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POWELL,T.J. Washington Public Power Supply System
BEMIS,P.R. Washington Public Power Supply System
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 98-007-00:on 980530,inadvertent full scram & division 1 ECCS injection was noted.Caused by failure to meet mgt work practice expectation when encountering deficient procedure. Incident Review Board convened to review event.W/980624 ltr.

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WASHINGTON PUBLIC POWER SUPPLY SYSTEM
P.O. Box 968 • Richland, Washington 99352-0968

June 24, 1998
GO2-98-105

Docket No. 50-397

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

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NPF-21**
LICENSEE EVENT REPORT NO. 98-007-00

Transmitted herewith is Licensee Event Report No. 98-007-00 for WNP-2. This report is submitted pursuant to 10 CFR 50.73 and discusses the items of reportability, corrective action taken, and action to preclude recurrence.

Should you have any questions or desire additional information pertaining to this letter, please call me or Mr. P. J. Inserra at (509) 377-4147.

Respectfully,

P. R. Bemis
Vice President, Nuclear Operations
Mail Drop PE23

Attachment

cc: EW Merschoff - NRC RIV
KE Perkins, Jr. - NRC RIV, WCFO
C Poslusny, Jr. - NRR
INPO Records Center - Atlanta, GA
NRC Senior Resident Inspector - MD927N (2)
DL Williams - BPA, MD399
PD Robinson - Winston & Strawn

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Washington Nuclear Plant - Unit 2	50-397	1 OF 3

TITLE (4)

INADVERTENT FULL SCRAM AND DIVISION 1 ECCS INJECTION

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV. NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
05	30	98	98	007	00	06	24	98	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
	4		20.402(b)		20.405(c)	X	50.73(a)(2)(iv)		73.71(b)	
POWER LEVEL (10)			20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)	
	0		20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER	
			20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)			
			20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)			
			20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)			

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
T.J. Powell, Licensing Technical Specialist	(509) 377-4161

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	MONTH	DAY	YEAR
	YES (If yes, completed EXPECTED SUBMISSION DATE).	NO X				

ABSTRACT:

On May 30, 1998 at 14:49, during the performance of an Instrument & Control (I&C) surveillance procedure, WNP-2 experienced an unexpected full scram, emergency diesel generator actuation, and injection through Division 1 Emergency Core Cooling System (ECCS) pumps. Reactor pressure increased from 107 psig to a maximum pressure of 425 psig and temperature decreased from 222° F to a minimum temperature of 219° F. The resultant pressure / temperature transient has no safety significance since it is bounded by the limits specified by the "Inservice Leak and Hydrostatic Testing Curve" contained in the WNP-2 Technical Specifications. The root cause of this event was a failure by supervision and technicians to meet management's work practice expectation when a deficient procedure is encountered.

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 copies of NRC Form 366A) (17)

Event Description

On May 30, 1998 at 14:49, while performing an excess flow check valve test with the plant in Mode 4 under Technical Specification 3.10.1, WNP-2 experienced a full reactor scram. The Low Pressure Core Spray (LPCS) pump [BM] and the Low Pressure Coolant Injection (LPCI) 'A' pump [BO] received a start signal and injected approximately 2,600 gallons of water into the Reactor Pressure Vessel (RPV). Division 1 and Division 3 Emergency Diesel Generators [EK] started but did not load their respective buses because the normal bus power supplies remained available. Reactor pressure increased from 107 psig to a maximum pressure of 425 psig and temperature decreased from 222° F to a minimum temperature of 219° F. This pressure / temperature transient has no safety significance since it is bounded by the limits specified in the "Inservice Leak and Hydrostatic Testing Curve" contained in Technical Specification 3.4.11.

Further Evaluation

This event is being reported per the requirement of 10CFR50.73(a)(2)(iv) as an event or condition that resulted in an automatic actuation of an Engineered Safety Feature (ESF).

Direction on backfilling instrument lines in the procedure governing excess flow check valve surveillance testing was vague. The technician had just completed testing two instruments (MS-FT-33A & MS-LT- 44A) when the event occurred. A line connected to MS-LT-44A also connected to other transmitters. When this line was backfilled the commonly attached instruments, not associated with the test, reacted to the perturbation in the line and in turn caused the event.

The procedure was last performed and completed successfully two years ago (during refueling outage R-11) by a dedicated backfill crew. Solutions to any problems encountered in R-11 by this experienced crew were not incorporated into the procedure to aid the less experienced group that performed the surveillance in refueling outage R-13.

Root Cause

The root cause of this event was a failure by supervision and technicians to meet management's work practice expectation that, when a deficient procedure is encountered, work should be stopped and not continued until the procedure has been corrected. Had this occurred, this event could have been averted.

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

Further Corrective Action

All testing of excess flow check valves was terminated until the cause of the event was found and an Incident Review Board was convened to review the event.

This event will be reviewed with the involved supervision and craft to emphasize the expectation that when a procedure deficiency is encountered, all work should be stopped and the procedure corrected before work is continued.

After a study of plant process and instrumentation drawings, a Temporary Change Notice was initiated to revise the procedure and identify the specific valves that were to be manipulated to complete the backfill.

All excess flow check valve testing procedures will be reviewed and revised as necessary.

A training module will be prepared and presented to I&C technicians on excess flow check valve testing that includes the procedures, instrument / valve connections, system drawings, and excess flow check valve backfill cart operation.

Assessment of Safety Consequences

All systems operated as expected. This event did not impact plant safety because the pressure/temperature transient that occurred is bounded by the limits specified in the "Inservice Leak and Hydrostatic Testing Curve" under Technical Specification 3.4.11.

Similar Events

In 1989 three PERs were initiated relating to excess flow check valve testing (Ref. LER #89-025):

- PER 289-0528 documents a RHR-V-9 automatic isolation during testing because the procedure did not caution against increasing pressure to a value that would cause the RPV high pressure isolation actuation.
- PER 289-0532 documents a HPCS auto actuation during testing because the procedure did not list the corresponding drain valves required to test specific excess flow check valves.
- PER 289-0535 documents a RHR-V-9 auto closure during testing because the procedure did not explicitly state the impact of isolating an instrument.