

The Light company

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

July 06, 1990

ST-HL-AE-3499

File No.: G26

10CFR50.73

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

South Texas Project Electric Generating Station
Unit 1
Docket No. STN 50-498
Licensee Event Report 90-011 Regarding an
Inoperable Radiation Monitor Due to an Inadequate Procedure

Pursuant to 10CFR50.73, Houston Lighting & Power Company (HL&P) submits the attached Licensee Event Report (LER 90-011) regarding an inoperable radiation monitor due to an inadequate procedure. This event did not have any adverse impact on the health and safety of the public.

If you should have any questions on this matter, please contact Mr. S. M. Head at (512) 972-7136 or myself at (512) 972-7921.

for *Warren H. Kinsey*
G. E. Vaughn
Vice President
Nuclear Generation

BEM/nl

Attachment: LER 90-011 (South Texas, Unit 1)

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PDR ADOCK 05000498
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A Subsidiary of Houston Industries Incorporated

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Houston Lighting & Power Company
South Texas Project Electric Generating Station

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Revised 12/15/89

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) South Texas, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 4 9 8	PAGE (3) 1 OF 0 3
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TITLE (4)
An Inoperable Radiation Monitor Due to an Inadequate 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)				
0	6	12	90	0	1	1	0	7	0	6	9	0			0 5 0 0 0

OPERATING MODE (9) 3

POWER LEVEL (10) 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(e)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(f)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(k)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Scott Head - Supervising Licensing Engineer	TELEPHONE NUMBER AREA CODE: 5 1 2 9 7 2 - 7 1 3 6
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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

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On June 12, 1990, Unit 1 was in Mode 3 following a refueling outage. During the performance of the weekly Technical Specification required surveillance of the Condenser Air Removal System (CARS) particulate and iodine levels, the Chemical Technician supervisor discovered that no sample had been collected in the CARS radiation monitor moisture collection tank. Upon further investigation, it was determined that the sample line between the CARS radiation monitor and the moisture collection tank had been left disconnected following corrective maintenance on May 30, 1990. The cause of this event was an inadequate procedure for connection of temporary sampling equipment. Procedures which affect operation of radiation monitors will be reviewed and revised as necessary to ensure that sufficient requirements exist to control installation and removal of temporary equipment. Training on the new requirements will be provided following their completion.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) South Texas, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 4 9 8 9 0	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
			0 1 1	0 0	0 2	OF 0 3

TEXT (If more space is required, use additional NRC Form 306A's) (17)

DESCRIPTION OF EVENT:

On June 12, 1990, Unit 1 was in Mode 3 following a refueling outage. During the performance of the weekly Technical Specification required surveillance of the Condenser Air Removal System (CARS) particulate and iodine levels, the Chemical Technical Supervisor discovered that no sample had been collected in the CARS radiation monitor moisture collection tank. Upon further investigation it was determined that the sample line between the moisture collection unit and the noble gas monitor was disconnected. This resulted in the monitor sampling ambient air instead of CARS effluent. The sample line was reconnected and the monitor returned to service.

An investigation was performed to determine the cause of the disconnected sample line. On May 29, 1990, the CARS radiation monitor was removed from service. In order to satisfy requirements for continuous sampling, temporary sampling equipment was installed and connected in place of the noble gas monitor. This equipment drew a sample through the existing moisture collection tank. The procedure for installation of the temporary sampling equipment provided general instructions for connection and operation, but did not cover disconnection and restoration of the permanent equipment. Work on the CARS radiation monitor was completed on May 30, 1990 and the system was declared operable. However, when a Senior Chemical Technician removed the temporary sampling equipment, he failed to reconnect the permanent CARS radiation monitor. Since training on this task was based upon the deficient procedure, the technician was not aware of the need to reconnect the CARS radiation monitor. The monitor continued to sample ambient air and was effectively inoperable until discovered on June 12, 1990. Failure to estimate CARS sample flow rate every four hours and to take grab samples every 12 hours with the CARS radiation monitor inoperable is a violation of Technical Specification 3.3.3.11. The NRC was notified of this violation at 1621 hours on June 12, 1990.

CAUSE OF EVENT:

The cause of this event was that the procedure for connection of the temporary sampling equipment did not provide steps for reconnection of the permanent monitor.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) South Texas, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 4 9 8 9 0	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0	0 1 1	0 0 0	3	OF	0 3

TEXT (If more space is required, use additional NRC Form 300A's) (17)

ANALYSIS OF EVENT:

Failure to estimate the CARS sample flow rate every four hours and to take grab samples every 12 hours with the CARS radiation monitor inoperable is a violation of Technical Specification 3.3.3.11 which is reportable pursuant to 10CFR50.73(a)(2)(i)(B). The effluent flow rate from the CARS exhaust is less than 200 SCFM as compared to the Unit Vent flow rate of approximately 210,000 SCFM. This flow is a small contributor to the total offsite dose. The CARS radiation monitor is also used to detect activity in the secondary plant. Other monitors, including the main steam line and steam generator blowdown monitors are also available to provide an indication of secondary side activity. During this event, Unit 1 was shutdown. The majority of the secondary steam was being supplied by Unit 2 which had an operable monitor. Small amounts of steam from the Unit 1 steam generators was dumped to the condensers periodically to maintain temperature. Secondary activity samples on the Unit 1 steam generators indicated no activity during this event. Based on the above, it can be concluded that no unmonitored release of radioactivity to the environment occurred during this event.

CORRECTIVE ACTION:

The following corrective actions are being taken as a result of this event:

1. Procedures which affect the operation of radiation monitors will be reviewed and revised as necessary to ensure that sufficient requirements exist to control installation and removal of temporary equipment. This action will be completed by September 1, 1990.
2. In the interim, a Special Order has been issued to Chemical Analysis personnel which requires that the Chemical Technician Supervisor verify that radiation monitors are restored properly following completion of activities which effect monitor operability.
3. Following completion of the procedure changes identified in Corrective Action 1, Chemical Technicians responsible for connection of temporary sampling equipment will be trained on the changes. This training will be completed by December 1, 1990.

ADDITIONAL INFORMATION:

A previous similar event was reported under LER 89-002 on Unit 2 regarding failure to properly restore the Control Room Ventilation System following a surveillance test.

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