

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) South Texas Project Electric Generating Station DOCKET NUMBER (2) 0 5 0 0 0 4 9 8 1 OF 0 4 PAGE (3)

TITLE (4) Failure to Perform Local Leakage Rate Testing on Containment Isolation Valves

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 NAMES	DOCKET NUMBER(S)	
0	1	0	5	8	8	8	8	8		0 5 0 0 0	
				0	0	2	0	0	0	0 5 0 0 0	

OPERATING MODE (9) 5 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

20.402(b)	20.406(c)	50.73(a)(2)(iv)	73.71(b)
20.406(a)(1)(ii)	50.36(e)(1)	50.73(a)(2)(v)	73.71(c)
20.406(a)(1)(iii)	50.36(e)(2)	50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.406(a)(1)(iv)	50.73(a)(2)(i)	50.73(a)(2)(vii)(A)	50.73(a)(2)(i)
20.406(a)(1)(v)	50.73(a)(2)(ii)	50.73(a)(2)(vii)(B)	
20.406(a)(1)(vi)	50.73(a)(2)(iii)	50.73(a)(2)(viii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Charles A. Ayala - Supervisor Licensing Engineer	5 1 1 2 9 7 1 2 - 1 8 1 3 1 5

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

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 fifteen single space typewritten lines) (16)

On January 5, 1988, with Unit 1 in Mode 5 prior to initial criticality, it was determined that a required post maintenance test (PMT) had not been performed on a pair of containment isolation valves (CIVs) as required by Technical Specification 4.0.5 prior to entering Mode 4. The Unit had been operated in Mode 4 after the maintenance work and prior to discovery of the inadequate PMT. Subsequent testing revealed that one of the two CIVs exceeded its local leakage rate requirements. This event occurred as a result of a lack of training with regard to the post maintenance testing requirements for containment isolation valves and failure of supervisory personnel to identify that containment isolation valves had not received adequate post maintenance testing. The valves were retested and reworked as appropriate to a satisfactory condition within approximately twenty-seven hours of discovery of the event. Maintenance supervisory personnel and maintenance work planners have been counselled with regard to the importance of PMT requirements of CIVs. Plant procedures will be clarified and enhanced. Training will be given on the procedures and the PMT requirements for CIVs. No adverse affect upon the safety of the public occurred as a result of this event.

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

DESCRIPTION OF OCCURRENCE:

At approximately 1305 hours on January 5, 1988 with Unit 1 in Mode 5 and prior to initial criticality, it was discovered that limit switch adjustments had been made to Motor Operated Valves (MOVs) A1RAMOV0006 and B1RAMOV0003 without performing a post maintenance Local Leak Rate Test (LLRT) as required by Technical Specification 4.0.5. This event was discovered by a NRC inspector conducting a random review of work documents during an operational readiness review. Containment integrity is not required by Technical Specifications when the plant is in Mode 5.

A1RAMOV0006 and B1RAMOV0003 are one inch ball valves located on the Reactor Containment Building (RCB) Radiation Monitor (N1RART8011) sample exhaust line. These valves serve a containment isolation function. At approximately 0015 hours on January 6, 1988, an LLRT was performed on these valves. Valve A1RAMOV0006 tested satisfactorily; however, leakage from valve B1RAMOV0003 was excessive. Maintenance and retesting were completed at approximately 1550 hours on January 6, 1988. MOV B1RAMOV0003 was then declared operable at approximately 2200 hours on January 6, 1988.

A review of records determined that the limit switches for MOV A1RAMOV0006 were adjusted on October 17, 1987. A Valve Operability Test (VOT) was satisfactorily performed on October 28, 1988. However, the required LLRT was not performed.

The limit switches for MOV B1RAMOV0003 were adjusted on October 26, 1987. The VOT was satisfactorily performed on November 17, 1987. However, the required LLRT was not performed.

The NRC was notified of the condition at 1839 hours on January 6, 1988.

A review of project maintenance documentation determined that the LLRT requirement was not included on the Maintenance Work Request (MWR) by the maintenance planners. Maintenance Supervisor and Shift Supervisor concurrence was indicated on the MWR. Procedural guidance existed to assist maintenance planners (and supervisors) in determining the appropriate PMT for these MOVs. Training on this guidance had not been given.

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TEXT (if more space is required, use additional NRC Form 368A's) (17)

CAUSE OF OCCURRENCE:

The root causes of the event were determined to be:

1. Failure to provide maintenance planners and maintenance supervisors with training concerning containment integrity and PMT requirements.
2. Failure on the part of personnel to identify the inadequate PMT requirements on the MWR during supervisory review.

ANALYSIS OF EVENT:

The event was reportable pursuant to 10CFR50.73(a)(2)(i)(B) in that the plant was operated in a condition prohibited by Technical Specifications 3.6.1.1 and 3.6.1.2. Containment integrity was not confirmed by the appropriate LLRT, and subsequent testing could not confirm that the integrated containment leakage Technical Specification was not violated.

Unit 1 had not reached initial criticality nor produced appreciable radioactivity at the time of the event. Only one of the two valves on the penetration had excessive leakage. Therefore, the event caused no adverse safety consequences. For the same reasons, no adverse safety consequences would have occurred if Unit 1 was operating at full power.

Approximately seventy-three (73) days elapsed between the time that the maintenance was performed on valve B1RAMOV0003 until the event was discovered.

CORRECTIVE ACTION:

To prevent recurrence of the event, the following corrective actions are being taken:

1. Information regarding this event was discussed with maintenance supervisory personnel and maintenance planners. The intent of these briefings was to make these personnel aware of the importance of maintaining containment integrity. Maintenance planners were advised to discuss PMT requirements with the cognizant system engineer prior to issuing a MWR, especially in regards to containment isolation valves.
2. Training of shift supervisors and support personnel will be conducted to reinforce the importance of post maintenance testing with regard to containment integrity requirements by February 29, 1988.

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ADDITIONAL INFORMATION:

There have been no other similar reportable events.

Valve A1RAMOV0006 and valve B1RAMOV0003 are one inch ball valves manufactured by Hills-McCanna. No model numbers for these MOVs are available, but the engineering generic identification number for both valves is 105M42BP2B-E.

As an enhancement to the current MWR program, the MWR program procedure, OPGP03-ZM-0003, will be revised by February 26, 1988, to assure containment isolation valves and the required PMT are readily identified on the MWR.

NL.LER88002

The Light company

Houston Lighting & Power

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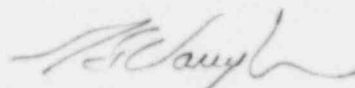
February 04, 1988
ST-HL-AE-2513
File No.: G26
10CFR50.73

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
Licensee Event Report 88-002 Regarding Failure
to Perform Post Maintenance Local Leakage Rate
Testing on Containment Isolation Valves

On January 6, 1988 Houston Lighting & Power (HL&P) notified the NRC of a reportable event regarding a failure to perform local leakage rate testing (LLRT) on two containment isolation valves after maintenance of the valves. This event had no adverse safety or radiological consequences since the plant had not yet been critical and no radioactivity had been produced. The event did not result in additional risk to the public. In accordance with 10CFR50.73 HL&P submits the attached Licensee Event Report (LER 88-002).

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



G. E. Vaughn
Vice President
Nuclear Plant Operations

GEV/WPE/krm

Attachment: Licensee Event Report 88-002 Regarding
Failure to Perform Post Maintenance Local
Leakage Rate Testing on Containment
Isolation Valves Due to Lack of Training
on Post Maintenance Testing Requirements

NL.LER88002

A Subsidiary of Houston Industries Incorporated

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