSTON LIGHTING & POWER ENFORCEMENT ACTIONS

The Nuclear Regulatory Commission staff has informed Houston Lighting & Power Company (HL&P) that it proposes to fine the company a total of $175,000 for apparent violations connected with three enforcement cases involving the South Texas Project in Matagorda County, Texas.

HL&P has 30 days to respond to the NRC notification. During that time it may pay the civil penalties, or protest any or all of them. If a protest is made and denied, the company may ask for a hearing.

These enforcement actions are all being taken for violations found during the regular inspection program conducted by NRC's Region IV office in Arlington, Texas. They are independent of the NRC diagnostic examination currently under way at the South Texas Project.

Situations which brought about the enforcement actions are these:

- Failure of some plant managers in May 1992 to inform NRC-licensed control room operators promptly of a potentially significant condition that could have affected plant operations in both South Texas units. Proposed fine: $75,000.

- Numerous examples of personnel errors involving individuals working on equipment on the wrong unit or wrong system. Proposed fine: $25,000.

- The company's failure to repair an inoperable motor-operated valve in a South Texas Unit 2 safety sub-system for 18 months (from April 1989 to October 1990); and its failure to shut down the unit during that time as required by the operating license. Proposed fine: $75,000.

COMMUNICATION WEAKNESSES BETWEEN MANAGERS AND OPERATORS

The communications problem between some managers and control room operators first came to light in May 1992, when plant officials declared inoperable the South Texas reactor shutdown system after concluding that a portion of the system had not been tested as required.

Because both units were operating at full power at the time, plant management moved to seek a temporary NRC waiver of the test requirements, but did not notify control room operators for two and a half hours that the system had been declared inoperable. (License specifications require that, in such a situation, the units involved must initiate actions to shut down.) In fact, the control room operators' supervisors were not informed until after NRC prompted HL&P to do so during a telephone conference call when the temporary waiver of compliance was being discussed.

Another weakness in plant management-control room communication occurred on September 3, 1992. Control room operators were two and a half minutes away from beginning a plant shutdown in compliance with license specifications when they received by facsimile transmission new guidance from a plant manager which conflicted with the operators' previous training. NRC believes this action caused unnecessary confusion because the new guidance had not been subjected to formal reviews required by plant procedures.

James L. Milhoan, NRC regional administrator, told HL&P in his letter concerning this enforcement action that both the May and September incidents concern NRC "because plant management's actions could have interfered with the ability of licensed personnel to carry out their assigned responsibility and plant management's actions violated established procedures."

PERSONNEL ERRORS DURING WORK ON PLANT EQUIPMENT

HL&P discovered eight instances between September 1992 and January 1993 when South Texas employees failed to verify that they were dealing with the correct unit, correct train or correct device before doing testing or maintenance work, even though such verification is required by South Texas procedures. NRC inspections verified these occurrences and examined the circumstances. The instances are:

(1) Maintenance work begun on the wrong condenser waterbox before the error was discovered.
(2) Maintenance performed on a wrong pipe support in the essential cooling water system.

(3) Operational test performed on the wrong reactor cooling pump shutdown actuating device.
(4) Leak rate test performed on the wrong containment isolation valves.
(5) Wrong wiring disconnected during testing of an emergency cooling water system component.
(6) Maintenance performed on a control room parameter display system in the wrong unit.
(7) Service request written for the wrong feedwater heater drain valve (although work was performed on the correct valve).
(8) One automatic reactor shutdown setpoint set incorrectly.

Mr. Milhoan's letter about these violations said NRC acknowledges that the errors involved had no immediate impact on plant or personnel safety. But he said they represent a "significant regulatory concern in the area of personnel performance and, more significantly, attention to detail."

He added: "These examples. . . indicate that HL&P's efforts to correct these problems have not yet been effective." He also said it is difficult to gauge now the effectiveness of a corrective action program HL&P has outlined, since many of its more important actions have not been implemented or completed. Mr. Milhoan further said NRC reviewed four more instances of similar personnel errors during an inspection completed on April 12.

VIOLATIONS ASSOCIATED WITH MOTOR-OPERATED VALVES

HL&P discovered in February of this year that a motor-operated valve in a South Texas Unit 2 safety system — which failed in April 1989 after its motor burned up during an attempt to open it — was not repaired until October 1990. Thus, it was inoperable for 18 months while the plant was in operation. The valve is in a sub-system of one of Unit 2's three redundant emergency core cooling systems.

What brought the matter to HL&P's attention was another motor burn-up with this same valve, which occurred February 9. During its follow-up investigation, HL&P discovered the previous 18-month delay in replacing the valve motor and putting the component back into service. (In both instances, valve motors burned up after control room operators actuated them in an effort to open the valve during routine valve operations. HL&P now believes the malfunction was caused by the valve gear box being packed with slightly hardened grease.) An NRC inspection February 17-26 documented the circumstances of the valve problems.

The HL&P investigation showed that, after the valve motor burned out in April 1989, a work request was prepared for the motor's replacement, but no steps were taken to determine the root cause of the failure. The motor was again checked and determined to be inoperable in November 1989, but was never replaced until October 1990. During that time, HL&P took no action to shut down Unit 2, despite a license requirement that a shutdown begin if such an inoperable valve cannot be restored to operable status within 72 hours.

In his letter to HL&P about this matter, Mr. Milhoan said NRC recognizes that an HL&P analysis showed that redundancies in the plant's safety system would have compensated for this inoperable valve during an accident.

"Nevertheless," he added, "the NRC considers [these violations] to be a significant regulatory concern because (1) a safety related [motor-operated valve] went unrepaired for 18 months, despite multiple opportunities to recognize the significance of the deficiency and take corrective action, and (2) operations personnel did not recognize the. . . implications of operating the reactor with [this specific valve] inoperable."

Mr. Milhoan noted that HL&P has acknowledged past weaknesses in its corrective action program and has contended that it has significantly enhanced it. The NRC administrator said, however, that other NRC inspections suggest that these HL&P corrective action program improvements have not been completely effective. Specifically, he suggested that HL&P consider changing the frequency of its inspection of valve lubricants to avoid another situation with hardened grease.

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