Licensee/Facility: Notification:

MR Number: H-93-0024
Usnrc Events Assessment Branch Date: 08/05/93

Subject: SOUTH TEXAS - COMBINED PERSONNEL, MAINTENANCE, AND PROCEDURAL ERRORS

Reportable Event Number: N/A

Discussion:

The NRR/AEOD Significant Events Panel on July 27, 1993, classified certain personnel, maintenance, and procedural errors at the South Texas Project (STP) as a Significant Event for the Performance Indicator Program. The STP licensee committed a number of violations of established procedures which resulted in licensed control room operators not being informed of potentially significant conditions that could have affected the operation of the plant.

On May 19, 1992, with both STP units operating at 100-percent power, plant officials concluded after extensive review that a deficiency existed in the surveillance test of the reactor trip system. Although about 26 plant personnel were involved in reviewing the deficiency that led to the plant manager declaring the reactor trip system for both units inoperable, the unit shift supervisors were not notified until two and one-half hours after a decision was made to enter Technical Specificat

ion
3.0.3. This delay prevented shift supervisors from taking steps to prepare for or initiate plant shutdown and also prevented them from making required notifications in a timely manner.

On September 3, 1992, while control room operators were implementing T/S
3.0.3 in response to a component operability problem and were 2 minutes
from initiating a facility shutdown, management personnel electronically
transmitted to the control room revised guidance for implementing T/S 3.0.3. No explanatory information accompanied the transmittal. The revised guidance caused confusion among control room licensed operators.
They, therefore, chose to ignore the guidance. The revised guidance would
have allowed additional time for troubleshooting and repair of the problem before initiating shutdown. The manager's actions demonstrated very poor judgment in providing guidance without explanation and in circumventing established procedures. He also could have eliminated the
considerable confusion by simply entering the control room and speaking
directly to the operators.

Between September 28, 1992 and January 9, 1993, there were eight instances of personnel errors that resulted in work being performed on equipment in the wrong train or wrong unit. While none of these errors resulted in adverse safety consequences, collectively they represent a significant regulatory concern.

Because of procedural errors, the licensee did not take corrective actions to replace a motor on a motor-operated valve (MOV) in the Unit 2 A train low-head safety injection (LHSI) system. The valve remained inoperable for a period of 19 months. Technical specifications require

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the valve to be open with power removed while operating in modes 1 through 3. During a power ascension, the valve motor was found to be failed. Operators manually opened the valve and removed power from the actuator. The operators concluded that this configuration placed the valve in compliance with technical specifications and the power ascension was continued. Operations personnel did not recognize that the inoperable valve caused the A train, LHSI hot leg recirculation function to be degraded. The valve must be in a closed position during LHSI hot leg recirculation. With the failed motor operator, the valve could not have been closed remotely. Local manual action would have been required before LHSI hot leg recirculation could have been established.

The above described events indicate management and procedural deficiencies which individually may not present immediate safety concerns. However, when viewed collectively, they are indicative of serious programmatic weaknesses in the licensee's management of the plant.

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