The Light company
Houston Lighting & Power

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

September 29, 1988
ST-HL-AE-2805
File No.: G02.04
10CFR2.201

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
Response to Notice of Violation 498/8847-01

Houston Lighting & Power Company (HL&P) has reviewed Notice of Violation 498/8847-01 dated August 31, 1988. HL&P concurs that the cited violations occurred. These Licensee violations were fully addressed as the subject of the attached Licensee Event Reports. The status of actions addressed in the attached is updated as follows:

Licensee Event Report 88-040, "Failure to Stagger Reactor Trip Breaker Surveillance Test Intervals"

Corrective actions described in the attached LER have been completed.

Licensee Event Report 88-043, "Failure to Perform Surveillance Test of Diesel Generator Fuel Oil for Contamination"

Corrective actions described in the attached LER have been completed.

Appropriate actions have been taken to ensure compliance in the future.

If you should have any questions on this matter, please contact Mr. M. A. McBurnett at (512) 972-8530.

G. E. Vaughn
Vice President
Nuclear Plant Operations

GEV/PLW/nl

Attachments: 1) Licensee Event Report 88-040
2) Licensee Event Report 88-043

IE01
1/1

cc:

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The Light company
Houston Lighting & Power

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

July 25, 1988
ST-HL-AE-2732
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
License Event Report 88-040 Regarding Failure
to Stagger Reactor Trip Breaker Surveillance Test Intervals

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Licensee Event Report (LER 88-040) regarding failure to stagger reactor trip breaker surveillance test intervals. 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 (512) 972-8628.

G. E. Vaughn
Vice President
Nuclear Plant Operations

GEV/BEM/pw

Attachment: LER 88-040

8808030160

IE22

cc:

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NRC Form 366
(9-83)

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

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
South Texas Unit 1	0 5 0 0 0 4 9 8	1 OF 0 5

TITLE (4)

Failure To Stagger Reactor Trip Breaker Test Intervals

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 6	2 3	8 8	8 8	— 0 4 0	— 0 0		0 7	2 5	8 8		0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
3	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 1 0 0	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Charles Ayala - Supervising Licensing Engineer	AREA CODE 5 1 2 9 7 2 — 8 6 2 8

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	
E											

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On June 23, 1988, during the annual review of the plant surveillance database as required by procedure, the HL&P Plant Surveillance Coordinator identified that the surveillances associated with Technical Specification 4.3.1.1 and 4.3.2.1 were scheduled with a method that could result in improper staggering of test intervals. Subsequent review by the responsible Divisional Surveillance Coordinator identified that the surveillance tests for the Reactor Trip Breakers undervoltage and shunt trip devices did not meet the staggered test basis requirement between June 20, 1988 and June 23, 1988. However, the tests were performed within their required interval. Surveillance testing for all other divisions was also reviewed for proper application of the staggered test basis. The root cause was determined to be failure of the surveillance test program to properly schedule and review staggered tests. Corrective actions include revision to the method for scheduling staggered surveillances and creation of a Surveillance Program Task Force Subcommittee to study staggered test basis surveillances.

NL.LER88040

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas Unit 1	0 5 0 0 0 4 9 8	8 8	— 0 4 0	— 0 0	0 2 OF 0 5

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

DESCRIPTION OF OCCURRENCE:

On June 23, 1988, during the annual review of the plant surveillance database as required by procedure, the HL&P Plant Surveillance Coordinator identified that the surveillances associated with Technical Specification 4.3.1.1 and 4.3.2.1 were scheduled with a method that could result in improper staggering of test intervals. This method, known as frequency based scheduling, determines the next due date for a given surveillance by adding the surveillance interval to the last date the surveillance was performed and adjusting the due date as required by Technical Specification 4.0.2. The result of this calculation assures that the surveillance interval for each train meets the Technical Specification requirement, however, the stagger (equal to the test interval divided by the number of trains) between tests of redundant trains may not remain constant.

Upon the discovery of the error in the scheduling method used, the Plant Surveillance Coordinator requested the responsible Divisional Surveillance Coordinator to review his surveillances for compliance with the staggered test basis. The review identified that the surveillance tests for the Reactor Trip Breakers undervoltage and shunt trip devices did not meet the staggered test basis of Technical Specification 4.3.1.1.20 between June 20, 1988 and June 23, 1988. Subsequently, "Staggered Test Basis" surveillances for all other divisions were reviewed to assure that Staggering intervals were correct for the current mode. The history of these surveillances was also reviewed back to the issuance of the Operating License. Two surveillances were found to have been improperly staggered on Pressurizer Water Level Protection and Extended Range Nuclear Instrumentation.

On June 24, 1988, with Unit 1 in Mode 3, the Divisional Surveillance Coordinator notified the Shift Supervisor of the failure to meet the staggered test basis which was a violation of Technical Specification 4.3.1.1.20. The condition was subsequently determined to be reportable on June 25, 1988 and the NRC was notified pursuant to 10CFR50.72 at 1602 hours. The test had already been performed on June 23, 1988, as scheduled, within its required surveillance interval.

CAUSE OF OCCURRENCE:

The root causes of this event were:

1) Staggered test basis surveillances utilized frequency based scheduling which did not control the interval between tests of redundant trains.

2) Inadequate surveillance program in that no requirement exists for assuring staggered intervals are restored and maintained after mode changes.

ANALYSIS OF EVENT:

This condition resulted in the violation of the staggered test basis for the Reactor Trip Breaker undervoltage and shunt trip devices, Pressurizer Water Level Protection and Extended Range Nuclear Instrumentation as required by Technical Specifications which is reportable under 10CFR50.73(a)(2)(i)(B). The surveillance interval requirements were met. There were no adverse safety or radiological consequences as a result of this event. The event did not produce any additional risk to the public.

CORRECTIVE ACTION:

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

1. The surveillance data base was revised to establish calendar based scheduling for all staggered test basis surveillances associated with Technical Specification paragraphs 4.3.1.1 and 4.3.2.1.

2. 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. As a result of this incident, a subcommittee to the Surveillance Program Task Force has been created whose objectives are to more fully evaluate Staggered Test Basis surveillances, identify any additional corrective actions, and to implement changes to the staggering methods employed at STP. This activity will be completed by September 30, 1988.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas Unit 1	0 5 0 0 0 4 9 8	8 8	— 0 4 0	— 0 0	0 4 OF 0 5

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

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 Scheduled 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 Essential Cooling Water Screen Wash Booster Pump Due to an Inadequate Procedure

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas Uuit 1	0 5 0 0 0 4 9 8	8 8	— 0 4 0	— 0 0	0 5 OF 0 5

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

ADDITIONAL INFORMATION (Cont'd.)

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

LER 88-038 Failure to Perform Surveillance Testing of Intermediate Range Nuclear Instrumentation Prior to Entering Mode 2

The Light company
Houston Lighting & Power

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

August 9, 1988
ST-HL-AE-2754
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 88-043 Regarding Failure to Perform
Surveillance Testing of Diesel Generator Fuel Oil for Contamination

Pursuant to 10CFR50.73, Houston Lighting & Power (HL&P) submits the attached Licensee Event Report (LER 88-043) regarding failure to perform surveillance testing of diesel generator fuel oil for contamination due to a personnel error. 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 (512) 972-8628.

G. E. Vaughn
Vice President
Nuclear Plant Operations

GEV/BEM/nl

Attachment: LER 88-043

8808190012

cc:

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3160-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
South Texas, Unit 1	0 5 0 0 0 4 9 8	1 OF 0 4

TITLE (4)
Failure to Perform Surveillance Testing of Diesel Generator Fuel Oil for Contamination

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 7	1 2	8 8	8 8	— 0 4 3	— 0 0	0 8	0 9	8 8		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 7 6	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Charles A. Ayala - Supervising Licensing Engineer	AREA CODE 5 1 2 9 7 2 - 8 6 2 8

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	
A											

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On July 12, 1988, with Unit 1 in Mode 1 at 76 percent power, the Houston Lighting & Power (HL&P) Chemical Operations and Analysis Department Divisional Surveillance Coordinator discovered that the monthly surveillance on Standby Diesel Generator (SDG) #11 Fuel Oil Storage Tank for particulate contamination had not been performed within its required interval. The Shift Supervisor was notified at 0945 hours and the test was performed at 1007 hours, two days past the end of the grace period. The cause of the occurrence was failure of the Divisional Surveillance Coordinator to take proper action in response to the surveillance schedule and overdue reports for this surveillance test. Corrective actions include the addition of requirements for the performance of surveillances on their due dates with limited use of the grace period and review of overdue surveillance reports by responsible department management.

NL.LER88043

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	0 5 0 0 0 4 9 8	8 8	— 0 4 3	— 0 0	0 2 OF 0 4

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

DESCRIPTION OF OCCURRENCE:

On July 12, 1988, with Unit 1 in Mode 1 at 76 percent power, the Houston Lighting & Power (HL&P) Chemical Operations and Analysis (CO&A) Department Divisional Surveillance Coordinator discovered that the monthly surveillance on Standby Diesel Generator (SDG) #11 Fuel Oil Storage Tank for particulate contamination had not been performed within its required interval. The Shift Supervisor was notified at 0945 hours and preparations were made to perform the test. The surveillance test was completed satisfactorily at 1007 hours. The NRC was notified at 1613 hours.

A subsequent investigation revealed that on June 17, 1988 the CO&A backup Divisional Surveillance Coordinator received the surveillance test package and misfiled it in a hold file instead of forwarding it to the Lead Chemical Technician's Office. When the surveillance became due on the Chemistry Sampling Schedule on June 30, 1988, the HL&P Lead Chemical Technician could not locate the surveillance test package or the test completion notice.

On July 1, 1988, the surveillance test appeared on the daily overdue surveillance report. The Divisional Surveillance Coordinator was advised by another Lead Chemical Technician that he thought the surveillance test had been completed as scheduled and took no further action. The surveillance test again appeared on the overdue report on July 5, 1988. At that time, the Divisional Surveillance Coordinator believed that the test completion notice had been misplaced, and did not take the time to investigate until July 12, 1988 when the missing surveillance test package was found in the hold file. By then the grace period for this surveillance had been exceeded by two days.

CAUSE OF OCCURRENCE:

The cause of this event was failure of the Divisional Surveillance Coordinator to take proper action in response to the surveillance schedule and overdue reports for this surveillance test.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	0 5 0 0 0 4 9 8	8 8	0 4 3	0 0	0 3 OF 0 4

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

ANALYSIS OF EVENT:

Failure to perform surveillance testing of Standby Diesel Generator Fuel Oil Storage Tank for particulate contamination is a violation of Technical Specification 4.8.1.1.2.D and is reportable under 10CFR50.73(a)(2)(i)(B). The test was performed on July 12, 1988 and the particulate contamination level was determined to be acceptable.

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

CORRECTIVE ACTION:

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

1. The Plant Manager has issued a directive to emphasize the requirement that surveillances be performed on their due dates and that the use of the grace period be limited. Additionally, direction has been included instructing personnel to review objective evidence to verify surveillance completion.

2. The Plant Surveillance Program procedure has been revised to require the responsible department manager to review the overdue report and allocate sufficient resources to insure timely completion of surveillance tests.

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

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
South Texas, Unit 1	0 5 0 0 0 4 9 8	8 8	— 0 4 3	— 0 0	0 4 OF 0 4

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

ADDITIONAL INFORMATION (Cont'd.)

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 Scheduled 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 Essential 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

LER 88-038 Failure to Perform Surveillance Testing of Intermediate Range Nuclear Instrumentation Prior to Entering Mode 2

LER 88-040 Failure to Stagger Reactor Trip Breaker Surveillance Intervals