

The Light company

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

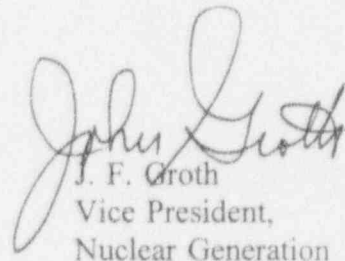
July 21, 1994
ST-HL-AE-4847
File No.: G26
10CFR50.73

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

South Texas Project
Unit 2
Docket No. STN 50-499
Licensee Event Report 94-006
Failure to Fully Meet the Requirements of Technical Specifications
Due to an Inadequate Surveillance Procedure

Pursuant to 10CFR50.73, Houston Lighting & Power submits the attached Unit 2 Licensee Event Report 94-006 regarding a failure to fully meet the requirements of Technical Specifications due to an inadequate surveillance procedure. 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.


J. F. Groth
Vice President,
Nuclear Generation

JMP/esh

Attachment: LER 94-006 (South Texas, Unit 2)

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Houston Lighting & Power Company
South Texas Project Electric Generating Station

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c:

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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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 (MN88 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) South Texas Unit 2	DOCKET NUMBER (2) 05000 499	PAGE (3) 1 OF 4
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TITLE (4) Failure to Fully Meet the Requirements of Technical Specification Due to an Inadequate Surveillance 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 NAME	DOCKET NUMBER
06	22	94	94	-- 006 --	00	07	21	94	SOUTH TEXAS, UNIT 1	05000498
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)									
POWER LEVEL (10) 100	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.405(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"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER						
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)							

LICENSEE CONTACT FOR THIS LER (12)

NAME Jairo Pinzon - Staff Engineer	TELEPHONE NUMBER (Include Area Code) (512) 972-8027
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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)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (if yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/>	NO					

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On June 22, 1994, at 1610 hours, Unit 2 was in Mode 1 at 100% power. It was determined that an event that was identified on June 21, 1994 at 0530 hours, was reportable. During performance of the monthly surveillance test (channel check) for Accident Monitoring Instrumentation, the Containment secondary sump level indicator was declared inoperable and the action statement was entered. During subsequent investigation as to the cause of the inoperable level indicator, it was discovered that the power supply breaker for the instrument was open. Further investigation revealed that the breaker had most probably been open since March 16, 1994. Unit 2 entered Mode 3, the applicable mode for Accident Monitoring, on May 16, 1994.

On July 11, 1994 at 1600 hours, both Units 1 and 2 were in Mode 1 at 100% power. During the follow-up review of the June 21 event it was discovered that a surveillance procedure used to verify operability of Accident Monitoring Instrumentation and Remote Shutdown Monitoring Instrumentation was inadequate in that it did not ensure operability of selected channels. This condition has existed since initial fuel load.

The cause of these events was an inadequate surveillance procedure. Surveillance procedures are used to satisfy Technical Specifications to ensure that the required equipment is operable. This procedure did not provide adequate guidance to allow detection of inoperable channels.

Corrective actions are described within the Licensee Event Report.

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 (MABB 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 NUMBER (6)		PAGE (3)	
South Texas, Unit 2	05000 499	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 4
		94	-- 006 --	00	

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

DESCRIPTION OF EVENT:

On June 21, 1994 at 0530 hours, Unit 2 was in Mode 1 at 100% power. During performance of the monthly surveillance test (channel check) for Accident Monitoring Instrumentation, the Containment secondary sump level indicator was reading "↓ LO" on the Qualified Display Processing System. A "↓ LO" reading is displayed by the Qualified Display Processing System when the input data is below the designated indication range. The affected instrument may be in tolerance, but since it is reading below its expected range, it is displayed as "↓ LO". The validity of these readings was questioned since normally the instrument reading has been three inches. A Service Request was written to investigate. The channel was declared inoperable and the action statement was entered. At approximately 1200 hours, an Instruments and Controls planner was performing a walkdown for the Service Request and discovered that the power supply breaker for the instrument was open. Subsequent review of the Plant Computer Display system and review of control room chart recorders, determined that the breaker had most probably been open since March 16, 1994.

On July 11, 1994, at approximately 1600 hours, after evaluation of the Remote Shutdown and Accident Monitoring Instrument Channel Check surveillance procedure, for both Units 1 and 2, it was determined that the surveillance was inadequate for performing a qualitative assessment for non-numeric indicating channels. The procedure did not adequately provide a qualitative acceptance criteria to determine the difference between off-scale and channel inoperability. This applied to all channels checks where the indication read less than zero or high.

The surveillances were re-performed for the affected channels to re-evaluate whether the indication was adequate for determining operability. Based on this re-performance, at 1833 hours and 1856 hours, it was determined that the Reactor Containment Building Wide Range Level instrument (one per unit) had not been adequately evaluated for operability by the existing surveillance. The affected instruments were declared inoperable and a Limited Condition for Operation action statement for Technical Specification 3.3.3.6 was entered for both Units 1 and 2.

CAUSE OF EVENT:

The cause of these events was determined to be an inadequate surveillance procedure. Surveillance procedures are used to satisfy Technical Specifications to ensure that the required equipment is operable. This procedure did not provide adequate guidance to allow detection of inoperable channels.

For the event that occurred on June 21, 1994, review of the Plant Computer Display system and control room chart recorders, indicated that the breaker had most probably been open since March 16, 1994. The investigation has not been able to determine why the breaker was opened.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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

ANALYSIS OF EVENT:

Noncompliance with Technical Specifications exists when the requirements of the Limiting Condition for Operations and associated ACTION requirements are not met within the specified time intervals. The Accident Monitoring Technical Specification action statement for containment sump narrow range level indication (Technical Specification 3.3.3.6) allows one channel to be out of service for up to seven days, then the unit must be placed in hot shutdown within the next 12 hours. This action statement was not met and is therefore reportable per 10CFR50.73(a)(2)(i)(B).

In addition, failure to have an adequate surveillance procedure for performing qualitative assessments for non-numeric, Technical Specification required indication channels is reportable for both Units 1 and 2 pursuant to 10CFR50.73(a)(2)(i)(B) as an operation prohibited by Technical Specifications. This event did not produce any additional risk to the public.

CORRECTIVE ACTIONS:

On June 21, 1994, the breaker for the Containment secondary sump narrow range level indicator was turned on and the surveillance was successfully performed.

After the July 11, 1994 discovery, the following actions were implemented:

- The surveillance was performed on both Units 1 and 2, to reevaluate whether the indication was adequate for determining operability. It was determined the Reactor Containment Building Wide Range Level instruments (one per unit) had not been adequately evaluated for operability by the existing surveillance.
- The Reactor Containment Building Wide Range Level instruments have been declared operable and Technical Specification 3.3.3.6 was exited on July 19, 1994, at 1157 hours for Unit 2 and July 21, 1994 at 1412 hours for Unit 1.
- The surveillance procedure was revised to provide adequate guidance to ensure instrument operability.
- This Licensee Event Report and the need to monitor for abnormal, excessively low or high channel readings during surveillance testing will be reviewed with Operations and Maintenance personnel by August 4, 1994.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

ADDITIONAL INFORMATION

Unit 2 Licensee Event Report 93-014, Failure to meet Technical Specification Testing Requirements of the containment Hydrogen Monitors was submitted to the Nuclear Regulatory Commission on September 15, 1993. The cause of this event was an inadequate surveillance test procedure.

Unit 1 Licensee Event Report 92-004 described a previous, similar event in which a surveillance test procedure did not adequately perform the testing required by Technical Specifications. Reviews performed as a result of this Licensee Event Report identified several deficiencies; however, they did not identify this particular problem with testing of the Reactor Trip Bypass Breakers. This Licensee Event Report, as well as other Licensee Event Reports, led to the development of the Surveillance Enhancement Program. The previous ineffective corrective actions have been recognized and are being dealt with under the Surveillance Procedure Enhancement Program.

A pilot project to enhance 51 high impact procedures, determined to be the most problematic by Licensee Event Reports, Station Problem Reports and experience has been completed. This project yielded 211 discrepancies, only 37 of which were technical in nature. An additional nine required further review to ensure Technical Specification compliance. None of the problems were safety significant, and the lessons learned have been incorporated into the ongoing Surveillance Procedure Enhancement Program. While additional discrepancies are expected to be discovered during the course of the remainder of the Surveillance Procedure Enhancement Program, the results of the pilot project, as well as the manner in which the pilot project procedures were chosen, gives confidence that the discrepancies that may be found should also be of low significance.