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September 26, 2005
GO2-05-159

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 NO. 2005-005-00

Dear Sir or Madam:

Transmitted herewith is Licensee Event Report No. 2005-005-00 for Columbia Generating Station. This report is submitted pursuant to 10 CFR 50.73(a)(2)(i)(B) as an operation or condition prohibited by technical specifications. The enclosed report discusses items of reportability and corrective actions taken.

If you have any questions or require additional information, please contact Mr. GV Cullen at (509) 377-6105.

Respectfully,

WS Oxenford
Vice President, Technical Services
Mail Drop PE04

Enclosure: Licensee Event Report 2005-005-00

cc: BS Mallett – NRC RIV
BJ Benney – NRC NRR
INPO Records Center
NRC Sr. Resident Inspector – 988C (2)
RN Sherman – BPA/1399
WA Horin – Winston & Strawn
CE Johnson – NRC RIV/fax

IE22

NRC FORM 366 (6-2004) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 6-30-2007

Estimated burden per response to comply with this mandatory 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 and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington DC 20555-0001, or by internet e-mail to infocollects@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 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 collection.

LICENSEE EVENT REPORT (LER)

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

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

4. TITLE
Inoperable Standby Liquid Control Pump due to Incorrect Fuse

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
										05000
07	28	05	2005	-005	-00	09	26	05	FACILITY NAME	DOCKET NUMBER 05000

9. OPERATING MODE
1

10. POWER LEVEL
100

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: *(Check all that apply)*

- ☐ 20.2201(b)
- ☐ 20.2201(d)
- ☐ 20.2203 (a)(1)
- ☐ 20.2203(a)(2)(i)
- ☐ 20.2203(a)(2)(ii)
- ☐ 20.2203(a)(2)(iii)
- ☐ 20.2203(a)(2)(iv)
- ☐ 20.2203(a)(2)(v)
- ☐ 20.2203(a)(2)(vi)
- ☐ 20.2203(a)(3)(i)
- ☐ 20.2203(a)(3)(ii)
- ☐ 20.2203(a)(4)
- ☐ 50.36(c)(1)(i)(A)
- ☐ 50.36(c)(1)(ii)(A)
- ☐ 50.36(c)(2)
- ☐ 50.46(a)(3)(ii)
- ☐ 50.73(a)(2)(i)(A)
- ☒ 50.73(a)(2)(i)(B)
- ☐ 50.73(a)(2)(i)(C)
- ☐ 50.73(a)(2)(ii)(A)
- ☐ 50.73(a)(2)(ii)(B)
- ☐ 50.73(a)(2)(iii)
- ☐ 50.73(a)(2)(iv)(A)
- ☐ 50.73(a)(2)(v)(A)
- ☐ 50.73(a)(2)(v)(B)
- ☐ 50.73(a)(2)(v)(C)
- ☐ 50.73(a)(2)(v)(D)
- ☐ 50.73(a)(2)(vii)
- ☐ 50.73(a)(2)(viii)(A)
- ☐ 50.73(a)(2)(viii)(B)
- ☐ 50.73(a)(2)(ix)(A)
- ☐ 50.73(a)(2)(x)
- ☐ 73.71(a)(4)
- ☐ 73.71(a)(5)
- ☐ OTHER

Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

NAME	TELEPHONE NUMBER *(Include Area Code)*
Michael K Brandon – Licensing Engineer	509-377-4758

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

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

14. SUPPLEMENTAL REPORT EXPECTED

☐ YES *(If yes, complete 15. EXPECTED SUBMISSION DATE)* ☒ NO

15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR

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

On July 28, 2005, an incorrect fuse was found to have been installed in the circuitry associated with Standby Liquid Control System Pump 1A. This condition resulted in the pump being inoperable for a period of approximately 22.5 days. The fuse was promptly replaced with the correct fuse and the pump was restored to an operable status. The cause of this event was an inadequate self verification process combined with a less than adequate implementing procedure for controlling the fuse replacement process. An extent of condition review has identified additional instances of incorrect fuses; however, no additional operability concerns have been identified. Long term corrective actions to prevent recurrence are being developed within the Energy Northwest Corrective Action Program. A risk assessment of this condition was performed and this condition was not safety significant. No recent similar events have been reported by Energy Northwest.

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

PLANT CONDITION

The plant was operating in Mode 1 at 100 percent power at the time of this event.

EVENT DESCRIPTION

On July 6, 2005 preventive maintenance was performed on the motor control center [MCC] bucket for Standby Liquid Control (SLC) System [BR] Pump [P] 1A, which included fuse [FU] replacement. During the evolution, the existing time delay fuse was replaced with a standard quick blow fuse. On July 28, 2005 a subsequent review of the fuse control log identified that the replacement fuse was incorrect and a work request (WR) was generated to correct the condition. Operations reviewed this WR and questioned the effect of this condition on the operability of the pump. This concern was immediately investigated and it was determined this configuration did not meet the electrical design requirements of the pump. The pump was subsequently declared inoperable. The fuse was promptly replaced and the pump was restored to an operable status at 0137 hours on July 29, 2005. This condition resulted in the pump being inoperable for a period of approximately 22.5 days. Since this period of inoperability is longer than the seven day Completion Time provided in the Columbia Technical Specification 3.1.7 for one inoperable SLC subsystem, this condition is reported as a condition prohibited by the technical specifications pursuant to 10 CFR 50.73(a)(2)(i)(B).

IMMEDIATE CORRECTIVE ACTION

The SLC Pump 1A was restored to operable status on July 29, 2005 by replacing the fuse with the correct type.

The corresponding fuse in the opposite train, SLC Pump 1B, was verified to be the correct fuse.

Energy Northwest performed a review of the fuse replacements for the last two years.

CAUSE

The root cause of this event is an inadequate self verification process combined with a less than adequate implementing procedure for controlling the fuse replacement process.

FURTHER CORRECTIVE ACTION

Interim action: Revise PPM 1.3.47 to require "exact for exact" fuse replacement (amps, voltage, and model/type). If an alternate fuse must be used, then a supervisor or appropriate engineering personnel must verify that the replacement fuse is the correct type.

Additional corrective actions will be taken as developed in PER 205-0502 of the Energy Northwest Corrective Action Program.

ASSESSMENT OF SAFETY CONSEQUENCES

This event posed no threat to the health and safety of the public or plant personnel. A risk assessment was performed on this condition. For a condition of the SLC Pump 1A being inoperable for a period of 23 days, a delta core damage probability (ΔCDP) of 1.78E-7 was calculated. The calculated ΔCDP is well below the threshold of a safety significant condition and is therefore not safety significant.

The SLC System is not credited for the mitigation of design basis events. The SLC System satisfies the requirements of 10 CFR 50.62. Per 10 CFR 50.62, the purpose of the SLC System is to reduce the risk associated with a postulated anticipated transient without a scram. The SLC System was not designed to meet the single failure criteria. The remaining SLC Pump would have been capable of injecting the entire contents of the boric acid storage tank. This condition is not considered to be a safety system functional failure.

SIMILAR EVENTS

No recent similar events have been reported at Columbia. Following the identification of this condition, a review to assess the extent of condition was performed. Several conditions involving incorrect fuses were identified. None of these instances represented a reportable condition or an operability concern.

EIIS information denoted as [XX]