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Houston Lighting & Power

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February 19, 1988
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File No.: G02.04, G03.07
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Director, Office of Enforcement
U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

South Texas Project Electric Generating Station
Unit 1
Docket No. STN 50-498
Reply to Notice of Violation and Proposed
Imposition of Civil Penalty - Enforcement Action 87-240

Houston Lighting and Power Company's (HL&P) response to the above referenced Notice is attached. As noted in the response, HL&P concurs that the items identified were violations of the applicable Technical Specifications and is, therefore, not contesting the proposed civil penalty.

HL&P recognizes that any violation of Technical Specification is serious and believes that the corrective action described in this response will yield the desired results. An electronic funds transfer (IMA# 02171632 KKB01-1106), for the full amount of the civil penalty, payable to the Treasurer of the United States, was made on February 17, 1988.

If you should have any questions on this matter, please contact me.

G. E. Vaughn
Vice President
Nuclear Plant Operations

GEV/SMH/dg

Attachments: Response to Notice of Violation and Proposed Imposition of Civil Penalty - Enforcement Action 87-240

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Violation A

I. Statement of Violation

Technical Specification 3.5.3.1c, requires a minimum of two operable ECCS flow paths to the RCS for Mode 4 of plant operations. ACTION requirement a. of TS 3.5.3.1 requires that with less than two operable flow paths restore the minimum flow paths within 1 hour or be in COLD SHUTDOWN within the next 20 hours.

Contrary to the above, the plant was operated in Mode 4 from October 31 to November 2, 1987, without two operable ECCS flow paths. All three High Head Safety Injection (HHSI) cold leg injection valves were closed during this entire period.

II. Houston Lighting and Power Position

As previously noted in Licensee Event Report 87-0012 transmitted to the NRC on December 11, 1987, HL&P admits that the violation occurred.

III. Reason for Violation

A well intentioned management decision made to provide assurance that the plant was being operated properly was inadequately planned and carried out. Plant Operations Management and plant operators did not recognize that the SI System Normal Lineup Procedure would realign these valves to the closed (Mode 5), rather than open (Mode 4), position. A contributing factor was the operators incorrect response to bypass and inoperable status indications on the Control Board. This indicates a lack of full awareness for Mode 4 requirements. The root causes of this occurrence are inadequate training on procedures and the fact that this was the first time the plant was moved from Mode 5 to Mode 4 requiring the use of the involved procedures.

IV. Corrective Actions

The following corrective actions were taken as a result of this violation:

1. At approximately 0510 hours on November 2, 1987, the operators recognized that the HHSI Cold Leg Injection Valves were closed and the Train B & C valves were subsequently opened. Opening these valves met the Technical Specification requirements for two operable flow paths of HHSI. At approximately 0554 all three HHSI Cold Leg Injection Valves were verified to be open as a result of reperformance of the ECCS valve surveillance procedure.

2. Detailed discussions were conducted by the Operations Managers with the operators to provide management re-emphasis and remedial training on the proper use of procedures, use of annunciators, attention to detail and understanding of plant status.

3. The Plant Heatup Procedure has been changed to ensure that the HHSI Cold Leg Injection Valves are open before entering Mode 4.

4. Other safety-related system operating procedures which perform valve lineups have been reviewed to ensure similar problems did not exist. Only one additional procedure required change. This change has been made.

5. A list of the minimum equipment required for each mode has been added to the shift relief and turnover logs to assist the operators in recognizing abnormal conditions and assuring equipment required by Technical Specifications is available.

6. Operators have received additional simulator training on revised procedures for heatup, cooldown, and plant startup.

V. Corrective Actions Which Will Be Taken

No further corrective action with regard to this Technical Specification Violation is considered necessary.

VI. Date when Full Compliance will be Achieved.

HL&P is currently in full compliance.

Violation B

I. Statement of Violation

Technical Specification Table 3.3-4, Item 1.e requires the pressurizer pressure-low setpoint to be set at equal to or greater than 1869 psig with an allowable value of equal to or greater than 1861 psig. Technical Specification Table 3.3-3, Item 1.e requires the pressurizer pressure-low trip function to have a minimum of three safety injection trip channels operable prior to entering Mode 3 of plant operation.

Contrary to the above, the plant entered Mode 3 on November 22, 1987, with all four pressurizer pressure-low trip channels inoperable due to being set to trip at 1850 psig, an incorrect, nonconservative setting.

II. Houston Lighting and Power Position

HL&P admits that the above violation occurred.

III. Reason for Violation

The four analog channel operational test (ACOT) surveillance procedures (PSP02s) and four calibration surveillance procedures (PSP05s) were initially developed using the setpoints generated by the Plant Scaling Manual. The Manual was originally developed in September and October of 1986. The surveillance procedures were issued as revision 0 shortly after that time with a pressurizer low pressure setpoint of 1877 psig. Subsequently, revision 1 to these surveillance procedures was generated utilizing the Final Draft STPEGS Technical Specifications issued in June of 1987 and at this time the setpoint value in the surveillance procedure was changed to 1850 psig. The Final Draft Technical Specifications incorporated the 1850 psig setpoint with a notation referring to the 1869 setpoint as a result of interim resolution of the Veritrak transmitter uncertainty issue for STPEGS. The new notation was not recognized as an interim change from the 1850 setpoint value when a side-by-side comparison was made of the Operating License Technical Specification and the previous revisions. This format for a setpoint value was not anticipated by the Procedure Development Group. It is the only case in the Technical Specifications where a setpoint is modified from a value in a table by a footnote. (The procedure revision process used at STPEGS does include a review process. A review was performed by a second party of the revision, but that person was also not sensitive to the unusual use of a footnote for an instrument setpoint.)

The root cause of this occurrence was use of the incorrect value during incorporation of Technical Specification changes into working procedures.

IV. Corrective Actions

The following actions have been taken as a result of this event:

1. The plant surveillance procedures have been revised to correct the pressurizer low pressure setpoint to 1869 psig.

2. The four affected pressurizer pressure bistables have been recalibrated to the 1869 psig setpoint.

3. The STPEGS Scaling Manual has been revised for each of the four pressurizer pressure channels to reflect an 1869 psig setpoint.

4. A review of Engineered Safety Feature and Reactor Trip System setpoints against Plant Surveillance Procedures has been completed. One additional case of concern was identified. The Technical Specification setpoint for power range flux high positive rate, applicable in Modes 1 and 2 in accordance with Specification 2.2.1 (Table 2.2.1), was not included in the surveillance procedures. Since the unit has not yet been critical, it has not operated in a condition prohibited by the Technical Specifications as a result of this item. The affected procedures have been revised to correct this deficiency and have been verified correct.

At the time of issuance of the operating license a more rigorous program for verification of Technical Specification changes was implemented. This program requires verification of implementation of changes by the Nuclear Assurance Department. The error described as the cause of this event occurred prior to implementation of this program.

V. Corrective Action Which Will Be Taken

No further corrective action with regard to this Technical Specification Violation is considered necessary.

VI. Date of Full Compliance

STPEGS is currently in full compliance.