APPENDIX B

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Inspection Report: 50-498/94-11
50-499/94-11

Licenses: NPF-76
NPF-80

Licensee: Houston Lighting & Power Company
P.O. Box 1700
Houston, Texas

Facility Name: South Texas Project Electric Generating Station, Units 1 and 2

Inspection At: Facility Site, Matagorda County, Texas

Inspection Conducted: March 14-18, 1994

Inspectors: Joseph I. Tapia, Reactor Engineer/Examiner, Operations Branch

Other Accompanying Personnel: Dennis N. Boal, Investigator, Office of Investigations

Approved: John L Pellet 3/25/94
John L. Pellet, Chief, Operations Branch Date
Division of Reactor Safety

Inspection Summary

Areas Inspected (Units 1 and 2): Special, unannounced inspection of circumstances related to the generation of Licensee Event Report 94-003.

Results (Units 1 and 2):

- An apparent violation was identified for failing to notify the NRC of a condition required to be reported under 10 CFR 50.72.
- An apparent violation of 10 CFR 50.9 was identified pertaining to the submittal of incorrect information in an LER.

Summary of Inspection Findings:

- The licensee had a reasonable basis for representing that Restart Issue 15 was ready for NRC review on October 29, 1993 and during the NRC inspection on November 1-3, 1993. The licensee failed to satisfy the requirements of 10 CFR 50.9 and 50.72. The inspector determined that

that these failures resulted from inadequate understanding of notification requirements and from a lack of adequate verification of statements submitted in a report to the NRC.

Attachment:

- Attachment - Persons Contacted and Exit Meeting

DETAILS

1 INTRODUCTION

On January 18, 1994, during the performance of Service Request VE-210282, maintenance personnel discovered an interference between the main plant exhaust vent tornado damper (1VDA113) linkage and a ductwork structural steel gusset plate. This damper consists of four separate sections, each of which has linkage that interconnects the individual damper blades. The interference limited the closing travel of the damper linkage in the upper left damper section to approximately 40 percent of full stroke. As a result, this damper section was prevented from closing completely and the damper was considered inoperable. The safety function of the main plant exhaust vent tornado damper is to prevent the rapid depressurization of several heating, ventilation, and air conditioning (HVAC) systems, including the Fuel Handling Building (FHB) Exhaust System, in the event of a tornado. The FHB Exhaust System is a safety-related component which mitigates the consequences of a fuel handling accident and a loss of coolant accident by limiting the site boundary dose within the guidelines of 10 CFR 100.

On January 24, 1994, Houston Lighting & Power determined that the condition discovered on January 18, 1994, was reportable pursuant to 10 CFR 50.73(a)(2)(ii) and submitted Licensee Event Report (LER) 94-003. This determination was based on the fact that the FHB Exhaust System was not protected at the main plant exhaust vent from the adverse effects of a tornado as provided in the design basis. This condition has existed since original construction. The purpose of this inspection was to evaluate the circumstances involving the submittal of the LER, in light of the fact that tornado dampers were recently a restart issue that had been previously closed.

2 BACKGROUND

On May 29, 1993, the NRC diagnostic evaluation team observed that there was no evidence of testing to show that tornado dampers would actuate when required. In response to this observation, the licensee initiated changes to existing Preventive Maintenance (PM) procedures to include manual stroking of the dampers. On October 21, 1993, revised PM Procedure MM-1-VE-93000491 was implemented to inspect, clean, lubricate, and stroke tornado Damper 1VDA113. At this time, only two of the four damper sections were able to be manually stroked. Two sections were not able to be stroked because of interference between the bolt head holding the constant force spring to the linkage and the manual override lever arm. Station Problem Report (SPR) 933029 was written on October 22, 1993, to describe the problem and initiate operability and reportability reviews. Immediate compensatory actions taken by the shift supervisor included entering the damper in the control room operability tracking log and declaring the FHB HVAC inoperable. The licensee's engineering department, subsequently, determined that the interference would not prevent the damper blades from stroking since the interference only prevented manual stroking using the override lever arm. The licensee then

concluded that tornado Damper 1VDA113 would perform its design function and considered it operable. Nevertheless, Service Request (SR) 210282 was written on October 24, 1993, to eliminate the interference. This SR remained in a work-on-hold status until January 17, 1994, when work start was authorized.

On October 29, 1993, an HL&P and NRC Management Meeting was conducted at the South Texas Project. At that meeting, Restart Issue 15, "Tornado Dampers," was statused as completed and ready for NRC review. NRC Inspection 50-498/93-12; 50-499/93-42 was conducted on November 1-3, 1993, and consisted of a review of the actions taken by the licensee to resolve the issue of testing of tornado dampers. During that inspection, damper testing requirements, previous tornado damper maintenance activities, and procedural enhancements were reviewed. Based on the results of this inspection, it was determined that Restart Issue 15 was considered resolved.

3 LICENSEE EVENT REPORT

On January 17, 1994, work start was authorized for SR 210282 and work commenced on the night shift to eliminate the interference between the bolt head and manual override arm that was not affecting operability. On January 18, 1994, after eliminating the interference and attempting to manually cycle the damper, an additional interference was identified. This previously unidentified interference between the main plant exhaust vent tornado damper (1VDA113) linkage and a ductwork structural steel gusset plate was documented on SPR 940120, dated January 18, 1994. An operability review, completed on January 19, 1994, determined that the structural interference would prevent full closure of damper 1VDA113 and that it was, therefore, inoperable. A reportability review was completed by the licensee's engineering department on January 24, 1994. This review concluded that the interference was reportable in accordance with 10 CFR 50.73(a)(2)(ii) because it satisfied "Any event or condition that resulted in the condition of the nuclear power plant, including its principle safety barriers, being seriously degraded, or that resulted in the nuclear power plant being . . . (B) in a condition that was outside the design basis of the plant . . . ."

Through interviews of personnel, it was determined that, upon receipt of the reportability review in the control room, the shift supervisor attempted to contact a representative of the licensing department, but was unable to since it was after normal work hours. The shift supervisor then contacted his immediate supervisor and discussed the reportability review. The shift supervisor did not believe that a notification under 10 CFR 50.72 was required and, therefore, one was not made. There was no subsequent contact with the licensing department by representatives of the operations department to discuss the reportability review. In part, 10 CFR 50.72(a)(2) states that the licensee shall notify the NRC as soon as practical, and in all cases, within four hours of the occurrence of any event found while the reactor is shut down that, had it been found while the reactor was in operation, would have resulted in the nuclear power plant, including its principal safety barriers, being seriously degraded. On January 24, 1994, with the reactor shut down, the licensee determined that the fuel handling building exhaust system was not

protected at the main exhaust vent from the adverse effects of a tornado as provided in the design basis and did not notify the NRC of this condition. Had this been found while the reactor was in operation, the fuel handling system would have been in a seriously degraded condition. As a result of having the emergency core cooling system (ECCS) pumps located in the lower elevation of the Fuel Handling Building, the fuel handling building exhaust system is utilized to maintain a slightly negative building pressure during post-loss of coolant accident (post-LOCA) conditions. The failure to notify the NRC is an apparent violation of 10 CFR 50.72(a)(2) (498/9411-01).

LER 94-003, submitted to the NRC on March 2, 1994, states that on January 24, 1994, Houston Lighting & Power determined that the condition discovered on January 18, 1994, was reportable and notified the NRC. From a review of NRC records and control room logs, there is no evidence that the NRC was notified. From interviews of cognizant licensing and engineering department personnel, it was determined that the statement concerning notification to the NRC was the result of an incorrect assumption which arose from inadequate communication of the events that transpired on January 24, 1994. The assumption was also the result of the common condition that practically all LER reports submitted in the past have had a corresponding notification.

In part, 10 CFR 50.9, states that information provided to the Commission by an applicant for a license or by a licensee, or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the applicant or the licensee shall be complete and accurate in all material respects. Licensee Event Report 94-003 inaccurately states that the licensee notified the NRC on January 24, 1994, of a condition which was reportable and which represented a condition that was outside the design basis of the plant. This is an apparent violation of 10 CFR 50.9 (498/9411-02).

4 CONCLUSIONS

From reviews of documentation and through interviews, it was determined that the licensee had a reasonable basis for representing that Restart Issue 15 was ready for NRC review on October 29, 1993, and during the NRC inspection on November 1-3, 1993. The licensee failed to satisfy the requirements of 10 CFR 50.9 and 50.72. The inspector determined that these failures resulted from inadequate understanding of notification requirements and from a lack of adequate verification of statements submitted in a report to the NRC.

ATTACHMENT

1 PERSONS CONTACTED

1.1 Licensee Personnel

D. Bize, Licensing Engineer
J. Centeno, Engineer
J. Conly, Licensing Engineer
J. Cottam, Supervising Engineer
*W. Cottle, Group Vice President - Nuclear
*T. Cloninger, Vice President - Engineering
*J. Groth, Vice President - Nuclear Generation
*S. Head, Senior Consulting Engineer
J. Pinzon, Licensing Engineer
K. Struble, Shift Supervisor

1.2 Other Personnel

*K. Shea, Attorney, Newman, Bouknight & Edgar

1.3 NRC Personnel

*D. Loveless, Senior Resident Inspector

*Denotes those attending the Exit Meeting

2 EXIT MEETING

An exit meeting was conducted on March 18, 1994. During this meeting, the inspector reviewed the scope and findings of the report. The licensee acknowledged the information presented at the exit meeting. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspector.