ENERGY NORTHWEST

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

January 5, 2004
GO2-04-001

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555-0001

Subject: **COLUMBIA GENERATING STATION, DOCKET NO. 50-397; LICENSEE EVENT REPORT 2003-012-00**

Dear Sir or Madam:

Transmitted herewith is Licensee Event Report No. 2003-012-00 for Columbia Generating Station. This report is submitted pursuant to 10 CFR § 50.73(a)(2)(v)(D) and 10 CFR § 50.73(a)(2)(vii)(D). The report discusses items of reportability and corrective actions taken.

If you have any questions or desire additional information regarding this matter, please contact Ms. CL Perino at (509) 377-2075.

Respectfully,

D. K. Atkinson

DK Atkinson
Vice President, Technical Services
Mail Drop PE08

Enclosure: Licensee Event Report 2003-012-00

cc: BS Mallet - NRC - RIV
BJ Benney - NRC - NRR
INPO Records Center
NRC Sr. Resident Inspector - 988C (2)
RN Sherman - BPA/1399
TC Poindexter - Winston & Strawn
WB Jones - NRC RIV/fax

IE22

NRC FORM 366 (1-2001)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3150-0104	EXPIRES 6-30-2001

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Columbia Generating Station	05000397	1 OF 3

TITLE (4)

Unanticipated Inoperability of both trains of Control Room Emergency Filtration system

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
11	4	2003	2003	- 012 -	00	1	5	2004	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
		20.2203(a)(2)(iii)	50.46(a)(3)(ii)	50.73(a)(2)(v)(C)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.73(a)(2)(i)(A)	X 50.73(a)(2)(v)(D)	
		20.2203(a)(2)(v)	50.73(a)(2)(i)(B)	X 50.73(a)(2)(vii)(D)	
		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)
Fred A. Schill	(509) 377-2269

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).	X	NO				

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

At 1953 on November 4, 2003, with the plant in mode 1, it was determined that a condition that could have prevented the fulfillment of a safety function needed to mitigate the consequences of an accident had existed on November 1, 2003. This condition occurred when the normal and both remote outside air intakes for the Control Room Emergency Filtration (CREF) [VI] system were manually isolated for a period of approximately 4 hours during testing to measure control room in-leakage. In this configuration, the CREF system cannot perform its design safety function to pressurize the main control room with filtered air as described in Columbia's accident analysis. When this discovery was made, the CREF system was in a normal standby configuration and the test procedure was revised to remove the errant steps. The inoperable CREF condition is also reportable as an event where a single condition caused two independent trains to become inoperable in a single system designed to mitigate the consequences of an accident.

The cause of this event is attributed to inadequate preparation and review of the test procedure used to measure control room in-leakage. The review did not identify that the procedure directed test personnel to place the CREF system in a configuration that would prevent the system from performing its design safety function. There were no safety consequences associated with the inoperable CREF system and this event did not represent an actual loss of a safety function for greater than the time allowed by Technical Specifications.

Event Description

At 1953 on November 4, 2003, with the plant in mode 1, it was determined that a condition that could have prevented the fulfillment of a safety function needed to mitigate the consequences of an accident had existed on November 1, 2003 when testing was conducted to measure control room in-leakage. The test employed tracer gas methodology and was not a routine surveillance test. A review of plant records indicated the normal and both remote outside air intakes for the Control Room Emergency Filtration (CREF) [VI] system were manually isolated for a period of approximately 4 hours. In this configuration, the CREF system cannot perform its design safety function to pressurize the main control room with filtered air as described in Columbia's accident analysis. The inoperable CREF condition is also reportable as an event where a single condition caused two independent trains to become inoperable in a single system designed to mitigate the consequences of an accident.

Immediate Corrective Action

The discovery of the prohibited CREF configuration was made during a review of test documents after the test was concluded. At that time, the CREF system was in a normal standby configuration and the test procedure was revised to remove the errant steps.

Root Cause

The cause of this event is attributed to inadequate preparation and review of the special test procedure used to measure control room in-leakage with the tracer gas methodology. The review did not identify that, contrary to Columbia's design and licensing basis, the procedure directed test personnel to place the CREF system in a configuration that would prevent the system from performing its design safety function.

Further Corrective Action

The procedure review process will be revised to explicitly require verification that proposed procedures and proposed procedure revisions will not be inconsistent with Columbia's design and licensing documents.

Assessment of Safety Consequences

Because there was no demand to pressurize the main control room with filtered air, there were no safety consequences associated with the inoperable CREF system. Additionally, this event did not represent an actual loss of a safety function for greater than the time allowed by Technical Specifications.

Similar Events

There have been no previous similar events in which a condition reportable pursuant to 10 CFR § 50.73(a)(2)(v)(D) or 10 CFR § 50.73(a)(2)(vii)(D) existed due to a prohibited system configuration allowed by a plant procedure.