The Light company

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

March 28, 1994 ST-HL-AE-4738 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
Licensee Event Report 94-008
Regarding a Failure to Stagger Reactor Trip Breaker Surveillance Test Intervals

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Unit 1 Licensee Event Report 94-008 regarding a failure to stagger Reactor Trip Breaker surveillance test intervals. This event did not have an adverse effect on the health and safety of the public but clearly does not meet the standards for expected operational performance.

If you should have any questions on this matter, please contact Mr. J. M. Pinzon at (512) 972-8027 or me at (512) 972-8664.

Vice President,
Nuclear Generation

JMP/eh

Attachment: LER 94-008 (South Texas, Unit 1)

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U. S. Nuclear Regulatory Comm. Attn: Document Control Desk Washington, D. C. 20555

NRC FO (5-92)				U.S	. NUCLE	AR I	REGULATOR	RY COMP	4ISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95						
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On February 24, 1994, Unit 1 was in Mode 1 at 7% power. While reviewing the performance history of the Solid State Protection System surveillance testing, it was determined that the reactor trip breaker surveillances associated with Technical Specifications 4.3.1 and 4.3.2 were not performed in accordance with Technical Specification requirements for staggered test intervals. This event occurred during the period in which the normal cyclic schedule was being re-established at the end of a long outage. The causes of this event were determined to be inadequate methods for assuring staggered intervals are restored following an outage and inadequate training of new Divisional Surveillance Coordinators. Corrective actions include conducting training for responsible surveillance coordinators with scheduling responsibilities for surveillances with Technical Specification stagger requirements and generating Conditional Surveillance Tasks in the Surveillance Task database for each division responsible for surveillance tasks subject to Technical Specification stagger requirements. These Conditional Surveillance Tasks will be required prior to increasing mode changes as appropriate.

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NRC FORM 366 (5-92)

LICENSEE EVENT REPORT (LER)
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ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), 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)	DOCKET NUMBER (2)		LER MUMBER (6)		PAGE (3)	
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

DESCRIPTION OF EVENT:

On February 24, 1994, Unit 1 was in Mode 1 at 7% power. While reviewing the performance history of the Solid State Protection System functional test surveillance procedures, it was determined that although the subject surveillances were individually within their required intervals, they were not within the grace interval associated with the monthly stagger requirement of Technical Specification Table 4.3-1, Note 7 and Table 4.3-2, Note 1. Both of these notes state that "Each train shall be tested at least every 62 days on a STAGGERED TEST BASIS."

During normal operation of the plant, the stagger requirements are maintained via a combination of the standard cyclic schedule for surveillance testing, and calendar-based scheduling of surveillances subject to the stagger requirement (as opposed to frequency-based scheduling, which would permit some drift in scheduled performance from cycle to cycle). The methods of ensuring that stagger requirements are maintained were established following Unit 1 LER 88-040, which addressed a similar event (see discussion under Additional Information below.) After outages, it becomes necessary to re-establish the surveillance schedule cycle in order to re-establish the stagger.

In early January, 1994, it was determined the 84 day schedule for surveillance testing on Unit 1 would be reestablished. Adherence to this schedule ensures that stagger requirements are maintained. In accordance with this schedule, the surveillances were scheduled for performance on January 23, 1994, which would have satisfied the required stagger interval. A few days before January 23, 1994, a problem was identified with the subject procedures, and it was determined that they should not be performed prior to revision. The Surveillance database was checked and it was determined that the subject surveillances would not reach their "Dead Dates" until March 10, 1994. As such, the schedule was slipped by two weeks to allow time for procedure revision. It was not recognized that on February 8, 1994, the grace period for the performance of either train of the subject procedures based upon the stagger requirement would expire, violating the Technical Specification stagger requirements identified above. The required schedule for resolving these procedural concerns was not recognized, due to the perception that the surveillances could be performed at any time up to March 10 without violating Technical Specification requirements. On February 22, 1994, walkdowns of the proposed revisions discovered more problems with the proposed changes, causing a further delay.

On February 24, 1994, it was identified that the stagger requirements of Technical Specifications were not met and Technical Specification 4.0.3 was applied. At 1447 hours, the NRC was notified of the failure to meet the stagger requirements of Technical Specifications. An evaluation of other surveillances subject to stagger requirements was performed, to ensure compliance with all stagger requirements. (Though some additional surveillance testing was conservatively conducted, it was determined on February 25, 1994, that no other surveillances subject to stagger requirements had exceeded their grace periods). Changes to the four subject procedures were approved and made effective. Subsequently, on February 25, 1994, at 0552 hours, all the required surveillances were satisfactorily performed, and the provision of Technical Specifications 4.0.3 were no longer applicable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), 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.

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DESCRIPTION OF EVENT: (Cont'd)

As part of the investigation of this event, a review was conducted to determine whether other violations of Technical Specification Stagger requirements have occurred since June 24, 1988 (the date of LER 1-88-040). This review identified two other occurrences where the Staggered Testing requirement was not satisfied as Unit 1 came out of an outage. These occurrences were as follows:

- Following the third refueling outage for Unit 1, the SSPS Logic Train R Functional Test and the SSPS Logic Train S Functional Test surveillance procedures were performed on March 6, 1991. The SSPS Logic Train S Functional Test surveillance procedure was next performed on April 23, 1991, exceeding the permitted grace period by two days.
- Following the fourth refueling outage for Unit 1, the SSPS Logic Train R Functional Test and the SSPS Logic Train S Functional Test surveillance procedures were performed on November 23, 1992 and November 24, 1992 respectively. The SSPS Logic Train R Functional Test was next performed on January 10, 1993, exceeding the permitted grace period by two days.

All other surveillances subject to Technical Specification Stagger requirements were reviewed (72 Stagger Groups), and there were no other occurrences of a violation of Technical Specification Stagger requirements.

CAUSE OF EVENT:

The causes of this event are two-fold. The first was determined to be inadequate methods for assuring staggered intervals are reestablished following an outage; the second involves inadequate training of new Divisional Surveillance Coordinators.

ANALYSIS OF EVENT:

This condition resulted in the violation of the staggered test basis for the Reactor trip Breaker surveillances as required by Technical Specifications which is reportable pursuant to 10CFR50.73(a)(2)(i)B). There were no adverse safety or radiological consequences as a result of this event. This event did not produce any additional risk to the public.

NRC FORM 366A (5-92)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20553-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

CORRECTIVE ACTIONS:

The following corrective actions have been taken or will be taken as a result of this event:

- As an interim measure, until the implementation of Corrective Action 4, the Plant Surveillance Coordinator will conduct reviews on a periodicity of approximately two weeks to ensure that Technical Specification Surveillance stagger requirements are maintained.
- The Plant Survei. nce Coordinator has conducted training for Divisional Surveillance Coordinators
 with scheduling responsibilities for surveillances with Technical Specification stagger requirements.
 This training addressed details of STP surveillance program implementation relative to ensuring that
 Technical Specification Surveillance stagger requirements are not exceeded.
- 3. Conditional Surveillance Tasks have been generated in the Surveillance Tasks database for each division responsible for surveillance tasks subject to Technical Specification stagger requirements. These conditional Surveillance Tasks are listed on the Mode Change Reports for Mode ascension up to Mode 3. The responsible surveillance coordinators will thereby be required to review the staggered due dates for all Surveillance Tasks subject to Technical Specification stagger requirements prior to each increasing mode change, as applicable.
- 4. A "Technical Specification Stagger Report," to be generated for responsible Surveillance Coordinator review on a periodic basis (e.g., biweekly) will be developed and implemented. The report will call to the attention of the responsible surveillance coordinators the need to maintain Technical Specification stagger requirements which are more limiting than the calculated "Dead Date." This action will be completed by May 1, 1994.
- An interdepartmental Task Force will be formed to develop recommendations for improving the process for replacing and training new responsible surveillance coordinators. Appropriate corrective actions will be developed as necessary.

ADDITIONAL INFORMATION:

There has been one previous reported occurrence of a failure to stagger surveillance test intervals per Technical Specification requirements, reported under LER 1-88-040. That occurrence was attributed primarily to the use of frequency-based scheduling rather than calendar-based scheduling for some of the surveillances subject to stagger requirements. Though the scheduling method was corrected, the corrective actions for that Licensee Event Report did not provide adequate controls to ensure that stagger requirements would be maintained while the calendar-based stagger was being re-established following an outage. Since the time of the previous event, many enhancements to the Corrective Action Program have been made which minimize the potential for establishing less than adequate corrective actions. No corrective actions to the current Corrective Action Program are necessary as a result of this event.