ENERGY NORTHWEST

P.O. Box 968 ■ Richland, Washington 99352-0968

April 10, 2001
GO2-01-056

Docket No. 50-397

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

Gentlemen:

Subject: **COLUMBIA GENERATING STATION, OPERATING LICENSE NPF-21, LICENSEE EVENT REPORT NO. 2001-001-00**

Transmitted herewith is Licensee Event Report No. 2001-001-00 for Columbia Generating Station. This report is submitted pursuant to 10 CFR 50.73. The enclosed report discusses items of reportability and corrective action taken.

Should you have any questions or desire additional information regarding this matter, please call me or Mr. PJ Inserra at (509) 377-4147.

Respectfully,

GO Smith,
Vice President, Generation
Mail Drop PE988V

Attachment

cc: EW Merschoff - NRC-RIV
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IE22

NRC FORM 366 (1-2001) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 6-30-2001

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose 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 collection.

# LICENSEE EVENT REPORT (LER)

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

| FACILITY NAME (1) | DOCKET NUMBER (2) | PAGE (3) |
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| Columbia Generating Station | 50-397 | 1 OF 2 |

**TITLE (4)**

TRAVERSING INCORE PROBE SYSTEM WAS OPERATED WITHOUT ADMINISTRATIVE CONTROLS AS REQUIRED BY TECHNICAL SPECIFICATION LCO 3.6.1.3, NOTE 1

| EVENT DATE (5) | | | LER NUMBER (6) | | | REPORT DATE (7) | | | OTHER FACILITIES INVOLVED (8) | |
|---|---|---|---|---|---|---|---|---|---|---|
| MO | DAY | YEAR | YEAR | SEQUENTIAL NUMBER | REV NO | MO | DAY | YEAR | FACILITY NAME | DOCKET NUMBER |
| 02 | 06 | 2001 | 2001 | - 001 - | 00 | 04 | 10 | 2001 | FACILITY NAME | DOCKET NUMBER |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| OPERATING MODE (9) | 1 | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11) | | | | | | | | | |
| POWER LEVEL (10) | 100 | | 20.2201(b) | | 20.2203(a)(3)(ii) | | 50.73(a)(2)(ii)(B) | | 50.73(a)(2)(ix)(A) | | |
| | | | 20.2201(d) | | 20.2203(a)(4) | | 50.73(a)(2)(iii) | | 50.73(a)(2)(x) | | |
| | | | 20.2203 (a)(1) | | 50.36(c)(1)(i)(A) | | 50.73(a)(2)(iv)(A) | | 73.71(a)(4) | | |
| | | | 20.2203(a)(2)(i) | | 50.36(c)(1)(ii)(A) | | 50.73(a)(2)(v)(A) | | 73.71(a)(5) | | |
| | | | 20.2203(a)(2)(ii) | | 50.36(c)(2) | | 50.73(a)(2)(v)(B) | | Other Specify in Abstract below or in NRC Form 366A | | |
| | | | 20.2203(a)(2)(iii) | | 50.46(a)(3)(ii) | | 50.73(a)(2)(v)(C) | | | | |
| | | | 20.2203(a)(2)(iv) | | 50.73(a)(2)(i)(A) | | 50.73(a)(2)(v)(D) | | | | |
| | | | 20.2203(a)(2)(v) | x | 50.73(a)(2)(i)(B) | | 50.73(a)(2)(vii) | | | | |
| | | | 20.2203(a)(2)(vi) | | 50.73(a)(2)(i)(C) | | 50.73(a)(2)(viii)(A) | | | | |
| | | | 20.2203(a)(3)(i) | | 50.73(a)(2)(ii)(A) | | 50.73(a)(2)(viii)(B) | | | | |

**LICENSEE CONTACT FOR THIS LER (12)**

| NAME | TELEPHONE NUMBER (Include Area Code) |
|---|---|
| R Brownlee | 509-377-2085 |

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

| CAUSE | SYSTEM | COMPONENT | MANU-FACTURER | REPORTABLE TO EPIX | | CAUSE | SYSTEM | COMPONENT | MANU-FACTURER | REPORTABLE TO EPIX |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

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


**ABSTRACT** (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) **(16)**

On February 6, 2001, a Local Power Range Monitor calibration surveillance was being performed which required the operation of the Traversing Incore Probe (TIP) System. While the TIP System was energized the requirement of Technical Specification LCO 3.6.1.3, Note 1 for administrative control of containment penetration flow paths was not met. An individual was not assigned to be the dedicated operator of TIP System control switches to ensure isolation of containment penetration flow paths in the event of a valid containment isolation signal.

The cause of this event was the lack of a procedural standard for establishing administrative controls in accordance with the Technical Specifications and Bases. A standard was not available when changing the method of administrative control of TIP System containment isolation valves from the use of a clearance order and tags to a revised procedure for operating the TIP System.

There are no safety consequences associated with this event.

The procedure for operating the TIP System has been revised to provide instructions for satisfying the TS LCO 3.6.1.3 requirement for administrative controls.

# LICENSEE EVENT REPORT (LER)

| FACILITY NAME (1) | DOCKET (2) | LER NUMBER (6) | | | PAGE (3) |
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| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | |
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**NARRATIVE** *(If more space is required, use additional copies of NRC Form 366A)* ***(17)***

Event Discription:

Traversing Incore Probe (TIP) System containment isolation valves TIP-V-1, 2, 3, 4, and 5 are considered inoperable due to the potential for spurious opening of the valves with the TIP drive units energized. Technical Specification (TS) LCO 3.6.1.3, Note 1 states "Penetration flow paths may be unisolated intermittently under adminstrative controls." TS Bases 3.6.1.3 states: "These controls consist of stationing a dedicated operator at the controls of the valve, who is in continuous communication with the control room. In this way, the penetration can be rapidly isolated when a need for primary containment isolation is indicated." At the time the concern with TIP valve spurious operation was identified, the power supply circuit breakers for the TIP drive units were danger tagged "open" per a clearance order. On those occasions when the danger tags were lifted for TIP System operation, one individual was assigned the responsiblity to verify closure of the TIP containment isolation valves should a valid containment isolation signal occur. This clearance order was removed permanently after the TIP operating procedure was revised to maintain the TIP drive power supply circuit breakers normally open. There are several steps in the TIP operating procedure that require the TIP drive power supply breakers to be closed. However, no guidance was included in the procedure to require "stationing a dedicated operator at the controls of the valve" to satisfy the TS requirements. On February 6, 2001, a Local Power Range Monitor calibration surveillance was being performed which required the operation of the TIP System. While the TIP System was energized the requirement of TS LCO 3.6.1.3, Note 1 for administrative control of containment penetration flow paths was not met. An individual was not assigned to be the dedicated operator of TIP System valves to ensure isolation of containment penetration flow paths in the event of a valid containment isolation signal.

Immediate Corrective Action:

Caution tags were hung on TIP System drive mechanism breakers and control switches so that the TIP System containment isolation valves will be controlled administratively per TS LCO 3.6.1.3.

Cause of the Event:

The cause of this event was the lack of a procedural standard for establishing administrative controls in accordance with the Technical Specifications and Bases. A standard was not available when changing the method of administrative control of TIP System containment isolation valves from the use of a clearance order and tags to a revised procedure for operating the TIP System. Two contributing causes were that control room personnel did not recognize key information available for determining the necessary TS actions while the TIP System was being operated, and that information regarding the inoperability of TIP System containment isolation valves was not adequately reviewed by the individuals who revised the procedure used to operate the TIP System.

Further Corrective Action:

Procedures associated with operation of the TIP System have been revised to provide explicit direction for satisfying TS administrative requirements when the TIP System is energized. Also, Columbia Generating Station will implement a procedural standard for establishing administrative controls when required for Technical Specification compliance.

Assessment of Safety Consequences:

There are no safety consequences associated with this event. Had there been an actual plant accident or transient requiring containment isolation while performing the LPRM surveillance, failure of the TIP containment isolation valves to close would have been identified and corrected by operations personnel as required by accident response procedures.

Similar Events:

There have been no similar events at Columbia Generating Station.