

The Light company

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

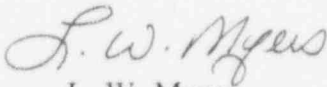
October 24, 1995
ST-HL-AE-5212
File No.: G26
10CFR50.73

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 95-010
Failure to Meet the Requirements of Technical
Specification Surveillance Times for Logging Axial Flux Difference

Pursuant to 10CFR50.73, South Texas Project submits the attached Unit 1 Licensee Event Report 95-010 regarding a failure to meet the requirements of Technical Specification surveillance times for logging Axial Flux Difference. Subsequent surveillances verified that the Axial Flux Difference remained within its limits. 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. S. M. Head at (512) 972-7136 or me at (512) 972-7239.


L. W. Myers
Unit 1 Plant Manager

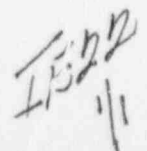
KJT/lf

Attachment: LER 95-010 (South Texas, Unit 1)

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PDR ADOCK 05000493
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LER-95\5212

Project Manager on Behalf of the Participants in the South Texas Project



Houston Lighting & Power Company
South Texas Project Electric Generating Station

ST-HL-AE-5212
File No.: G26
Page 2

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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 MANDATORY INFORMATION COLLECTION REQUEST 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT.

FACILITY NAME (1)

South Texas, Unit 1

DOCKET NUMBER (2)

05000 498

PAGE (3)

1 of 3

TITLE (4)

Failure to meet the requirements of Technical Specification surveillance times for logging Axial Flux Difference

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
09	26	95	95	-- 010	-- 00	10	24	95		05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)						
1	100	20.2201(b)		20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
		20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
		20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
		20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
		20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME

Scott M. Head - Sr. Consulting Engineer

TELEPHONE NUMBER (include Area Code)

(512) 972-7136

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)

YES

(If yes, complete EXPECTED SUBMISSION DATE).

X

NO

MONTH DAY YEAR

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

On September 26, 1995, Unit 1 was in Mode 1 at 100% power. On September 25, 1995 at 1059 hours, the Proteus Computer system for Unit 1 failed resulting in an inoperable Axial Flux Difference Monitor Alarm. Monitoring and logging the indicated Axial Flux Difference for each operable excor channel at least once per hour for the first 24 hours was initiated as required by Technical Specification 4.2.1.1.b. Technical Specification 4.2.1.1.b further requires that Axial Flux Difference be logged every 30 minutes when the Axial Flux Difference Monitor Alarm has been inoperable for greater than 24 hours. At approximately 1430 hours on September 26, 1995, it was found the indicated Axial Flux Difference for each operable excor channel was still being monitored and logged hourly instead of every 30 minutes. The cause of this occurrence was inadequate review of Technical Specification monitoring and logging requirements of indicated Axial Flux Difference. Corrective action includes discussion of the lessons learned from this event with the individuals involved and revising the operator log for monitoring Axial Flux Difference.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	05000 498	95	-- 010	-- 00	2 OF 3

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

DESCRIPTION OF EVENT:

On September 26, 1995, Unit 1 was in Mode 1 at 100% power. On September 25, 1995 at 1059 hours, the Proteus Computer system for Unit 1 failed resulting in an inoperable Axial Flux Difference Monitor Alarm. Monitoring and logging the indicated Axial Flux Difference for each operable excore channel at least once per hour for the first 24 hours was initiated as required by Technical Specification 4.2.1.1.b. Technical Specification 4.2.1.1.b further requires that Axial Flux Difference be logged every 30 minutes when the Axial Flux Difference Monitor Alarm has been inoperable for greater than 24 hours. At approximately 1430 hours on September 26, 1995, it was found the indicated Axial Flux Difference for each operable excore channel was still being monitored and logged hourly instead of every 30 minutes. The every 30 minute surveillance had been missed since approximately 1100 hours on September 26, 1995. Monitoring and logging of indicated Axial Flux Difference for each operable excore channel at least once per 30 minutes started at 1430 hours on September 26, 1995.

The Proteus Computer system failure was discussed during turnover between operating shift crews, but the Technical Specification requirement for monitoring and logging Axial Flux Difference every 30 minutes when the Axial Flux Difference Monitor Alarm has been inoperable for greater than 24 hours was not discussed. Supervision did not ensure that operators knew 30 minute surveillances of Axial Flux Difference should start at approximately 1100 hours on September 26, 1995 if the Axial Flux Difference Monitor Alarm remained inoperable.

CAUSE OF EVENT:

The cause of this occurrence was inadequate review of Technical Specification monitoring and logging requirements of indicated Axial Flux Difference when the Axial Flux Difference Monitor Alarm has been inoperable for greater than 24 hours.

ANALYSIS OF EVENT:

Failure to meet the requirements of Technical Specifications is reportable pursuant to 10CFR50.73 (a)(2)(i)(B). Failure to monitor and log Axial Flux Difference for each operable excore channel once per 30 minutes after the Axial Flux Difference Monitor Alarm is inoperable for 24 hours was discovered at 1430 hours on September 26, 1995, at which time 30 minute monitoring and logging started. Data review of hourly monitoring results indicated the Axial Flux Difference was within allowable limits. There were no adverse safety or radiological consequences from this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
South Texas, Unit 1	05000 498	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3
		95	-- 010	-- 00	

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

CORRECTIVE ACTION:

1. The lessons from this event were discussed with the individuals involved.
2. The lessons learned from this event will be included in licensed operator training by January 1996.
3. The operator log will be revised by December 1995 to consolidate all actions required by Technical Specification 4.2.1.1.b for monitoring Axial Flux Difference when the Axial Flux Difference Monitor Alarm is inoperable.

ADDITIONAL INFORMATION:

There were no previous events reported by the South Texas Project to the Nuclear Regulatory Commission within the last three years regarding failure to perform a Technical Specification surveillance at the correct frequency after recognizing the need for the surveillance.