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MEMORANDUM FOR: G. L. Constable, Chief
Projects Section D
Division of Reactor Projects
Region IV

FROM: Jack E. Rosenthal, Chief
Reactor Operations Analysis Branch
Division of Safety Programs
Office for Analysis and Evaluation
of Operational Data

SUBJECT: AEOD SALP INPUT FOR SOUTH TEXAS PROJECT, UNIT 1

In support of the ongoing SALP reviews, AEOD has reviewed the Licensee Event Reports (LERs) for South Texas Project, Unit 1, covering the period August 21, 1987 (plant licensed) to December 31, 1987. The enclosure provides our observations based on the safety significant LERs designated by our screening process. For further discussion, please contact S. Israel (x24437).

Jack E. Rosenthal, Chief
Reactor Operations Analysis Branch
Division of Safety Programs
Office for Analysis and Evaluation
of Operational Data

Enclosure: As stated

cc: J. Calvo, NRR
D. Carpenter, RIV
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ENCLOSURE

AEOD INPUT TO SALP REVIEW OF SOUTH TEXAS PROJECT, UNIT 1
AUGUST 21, 1987 TO DECEMBER 31, 1987

Houston Lighting and Power Company, submitted 25 LERs covering the period from August 21, 1987 to December 31, 1987. The large number of LERs in a short time span is typical for a new plant startup. Five of the LERs have been tentatively ranked significant by the AEOD screening process.

Two of the LERs were caused by personnel errors that led to the degradation and failure of vent radiation monitors in one case and the control room toxic gas monitors in the other case. The licensee attributed these events to unfamiliarity on the part of the participants and proviced additional training for the appropriate personnel. In the first instance, the system status lights did not provide adequate information so that recovery was unnecessarily delayed. The licensee is examining further corrective actions in this area. Loss of the toxic gas monitor occurred during maintenance of that system and it was thought that the many alarms during the isolation may have engendered a casual response.

One event involved failures and/or excessive vibrations in all the auxiliary feedwater trains within a short time span. This event was attributed to basic design deficiencies which resulted in piping with a natural frequency in the same range as the fluid oscillating frequency. Extensive modifications were made to correct these problems.

One event entailed the inoperability of two trains of containment spray for diverse reasons which were subsequently corrected.

The last event of interest involved improper motor shaft-to-pinion keys that were supplied by the valve operator vendor. In a separate report, another similar problem was identified for keys from a different valve vendor.

All of these events appear to be within the spectrum of expected situations during plant startup operations. The LERs appear to be reasonably complete. However, several of them were submitted late, e.g., LERs 87-16, 87-11, and 87-12.