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U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

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At 0655 hours on June 13, 1988, Unit 1 changed from Mode 3 to Mode 2. At approximately 1100 hours on the same day, it was discovered that the Intermediate Range Nuclear Instruments had not had an Analog Channel Operational Test performed on them in the previous thirty-one days as required by Technical Specification 4.3.1.1 prior to entering Mode 2. The tests had been performed at 1035 hours in preparation for entry into Mode 1 and the results were acceptable. However, Unit 1 had been in Mode 2 for approximately three hours and forty minutes prior to the completion of the required testing. The causes of this event were inadequate review of surveillance test status prior to the mode change and inadequate requirements for use of the Mode Change Report. Corrective actions include issuance of instructions and procedure revisions on the use of the Mode Change Report, a revision to the Mode Change Report format, a review of the surveillance program to improve scheduling of conditional surveillances and establishment of a Surveillance Program Task Force.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

FACILITY NAME (1)			DOCKET NUMBER (2)							LER NUMBER (6)								PAGE (3)			
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DESCRIPTION OF OCCURRENCE:

During the afternoon of June 12, 1988, plant personnel were making preparations for a plant mode change from Mode 3 to Mode 2. As part of the Plant Operations heatup procedure, the Shift Supervisor obtains various department manager's signatures. These signatures indicate that the managers have reviewed their responsible work activities, including surveillance tests. and that their department can support the upcoming mode change. At approximately 1530 hours, the Shift Supervisor called the Maintenance Manager to obtain his permission to sign for him. Normally, the Maintenance Manager would have checked with his Division Managers and his Divisional Surveillance Coordinators. However, since this occurred on a Sunday afternoon, he instead called the three maintenance shops. He mistakenly assumed that the mode change report had been reviewed on the previous Friday, and the mode restraints identified to the snops. However, the I&C Divisional Surveillance Coordinator had not known of the impending mode change on Friday, and thus had not reviewed the Mode Change Report. Therefore, the Maintenance Manager was erroneously told that there were no mode change restraints, which he then relayed to the Shift Supervisor.

At 0655 hours on June 13, 1988, Unit 1 entered Mode 2. Upon hearing that Unit 1 was critical, the I&C Divisional Surveillance Coordinator realized that conditional surveillances required for entry into Mode 1 had not been performed. He immediately notified the Shift Supervisor and made preparations to perform the Intermediate Range Nuclear Instrumentation Analog Channel Operational Tests. The tests were satisfactorily performed at 1035 hours. He subsequently reviewed the other surveillances required for the previous entry into Mode 2 and the upcoming change to Mode 1 and determined that the above instruments had not been tested prior to entry into Mode 2.

This event was determined to be reportable and the NRC was notified pursuant to 10CFR50.72 at 1504 hours on June 13, 1988.

CAUSE OF OCCURRENCE:

The root causes of this event were:

- Less than adequate review of surveillance test status by a
 Department Manager prior to his signature in the heatup procedure.
- Inadequate surveillance program, in that it failed to require the proper use of the Mode Change Report.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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

ANALYSIS OF EVENT:

There were no adverse safety or radiological consequences as a result of the event. The event did not produce any additional risk to the public.

The event is reportable pursuant to 10CFR50.73(a)(2)(i)(B). The Intermediate Range Nuclear Instruments were in an untested condition as required by Technical Specification 4.3.1.1 for three hours and forty minutes on June 13, 1988, while Unit 1 was in Mode 2, and, as such, the unit was in a configuration prohibited by Technical Specifications.

CORRECTIVE ACTION:

The following corrective actions are being taken to prevent recurrence of the event:

- The mode change report was reviewed. No other missed curveillances were identified for this startup.
- 2. On June 15, 1988, a memorandum was issued by the Plant Manager describing immediate corrective actions to be taken during upcoming mode changes. This includes department representative's signoff and Department Manager's signoff of the Mode Change Report. In addition, the Shift Supervisors were directed to review and sign the Mode Change Report prior to mode changes.
- 3. The appropriate procedures have been revised to require that the Mode Change Report is reviewed and signed by the Cognizant Department, followed by a final review, by a designated individual, of the complete Mode Change Report to ensure that all of the surveillance line items have been properly signed and that the departments have signed for the review of their sections. This action was completed on July 9, 1988.
- 4. The Mode Change Report has been revised to make it easier to review.
- 5. The surveillance program will be reviewed to determine if certain conditional surveillance requirements can be scheduled as routine tasks, or flagged by appropriate procedures. This will be completed by September 30, 1988.
- 6. A Surveillance Program Task Force has been established. This Task Force will review the entire surveillance program in detail and provide management with suggestions for improvement. The first Task Force Report was provided to plant management on July 8, 1988.

NRC Form 366A .

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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ADDITIONAL INFORMATION:

The following LER's have been previously submitted regarding surveillance test program deficiencies at STPEGS:

LER	87-009	Surveillance Deficiency Due to a Procedural Inadequacy Resulting in a Technical Specification Violation
LER	87-017	Pressurizer Low Pressure Safety Injection Setpoint Too Low Due to Procedural Error
LER	87-019	Slave Relay Surveillance Deficiency Due to a Personnel Error
LER	87-026	Degraded Undervoltage Coincident with a Safety Injection Circuitry Surveillance Deficiency Due to a Deficient Procedure
LER	88-005	Inadequate Surveillance Performed on a Control Room Intake Radioactivity Monitor
LER	88-006	Inadequate Surveillance Testing of Master Relays
LER	88-007	Incorrect Formula in a HVAC Surveillance Procedure
LER	88-010	Inoperability of Reactor Coolant Pump Seal Injection Containment Isolation Valves
LER	88-011	Nonperformance of Schedulei Surveillance Test for Essential Chilled Water Pump as a Result of a Lost Test Package
LER	88-012	Failure to Fully Implement Technical Specification Surveillance Requirements Due to Procedural Deficiency
LER	88-013	Failure to Test RCS Low Flow Times Due to Procedure Deficiencies
LER	88-023	Nonperformance of a Scheduled Surveillance Test for Escential Cooling Water Screen Wash Booster Pump Due to an Inadequate Procedure
LER	88-034	Failure to Test Containment Spray Sequencer Actuation
LER	88-035	Nonperformance of a Required Surveillance Test for a Component Cooling Water Valve Due to an Inadequate Procedure

The Light company

P.O. Box 1700 Houston, Texas 77001 (713) 228-9211

July 13, 1988 ST-HL-AE-2717 File No.: G26 10CFR50.73

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

South Texas Project Electric Generating Station
Unit !
Docket No. STN 50-498
Licensee Event Report 88-038 Regarding Failure
to Perform Surveillance Testing of Intermediate
Range Nuclear Instrumentation Prior to Entering Mode 2

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Licensee Event Report (LER 88-038) regarding failure to perform surveillance testing of Intermediate Range Nuclear Instrumentation prior to entering Mode 2. This event did not have any 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 (5!2) 972-8628.

G.E. Vaughn Vice President

Nuclear Plant Operations

GEV/BEM/nl

Attachment: LER 88-038 Regarding Failure to

Perform Surveillance Testing of

Intermediate Range Nuclear

Instrumentation Prior to Entering

Mode 2.

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ST-HL-A3-2717 File No.: G26 Page 2

cc:

Regional Administrator, Region IV Nuclear Regulatory Commission 611 Ryan Plaza Drive, Suite 1000 Arlington, TX 76011

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

Jack E. Bess
Resident Inspector/Operations
c/o U. S. Nuclear Regulatory Commission
P. O. Box 910
Bay City, TX 77414

Don L. Garrison
Resident Inspector/Construction
c/o U. S. Nuclear Regulatory Commission
P. O. Box 910
Bay City, TX 77414

J. R. Newman, Esquire Newman & Holtzinger, P.C. 1615 L Street, N.W. Washington, DC 20036

R. L. Range/R. P. Verret Central Power & Light Company P. O. Box 2121 Corpus Christi, TX 78403

R. John Miner (2 copies)
Chief Operating Officer
City of Au in Electric Utility
721 Barton prings Road
Austin, 7X 2704

R. J. Costello/M. T. Hardt City Public Service Board P. O. Box 1771 San Antonio, TX 78296 Rufus S. Scott Associated General Counsel Houston Lighting & Power Company P. O. Box 1700 Houston, TX 77001

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

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