Docket Nos

# UNITED STATES NUCLEAR REGULATORY COMMISSION

REGIONIV

S11 HYAN PLAZA DRIVE, SUITE 400 ARLINGTON, TEXAS 76011-8064

JUL | 3 1992

Docket Nos. 50-498 50-499 License Nos. NPF-76 NPF-80

Houston Lighting & Power Company ATTN: Donald P. Hall, Group Vice President, Nuclear P.O. Box 1700 Houston, Texas 77251

Gentlemen:

SUBJECT: RESPONSE TO NRC INSPECTION REPORT NO. 50-498/92-05; 50-499/92-05

Thank you for your letter of May 4, 1992, in response to cur letter and Notice of Violation (498/9205-01) dated April 8, 1992. We noted that Licensee Evert Report (LER) 50-498/92-003 was enclosed with your response and was intended to address some of the information required by the Notice of Violation (Notice). We find this practice to be acceptable provided that all the information required by the Notice is explicitly addressed, either in the cover letter, the LER, or both. We will review the implementation of your conscience has been achieved and will be maintained.

Sincerely,

A. Bill Beach, Director

Division of Reactor Projects

cc: (see next page)

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cc:
Houston Lighting & Power Company
ATTN: William J. Jump, Manager
Nuclear Licensing
P.O. Box 289
Wadswortn, Texas 77483

City of Austin Electric Utility Department ATTN: J. C. Lanier/M. B. Lee P.O. Box 1089 Austin, Texas 78767

City Public Service Board ATTN: R. J. Costello/M. T. Hardt P.O. Box 1771 San Antonio, Texas 78296

Newman & Holtzinger, P. C. ATTA: Jack R. Newman, Esq. 1815 L Street, NW Washington, D.C. 20036

Central Power and Light Company ATTN: O. E. Ward/T. M. Puckett P.O. Box 2121 Corpus Christi, Texas 76403

INPO Records Center 1100 Circle 75 Parkway Atlanta, Georgia 30339-3064

Mr. Joseph M. Hendrie 50 Bellport Lane Bellport, New York 11713

Bureau of Radiation Control State of Texas 1101 West 49th Street Austin, Texas 78/56

Judge, Matagorda County Matagorda County Courthouse 1700 Seventh Street Bay City, Texas 77414 Licensing Representative Houston Lighting & Power Company Suite 610 Three Matro Center Bethesda, Maryland 20814

Houston Lighting & Power Company ATTN: Rufus S. Scott, Associate General Counsel P.O. Box 61867 Houston, Texas 77208

bcc to DMB (IEO1)

bcc distrib. by RIV: R. D. Martin DRP Lisa Shea, RM/ALF, MS: MNBB 4503 DRSS-F1PS Project Engineer (DRP/D) Chief, Technical Support Section

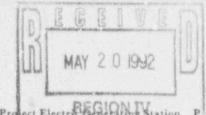
Resident Inspector Section Chief (DRP/D) MIS Sysiem RSTS Operator RIV File R. Bachmann, OGC, MS: 15-B-18

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The Light company



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

May 4. 1992 ST-HL-AZ-4080 File No.: G02.04 10CFR 2.201

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

South Texas Project
Unit 1
Docket No. STN 50-498
Reply to Notice of Violation 9205-01 Regarding
Failure to Follow Procedures During
RCS Flow Transmitter Restoration

Houston Lighting & Power Company (LL&P) has reviewed Notice of Violation 9205-01 dated April 8, 19 HL&P concurs that the cited violation occurred. The violat... has been fully addressed as the subject of the attached Libersee Event Report 92-003 (Unit 1).

HL&P is in full compliance and appropriate actions are being taken to prevent recurrence.

If you should have any quistions, please contact Mr. C. A. Ayala at (512) 972-8628 or me at (512) 972-7205.

William J. Jump

Manager,

Nuclear Licensing

RAD/lf

Attachment: Licensee Event Report 92-003

Regarding Failure to Follow Procedures During

RCS Flow Transmitter Restoration

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IR\92-112.002

A Subsidiary of Houston Industries Incorporated

Houston Lighting & Power Company South Texas Project Electric Generating Station

cc:

ST-HL-AE- 4080 File No.: G02.04 Page 2

Regional Administrator, Region IV

Nuclear Regulatory Commission

611 Ryan Plaza Drive, Suite 400

Arlington, TX 76011

Rufus S. Scott

Associate Gene
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F. O. Box 6186

George Dick, Project Manager U.S. Nuclear Regulatory Commission Washington, DC 20555

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Dr. Joseph M. Hendrie 50 Bellport Lane Bellport, NY 11713

D. K. Lacker
Bureau of Radiation Control
Texas Department of Health
1100 West 49th Street
Austin, TX 78756-3189

ATTACHMENT ST-HL-AE- 4090 PAGE \_ L OF \_ G

The Light company

COMPANY
H Iston Lighting & Power South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 27:483

April 13, 1992 ST-HL-AE-4068 File No.: G26 10CFR50.73

S. Nurlear Regulatory Commission Attentic . Document Control Desk Washington, DC 20555

South Texas Project
Unit 1
Docket No. STN 50-498
Licensee Event Report 92-003
Reactor Trip Due to Failure to Follow
Procedures During RCS Flow Transmitter Restoration

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Licensee Event Report 92-003 regarding a reactor trip due to failure to follow procedures during RCS flow transmitter restoration. This event did not have adverse impact on the health and safety of the public.

If you should have any questions on this matter, please contact Mr. C. A. Ayala at (512) 972-8628 or me at (512) 972-7205.

Low William J. Jump O Manager, Nuclear Licensing

MAC/nl

Attachment: LER 92-003 (South Texas, Unit 1)

9204210378 GIP

ATTACHMENT ST-HL-AE-4080 PAGF 3 DF

> ST-HL-AE-4068 File No.: G26 Page 2

Houston Lighting & Power Company South Texas Project Electric Generating Station

cc:

Regional Administrator, Region IV Nuclear Regulatory Commission 611 Ryan Plaza Drive, Suite 400 Arlington, TX 76011

George Dick, Project Lanager U.S. Nuclear Regulatory Commission Washington, DC 20555

J. I. Tapia
Senior Resident Inspector
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ST-HL-AE-Y080 PAGE 3 OF 4

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U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVEN ; REPORT (LER)

##### 0418 NO 3153-0104

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On March 14, 1992, Unit 1 was in Mode 1 at 100% power. A reactor trip occurred at approximately 1108 hours from a momentary false reactor coolant low flow trip signal. Instrumentation & Control Technicians calibrating the Reactor Coolan; flow transmitter reversed the procedural sequence of restoring the transmitter causing a momentary low (below setpoint) differential pressure to be detected by the two adjacent flow This event completed the logic in the Solid State transmitters. Protection System to trip the amactor. The cause of this event was failure to follow procedures which resulted from insufficient supervisory and management emphasis on the risk associated with the task, and a limited sense of responsibility by the technicians to ensure proper task completion. The actions being taken to correct this event are: supervision is required to be present to ensure emphasis is placed on completing the activity correctly when a potential reactor trip could occur; clear direction for use and physical presence of procedures has been provided to maintenance craftsmen; and a memoraneum from management was issued emphasizing the self-checking principle.

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ATTACHMENT

# TEXT CONTINUATION

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#### DESCRICTION OF EVENT:

On March 14, 1992, Unit 1 was in Mode 1 at 100 percent power. A reactor trip occurred at approximately 1108 hours from a momentary false reactor coolant low flow trip signal. At that time, Instrumentation and Control Mechnicians were calibrating a flow transmitter for Reactor Coolant Flow Loop 2 Protection Set 2. The work document to perform the calibration was initiated on March 13, 1992, due to an evaluation of the previous two transmitter data and channel comparisons rendering the transmitter calibration suspect. The work document instructions directed the technicians to use a surveillance procedure. The transmitter was removed from service and as found data was recorded. An adjustment was made to the transmitter to bring it within tolerance. While returning the transmitter to service, the transmitters high pressure side valve was opened first instead of the low pressure side valve to pressurize the transmitter which was contrary to the procedure. A momentary low (below sutpoint) differential pressure was detected by two adjacent flow transmitters. This completed the two-out-of-three coincidence logic in the Solid State Protection System and with the Nuclear Instrumentation System permissive P-8 being satisfied (Reactor Power above 40% Power), the reactor tripped on reactor coolant low flow. The plant was stabilized in Mode 3. The main steam isolatic valves were clused to limit Reactor Coolan: System cooldown. The NRC was notified on March 14, 1992 at 1327 hours.

The three transmitters, that measure reactor coolant flow, are connected to the process line by a common tap on the high pressure side. This is a unique piping arrangement. The opening of the high pressure valve first results in the two adjacent flow transmitters momentarily supplying the pressure needed to pressurize the transmitter being returned to service. A momentary pressure drop of approximately three pounds per square inch is all that is required to exceed the differential pressure setpoint.

### CAUSE OF EVENT:

The cause of this event was failure to follow procedures which resulted from insufficient supervisory and management emphasis on the risk associated with the task, and a limited sense of responsibility by the technicians to ensure proper task completion. In addition, management controls over procedure usage were not clearly stated resulting in confusion over requirements for having procedures present during task performance.

ATTACHMENT ST-HL-AE-40 8 0 FAGE TOF U.S. NUCLEAR RESULATORY COMMISSION NEC FORM SEGA EXPIRES 4/30/97 ESTIMPTED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST, 300 HRE FORWARD COMMINIST REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MALLY GENERAL READER (PS.20). US, NUCLEAR RECULATION COMMISSION WASHINGTON DC 20555, AND TO THE PAPERWORK REQUESTION PROJECT L'ISSOCIAGE). OFFICE OF MANAGE MENT AND BUDGET, WASHINGTON, DC 20501. LICENSEE EVENT REPORT (LER) TEXT CONTINUATION FACILITY NAME (1) DOCKET WUMBER (2) LER HIMBER IS SACE ON SEDUENTIAL NUMBER MEVENON \*\*\*\* 01 0 01 3 05 01 4 0 15 10 10 10 1 4 9 8 9 0 0 3 South Texas, Unit 1

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#### CAUSE OF EVENT: (Continued)

The technician in the Reactor Containment Building (RCB) performing the work to return the transmitter to service did not have a copy of the procedure in his possession, but rather was following verbal instructions from a technician in the relay rack area of the Electrical Auxiliary Building who did possess the procedure. The technician providing verbal direction failed to read and communicate specific steps for return to service. The technician in the RCB valved in the flow transmitter in the reverse order.

#### ANALYSIS OF EVENT:

The event is reportable pursuant to 10CFR50.73(a)(2)(iv). There were no adverse radiological or safety consequences as a result of this event. Engineered Safety Systems functioned as designed and no unexpected post-trip transients occurred.

#### CORRECTIVE ACTIONS:

- 1. Shift and Unit supervisors are being briefed and it is being emphasized that they will be held accountable for taking conservative action, including power reduction or other actions that will increase the safety margin and/or reduce the risk of a plant transient or trip when evaluating the safety impact of work or testing and to monitor these activities to ensure that they are controlled. This activity will be completed by May 1, 1992.
- 2. Plant Management has established a reactor trip prevention policy which adds administrative controls to work activities that have a potential to cause a reactor trip. These activities are required to be under direct control of an on-the-scene supervisory individual to ensure the job is completed correctly and within safety margins.
- 3. A Maintenance Department Standing Order was issued requiring that performers of a procedure will have a copy of the procedure or, at the minimum, a copy of the portion of the procedure that is to be performed by those personnel who are working at locations other than where the controlling procedure is maintained.

		ATTACHMENT ST-HL AE- 4080
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	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION	ESTIMATED BURDEN PER REPRONSO TO CONFLY WITH THIS INCOMMATION COLLECTION REQUEST 500 HRS FORWARD DOMESTERS REPORTED ING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F.5.0), U.S. MUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20635, AND TO THE FAPERWORK REDUCTION PROJECT (3150 DIOM), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

DOCKET NUMBER (2)

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South Texas, Unit 1
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FACILITY NAME 111

# CORRECTIVE LCTIONS: (Continued)

- 4. Department training sessions will be conducted for appropriate maintenance personnel. The session will discuss the lessons learned from this event and the training will be completed by May 28, 1992.
- 5. Management has issued a memorandum to emphasize the importance of the self-checking principle and to request line management to reinforce these principles with their personnel.

## ADDITIO 'AL INTOFMATION:

Similar events have been reported regarding reactor trips due to failure to follow procedure which are LER 89-011 (Unit 2) "Inadvertent Safety Injection and Reactor Trip System Actuations Due to Personnel Error", LER 90-013 (Unit 2) "Reactor Trip Caused by Manipulation of the Incorrect Reactor Trip Breaker Test Pushbutton" and LER 91-022 (Unit 1) "Reactor Trip During Performance of SSP3 Logic Functional Test".

boc to DMB (IEO1)

bcc distrib. by RIV:
R. D. Martin
DRF
Lisa Shea, RM/ALF, MS: MNBB 4503
DRSS-FIPS
Project Engineer (DRP/D)
DRS
Chief, Technical Support Section

Resident Inspector Section Chief (DRP/D) MIS System RSTS Operator RIV File R. Bachmann, OGC, MS: 15-B-18

RIV: DRP/D (NU) MASatorius: ww 7/1/92

C:DRP/RO ATHOWARD 7/7/92

D DAP ABBeach 7/11/92