

The Light company

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

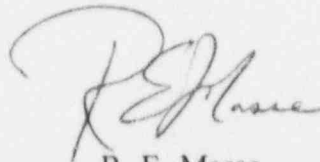
October 4, 1995
ST-HL-AE-5194
File No.: G26
10CFR50.73

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 95-006
Failure to Fully Meet the Requirements of Technical Specifications
Due to Not Placing the Control Room Envelope Heating,
Ventilation and Air Conditioning System in the Required Mode

Pursuant to 10CFR50.73, Houston Lighting & Power submits the attached Unit 2 Licensee Event Report 95-006 regarding a failure to fully meet the requirements of Technical Specifications due to not placing the Control Room Envelope Heating, Ventilation and Air Conditioning System in the required mode. 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) 972-7988.



R. E. Masse
Unit 2 Plant Manager

KJT/lf

Attachment: LER 95-006 (South Texas, Unit 2)

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S PDR

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

JEDJ

Houston Lighting & Power Company
South Texas Project Electric Generating Station

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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 2

DOCKET NUMBER (2)

05000 499

PAGE (3)

1 OF 3

TITLE (4)

Failure to fully meet the requirements of Technical Specifications due to not placing the Control Room Envelope Heating, Ventilation and Air Conditioning System in the required mode

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	05	95	95	-- 006	-- 00	10	04	95		05000
									FACILITY NAME	DOCKET NUMBER
										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)	<input checked="" type="checkbox"/>	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
X	IL	CPU	X999	N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES
(If yes, complete EXPECTED SUBMISSION DATE):

NO

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

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

On September 5, 1995, Unit 2 was in Mode 1 at 100% power. At 1352 hours, Control Room Ventilation Radiation Monitor, RI-8034, did not meet channel check requirements. The radiation monitor was declared inoperable and the Control Room Ventilation System was placed in the filtered make-up and recirculation mode. To comply with Technical Specification 3.3.2, as determined by data review, this action should have been taken at approximately 0521 hours on September 5, 1995 when an earlier channel check surveillance was performed but failed to note the inoperable radiation monitor. The root cause of this event is human error. Corrective action included counselling the individual, who misread the instrument, on the requirements and expectation for performing and verifying actions.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 2	05000 499	95	-- 006	-- 00	2 OF 3

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

DESCRIPTION OF EVENT:

On September 5, 1995, Unit 2 was in Mode 1 at 100% power. At 1352 hours, it was noted Control Room Ventilation Radiation Monitor, RI-8034, did not meet channel check requirements. The radiation monitor was declared inoperable. The Control Room Envelope was isolated and the Control Room Ventilation System was placed in the filtered make-up and recirculation mode required by Technical Specification 3.3.2.

Review of computer data revealed the Control Room Ventilation Radiation Monitor, RI-8034, failed at approximately 0100 hours on September 5, 1995. The channel check surveillance conducted at approximately 0521 failed to detect the inoperable monitor. The Control Room Ventilation Radiation Monitor indication, RI-8034, from the Radiation Monitoring Panel was misread. The inadequate surveillance at approximately 0521 hours resulted in violation of the Technical Specification 3.3.2. action statement. Technical Specification 3.3.2 requires the Control Room Ventilation system be placed in the filtered make-up and recirculation mode of operation within one hour if either of the Control Room Ventilation Radiation Monitors is inoperable.

Channel check surveillance of the Control Room Ventilation Radiation Monitor is performed by reading and recording the digital readout from the RM-23 Radiation Monitoring Panel, and comparing the reading with the reading for the second Control Room Ventilation Radiation Monitor. A reading of $1.20 \text{ E } -06 \text{ } \mu\text{ci/ml}$ for Radiation Monitor, RI-8034, and a reading of $1.33 \text{ E } -06 \text{ } \mu\text{ci/ml}$ for Radiation Monitor, RI-8033, was recorded during the surveillance performed at approximately 0521 on September 5, 1995. The recorded readings met the criteria for a successful channel check.

The Radiation Monitoring System Computer, RM-11, receives input from the Control Room Ventilation Radiation Monitors. The RM-11 Computer provides trend data. A review of trend data found the input from the Control Room Ventilation Radiation Monitor, RI-8034, to the RM-11 Radiation Monitoring System Computer went from a reading of $1.99 \text{ E } -06 \text{ } \mu\text{ci/ml}$ to a near constant reading of $1.22 \text{ E } -07 \text{ } \mu\text{ci/ml}$ at approximately 0100 hours on September 5, 1995, and remained at this constant reading until the instrument was declared inoperable at 1352 on September 5, 1995. Due to human error the RI-8034 digital readout exponential number was misread during the surveillance performed at approximately 0521 hours on September 5, 1995.

CAUSE OF EVENT:

The root cause of this event is human error.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
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South Texas, Unit 2	05000 499	95	-- 006	-- 00	3 OF 3

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

ANALYSIS OF EVENT:

Failure to meet the requirements of Technical Specifications is reportable pursuant to 10CFR50.73(a)(2)(i)(B). Control Room Ventilation Radiation Monitor, RI-8034, was found inoperable at 1352 hours on September 5, 1995, at which time the Control Room Ventilation System was placed in the filtered make-up and recirculation mode to comply with Technical Specification 3.3.2. Data review indicated RI-8034 should have been found inoperable at approximately 0521 hours on September 5, 1995 and the Technical Specification action taken then.

The radiation monitor involved is one of two which actuate the Control Room Envelope on high intake radiation levels to ensure Control Room habitability during an accident. The other radiation monitor, RT-8033, was operable during the event and was capable of actuating the ventilation systems if required. The actuation logic for this system is one out of two. There were no adverse safety or radiological consequences from this event.

CORRECTIVE ACTION:

The individual, who performed the inadequate surveillance, was counseled on the requirements and expectations for performing and verifying actions.

ADDITIONAL INFORMATION:

An assessment of operational human performance is being conducted. The assessment will focus on the root causes of recent human performance occurrences. The results of this assessment will be used by station management to provide a focus for enhancing the standards for operational performance.

Control Room Ventilation Radiation Monitor, RI-8034, failure was corrected by replacing the central processing unit circuit board.

There have been no previous events reported by the South Texas Project to the Nuclear Regulatory Commission within the last three years regarding an inadequate channel check resulting in a failure to fully meet the requirements of Technical Specifications due to not placing the Control Room Envelope Heating, Ventilation and Air Conditioning System in the required Mode.