

# ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8809080315 DOC.DATE: 88/09/02 NOTARIZED: NO DOCKET #  
 FACIL:50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397  
 AUTH.NAME AUTHOR AFFILIATION  
 ARBUCKLE,J.D. Washington Public Power Supply System  
 POWERS,C.M. Washington Public Power Supply System  
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-019-01:on 880520,control room emergency filtration  
 sys actuation during testing due to inadequate procedure.  
 W/8 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 5  
 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

### NOTES:

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INTERNAL:	ACRS MICHELSON	1 1	ACRS MOELLER	2 2
	ACRS WYLIE	1 1	AEOD/DOA	1 1
	AEOD/DSP/NAS	1 1	AEOD/DSP/ROAB	2 2
	AEOD/DSP/TPAB	1 1	ARM/DCTS/DAB	1 1
	DEDRO	1 1	NRR/DEST/ADS 7E	1 0
	NRR/DEST/CEB 8H	1 1	NRR/DEST/ESB 8D	1 1
	NRR/DEST/ICSB 7	1 1	NRR/DEST/MEB 9H	1 1
	NRR/DEST/MTB 9H	1 1	NRR/DEST/PSB 8D	1 1
	NRR/DEST/RSB 8E	1 1	NRR/DEST/SGB 8D	1 1
	NRR/DLPQ/HFB 10	1 1	NRR/DLPQ/QAB 10	1 1
	NRR/DOEA/EAB 11	1 1	NRR/DREP/RAB 10	1 1
	NRR/DREP/RPB 10	2 2	NRR/DRIS/SIB 9A	1 1
	NUDOCS-ABSTRACT	1 1	<del>REG FILE</del> 02	1 1
	RES TELFORD,J	1 1	RES/DSIR DEPY	1 1
	RES/DSIR/EIB	1 1	RGN5 FILE 01	1 1
EXTERNAL:	EG&G WILLIAMS,S	4 4	FORD BLDG HOY,A	1 1
	H ST LOBBY WARD	1 1	LPDR	1 1
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	NSIC MAYS,G	1 1		

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## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Washington Nuclear Plant - Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 3 9 7										PAGE (3) 1 OF 0 4																								
TITLE (4) Control Room Emergency Filtration System Actuation During Testing Due to Inadequate Procedure - Personnel Error																																												
EVENT DATE (5) MONTH DAY YEAR 0 5 2 0 8 8									LER NUMBER (6) YEAR SEQUENTIAL NUMBER REVISION NUMBER 8 8 - 0 1 9 - 0 1 0									REPORT DATE (7) MONTH DAY YEAR 0 9 0 2 8 8									OTHER FACILITIES INVOLVED (8) FACILITY NAMES DOCKET NUMBER(S) 0 5 0 0 0 0																	
OPERATING MODE (9) 5									THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																																			
POWER LEVEL (10) 0 0 0									20.402(b)									20.405(c)									<input checked="" type="checkbox"/> 50.73(a)(2)(iv)									73.71(b)								
									20.405(a)(1)(i)									50.38(c)(1)									50.73(a)(2)(v)									73.71(c)								
									20.405(a)(1)(ii)									50.38(c)(2)									50.73(a)(2)(vii)									OTHER (Specify in Abstract below and in Text, NRC Form 366A)								
									20.405(a)(1)(iii)									50.73(a)(2)(ii)									50.73(a)(2)(viii)(A)																	
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LICENSEE CONTACT FOR THIS LER (12)																																												
NAME J.D. Arbuckle, Compliance Engineer																				TELEPHONE NUMBER AREA CODE 5 1 0 9 3 1 7 1 4 2 1 1 5																								
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																												
CAUSE SYSTEM COMPONENT MANUFACTURER REPORTABLE TO NPDOS															CAUSE SYSTEM COMPONENT MANUFACTURER REPORTABLE TO NPDOS																													
SUPPLEMENTAL REPORT EXPECTED (14)																																												
YES (If yes, complete EXPECTED SUBMISSION DATE)																				<input checked="" type="checkbox"/> NO										EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR														

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

On May 27, 1988 it was determined that a Control Room Emergency Filtration System actuation which occurred on May 20, 1988 was reportable per 10CFR50.73. The inadvertent start of Control Room Emergency Filtration System Fan WMA-FN-54B was the failure of Plant Instrument and Control (I & C) Technicians to reset the trip logic (due to an inadequate procedure) during the performance of a Reactor Building Exhaust Plenum Radiation Monitor (REA-RIS-609B and D) Response Time Test.

The immediate cause of this event was the failure to reset the Balance of Plant Relay Cabinet (RC-2), Division II, trip circuitry due to an inadequate procedure. The root cause of the event is personnel error during the procedure revision and review process. A previously approved procedure deviation, which added steps to reset a subchannel half-trip condition prior to continuing with the procedure, was not incorporated during the two-year periodic review and revision process for the procedure.

After verification that no actual initiating condition existed, the trip condition was reset and the system was returned to normal lineup. Further corrective actions include 1) adding the requirement to the procedure that the WMA trip circuitry be reset, and 2) modifying the Periodic Procedure Revision Form to include verification that deviations have been incorporated.

This event posed no threat to the health and safety of either the public or Plant personnel.

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PDR ADDCK 05000397  
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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Washington Nuclear Plant - Unit 2	0 5 0 0 0 3 9 7	8 8	— 0 1 9	— 0 1	0 2	OF	0 4

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

Plant Conditions

- a) Power Level - 0%
- b) Plant Mode - 5 (Refueling)

Event Description

On May 27, 1988 it was determined that a Control Room Emergency Filtration System actuation which occurred on May 20, 1988 was reportable per 10CFR50.73. The inadvertent start of Control Room Emergency Filtration System Fan WMA-FN-54B was the result of a failure to reset the trip logic during the performance of Plant Procedure (PPM) 7.4.3.2.3.24, "Secondary Containment Isolation on Reactor Building Exhaust Radiation High (Channels B and D) - Response Time Test". The procedure provides instructions for performance of a Response Time Test of Reactor Building Exhaust Plenum Radiation Monitors REA-RIS-609B and REA-RIS-609D to demonstrate time response of the logic within the Secondary Containment Isolation System.

Plant Instrument and Control (I&C) Technicians had completed the installation of test equipment for REA-RIS-609B, which caused a half-trip in Balance of Plant Relay Cabinet (RC-2), Division II. However, the procedure did not require personnel to reset this half-trip prior to placing REA-RIS-609D in a test condition. Because the circuitry was not reset, there was a half-trip condition in existence for subchannel B. (To clear the trip conditions for Control Room Ventilation, personnel must reset WMA Reset Pushbuttons 3BX and 3BY.)

As a result, when the I&C Technicians disconnected the sensor input cable to REA-RIS-609D, a second half-trip condition was introduced in RC-2 (subchannel D) which caused a full trip of the WMA Start Logic and, by design, WMA-FN-54B automatically started. It should be noted that the I&C Technicians performed each step of the process as it was described in the procedure.

The immediate cause of this event was the failure to reset the RC-2 trip circuitry due to an inadequate procedure. The root cause of this event is personnel error during the procedure revision and review process. A procedure deviation had previously been approved which added steps to reset the subchannel half-trip condition prior to proceeding to the opposite channel. However, this deviation was not incorporated into the current revision during the two-year periodic review and update process. Plant Instrument and Control and Plant Administration personnel collectively failed to ensure that the deviation was incorporated. This event would not have occurred if the deviation had been included during the procedure revision process.

Immediate Corrective Action

After verification that no actual initiating condition existed, the trip condition was reset and the Control Room Emergency Filtration System was returned to normal lineup.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				PAGE (3)		
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Washington Nuclear Plant - Unit 2	0 5 0 0 0 3 9 7 8 8 -	0 1 9 -	0 1	0 3	OF	0 4		

TEXT (If more space is required, use additional NRC Form 368A's) (17)

Further Evaluation and Corrective Action

## A. Further Evaluation

1. The event was not considered to be reportable at the time of occurrence because a planned full actuation would have occurred later in the procedure and, therefore, it was considered to be a preplanned sequence and no four-hour or 30 day reports were necessary. However, upon later review (May 27, 1988) it was determined that since the actuation occurred prior to the expected step in the procedure, the event was subsequently determined to be reportable.
2. Since the time-frame that the deviation was written (1986), the procedure deviation process has been changed such that the affected pages are now removed from the procedure and the marked up pages are integrated in place of those pages. It is possible that the deviation would have been incorporated into the procedure had it been processed under the current program.
3. Upon further investigation of the specific group of I & C Surveillance procedures which were processed as part of the same two-year periodic review cycle, four more procedure deviations were found which had not been incorporated into their respective procedures.

## B. Further Corrective Action

1. Plant Procedure 7.4.3.2.3.24 has been deviated to require that the WMA trip circuitry be reset prior to continuing with the procedure.
2. The Periodic Procedure Revision Form has been modified to include verification that an outstanding procedure deviation has been incorporated.
3. A letter has been issued to appropriate Plant personnel which explains the modification to the Periodic Procedure Revision Form and the reason for the change.
4. An audit was conducted of the first forty procedure deviations written and implemented in 1988 on Surveillance procedures that have subsequently been revised. The audit scope was expanded to include procedures from all disciplines. The audit findings indicated that all of the procedure deviations reviewed were either incorporated into their respective procedures or were cancelled as "no longer required". No further corrective action is planned.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
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TEXT (If more space is required, use additional NRC Form 368A's) (17)

Safety Significance

There is no safety significance associated with this event in that there was no actual initiating condition which would have caused the system to actuate, and all equipment operated correctly to place the Control Room Ventilation System in an isolation condition. Accordingly, this event posed no threat to the health and safety of either the public or Plant personnel.

Similar Events

84-017, 84-018, 85-027, 85-036 and 87-009

EIIS InformationText Reference

Control Room Emergency Filtration System  
WMA-FN-54B  
REA-RIS-609A  
REA-RIS-609B

EIIS Reference

System	Component
VH	- - - - -
VH	Fan
VA	45
VA	45

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WASHINGTON PUBLIC POWER SUPPLY SYSTEM

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P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352

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Docket No. 50-397

September 2, 1988

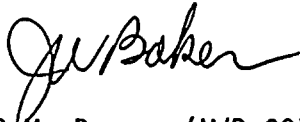
Document Control Desk  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

Subject: NUCLEAR PLANT NO. 2  
LICENSEE EVENT REPORT NO. 88-019-01

Dear Sir:

Transmitted herewith is Licensee Event Report No. 88-019-01 for the WNP-2 Plant. This report is submitted in response to the report requirements of 10CFR50.73 and discusses the items of reportability, corrective action taken, and action taken to preclude recurrence.

Very truly yours,



C.M. Powers (M/D 927M)  
WNP-2 Plant Manager

CMP:lg

Enclosure:  
Licensee Event Report No. 88-019-01

cc: Mr. John B. Martin, NRC - Region V  
Mr. C.J. Bosted, NRC Site (M/D 901A)  
INPO Records Center - Atlanta, GA  
Ms. Dottie Sherman, ANI  
Mr. D.L. Williams, BPA (M/D 399)

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