Nuclear Operating Company
South Texas Project Electric Generating Station P.O. Box 289 Wadsworth, Texas 77483

July 28, 2000
NOC-AE-00000890
File No.: G29
10CFR50.73
STI: 31142446

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

South Texas Project
Unit 2
Docket No. STN 50-499
Licensee Event Report 00-003
Reactor Containment Building Penetration M-85 Not Properly Isolated

Pursuant to 10CFR50.73, South Texas Project submits the attached Unit 2 Licensee Event Report 00-003, regarding Reactor Containment Building Penetration M-85 not being properly isolated in violation of Technical Specification 3.6.3. This event did not have an adverse effect on the health and safety of the public.

Licensee commitments are listed in the Corrective Actions section of the attachment. If there are any questions on this submittal, please contact either Mr. S.M. Head at (361) 972-7136 or me at (361) 972-7800.

Michael Lorenz for G. Parkey
G.L. Parkey
Plant General Manager

PLA

Attachment: LER 00-003 (South Texas, Unit 2)

IE22

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cc:

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U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
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NRC FORM 366 (6-1998) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 06/30/2001

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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TITLE (4)

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 NAME	DOCKET NUMBER
										05000
06	28	2000	2000	0 0 3	0				FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)					
		20.2201(b)	20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
POWER LEVEL (10)	100%	20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Scott Head - Licensing Supervisor	(512) 972-7136

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

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 15 single-spaced typewritten lines) (16)

While performing a surveillance test on December 25,1999 with Unit 2 at 100% power, the Reactor Coolant System Hot Leg Sample Line Inside Reactor Containment Isolation Valve, PS-FV-4454, failed to properly stroke closed. In order to comply with Technical Specifications PS-FV-4454 was tagged closed and de-energized. On June 12, 2000, Equipment Clearance Order 9071 was revised to move the boundary to the Outside Containment Isolation Valve PS-FV-4456 to allow for troubleshooting on PS-FV-4454. This revision (Rev.1) did not meet the Technical Specification requirements since Reactor Coolant System Sample to Post Accident Sampling System Outside Containment Isolation Valve AP-FV-2455 was not included on the equipment clearance order. On June 13, 2000, Equipment Clearance Order 9071 Rev. 2 restored power to PS-FV-4454 which resulted in the improper isolation of penetration M-85. This condition was not discovered until June 28, 2000 at which time Equipment Clearance Order 9071 was revised to comply with Technical Specifications. The cause of this event is failure to meet management expectations associated with work practices. Corrective actions include reinforcing management expectations regarding roles and responsibilities, Technical Specification compliance, peer checking and the use of error reduction tools.

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TEXT *(If more space is required, use additional copies of NRC Form 366A) (17)*

DESCRIPTION OF EVENT:

While performing a surveillance test on December 25, 1999 with Unit 2 at 100% power, PS-FV-4454 failed to stroke closed. In order to comply with Technical Specifications, Equipment Clearance Order 9071 was generated to close PS-FV-4454 and remove power to isolate penetration M-85. PS-FV-4454 remained in this configuration until June 13, 2000.

Maintenance was scheduled on June 12, 2000 to troubleshoot the valve position indication problem on PS-FV-4454. When the work schedule was reviewed the week of June 5, 2000, it was concluded that since PS-FV-4454 was already tagged closed and de-energized, no further equipment clearance order was required. However, on Monday June 12, 2000, it was realized that Equipment Clearance Order 9071 would require a revision to allow maintenance to stroke PS-FV-4454 as required.

On June 12, 2000 ECO 9071 was revised to allow troubleshooting of PS-FV-4454. Maintenance personnel were on standby for the revision to commence scheduled work activities. The review of the revision missed a parallel path on the Piping and Instrumentation Drawing that delineates the flow path to AP-FV-2455. The containment isolation boundary was moved from PS-FV-4454 to PS-FV-4456 to allow stroking PS-FV-4454 as required. This revision (Rev.1) failed to identify and include AP-FV-2455 for deactivation as an Outside Containment Isolation Valve and potential unisolated flow path from containment.

On June 13, 2000 Rev. 2 of Equipment Clearance Order 9701 restored power to PS-FV-4454 which resulted in penetration M-85 being improperly isolated. On June 27, 2000 and again on June 28, 2000 PS-FV-4454 was opened to allow for a monthly Chemistry surveillance on the Post Accident Sampling System. Following the sampling activities on June 28, 2000, it was noticed that PS-FV-4454 had no position indication from the control room. A review of Equipment Clearance Order 9071 revealed that when the revision on June 13, 2000 was performed, a violation of T.S.3.6.3 occurred resulting in penetration M-85 being improperly isolated. On June 28, 2000, Inside Containment Isolation Valve FV-4454 was deenergized in the closed position in order to restore compliance with Technical Specifications.

CAUSE OF EVENT

The cause of this event was due to failure to meet management expectations associated with work practices. The Shift and Unit Supervisors are ultimately responsible for maintaining the unit in compliance with Technical Specifications. In this event, neither the Shift nor the Unit Supervisor verified the equipment clearance order to ensure Technical Specification compliance due to overconfidence in the Work Start Authority's capability. The fact that the valve was already tagged to comply with Technical Specifications caused the Shift and Unit Supervisors to perceive this activity to be a low-risk evolution. In addition, the Shift and Unit Supervisors are responsible for ensuring the use of peer checks for Technical Specification compliance and no peer check for Equipment Clearance Order 9071 were performed. The Work Start Authority is a Senior Reactor Operator, knowledgeable of Technical Specification compliance requirements, responsible for the proper review and authorization of equipment clearance orders. The Equipment Clearance Writer is responsible for adequate preparation of equipment clearance orders to ensure proper protection of plant personnel and equipment.

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TEXT *(If more space is required, use additional copies of NRC Form 366A)* **(17)**

ANALYSIS OF EVENT

A notification was made to the NRC on Thursday June 29, 2000 at 1114 hours (Event # 36133) for Unit-2 not complying with T.S. 3.6.3 Action B regarding Reactor Containment Building Penetration isolation requirements. Penetration M-85 was improperly isolated from June 13, 2000 to June 28, 2000 due to an inadequate ECO revision that improperly isolated penetration M-85 by restoring power to an inoperable Reactor Containment Building isolation valve. There were no adverse safety or radiological consequences from this event. No equipment damage occurred as a result of this event.

The condition that led to PS-FV-4454 being declared inoperable on December 25, 1999 was improper valve position indication only. The Local Leak Rate Test for penetration M-85 was performed satisfactorily on October 11, 1998. Although not deenergized, valve FV-2455/2455A is a normally closed valve. This occurrence was reviewed for its effect on plant risk and was found to have no impact on plant risk during this period as these are small lines and automatic isolation would have closed them if they were open.

CORRECTIVE ACTIONS

1. Operations management discussed roles and responsibilities for Technical Specification compliance at a Shift Supervisor meeting.

2. Operations management will reinforce expectations regarding roles and responsibilities for Technical Specification compliance to Senior Reactor Operators. This will be completed by August 31, 2000.

3. Operations management will reinforce to operations personnel expectations regarding roles and responsibilities, Technical Specification compliance, peer checking, and the use of error reduction tools. This will be completed by October 26, 2000.

ADDITIONAL INFORMATION

There have been no other previous events reported by South Texas Project to the Nuclear Regulatory Commission within the last three years similar to this occurrence.

STP Nuclear Operating Company will continue to evaluate the generic implications associated with this issue as well as other Technical Specification related compliance issues to determine if additional measures or processes should be implemented to minimize the potential for future Technical Specification compliance events.