CATEGORY 1

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FACIL:50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
AUTH.NAME AUTHOR AFFILIATION
ARBUCKLE,J.D. Washington Public Power Supply System
BEMIS,P.R. Washington Public Power Supply System
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 98-010-00:on 980615,TS required shutdown due to inoperability of TIP sys isolation valve was noted.Caused by improper installation of TIP tubing.Reattached affected tubing & inspected other TIP tubing.W/980715 ltr.

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TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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

July 15, 1998
GO2-98-123

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. 98-010-00

Transmitted herewith is Licensee Event Report No. 98-010-00 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 report, please call me or 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 - NRC NRR
PD Robinson - Winston & Strawn
NRC Senior Resident Inspector - 927N (2)
DL Williams - BPA/399
INPO Records Center

IE22

LICENSEE EVENT REPORT (LE

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

TITLE (4)

Technical Specification Required Shutdown due to Inoperability of a Traversing Incore Probe System Isolation Valve

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
06	15	98	98	010	00	07	15	98	FACILITY NAME	DOCKET NUMBER

OPERATING MODE		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
	1		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)
POWER LEVEL			20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
	37		20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER
			20.405(a)(1)(iii)	X	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)
J.D. Arbuckle, Licensing Technical Specialist	(509) 377-4601

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).	X	NO				

ABSTRACT:

On June 15, 1998 at 0222 hours, with the plant in Mode 1 at 37 percent power, plant operators commenced a controlled reactor shutdown as required by the Technical Specifications due to a Traversing Incore Probe (TIP) system malfunction. The TIP "B" drive machine cabling would not retract and plant personnel were unable to close the associated penetration isolation ball valve due to the inability to withdraw the detector cabling. At the time of the event, the plant was in power ascension following the annual maintenance and refueling outage. On June 15, 1998 at 1947 hours, the plant entered cold shutdown, well within the time frame required by the Technical Specifications.

The cause of this event was improper installation of the TIP tubing due to inadequate self-checking. It was determined that the tubing had been installed in the reverse direction and not adequately tightened during TIP tube removal and replacement efforts in the recently-completed maintenance and refueling outage. This resulted in the tube fittings becoming loose.

There was no additional immediate corrective action other than control room operators taking appropriate and timely action to maneuver the plant to a shutdown condition as required by the Technical Specifications. Further corrective actions consisted of re-attaching the affected tubing, inspecting other TIP tubing and discussing this event and the importance of self-checking with the individuals involved and the maintenance organization in general.

The safety consequences associated with this event were low. The associated penetration isolation shear valve was operable to maintain a containment isolation function and the plant was shutdown well within the time-frame allowed by the Technical Specifications.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Washington Nuclear Plant Unit 2	50-397	98	010	00	2 OF 3

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

Event Description

On June 15, 1998 at 0222 hours, with the plant in Mode 1 at 37 percent power, plant operators commenced a controlled reactor shutdown as required by the Technical Specifications due to a Traversing Incore Probe (TIP) [IG] system malfunction. The TIP "B" drive machine cabling would not retract in channel 09 past position 0598.

On June 14, 1998 at 2007 hours, the plant had been in a power ascension following the annual maintenance and refueling outage when there was a concern that the TIP "B" detector cabling was mechanically bound and would not retract on an isolation signal. The TIP "B" drive isolation ball valve, TIP-V-2 [ISV], was declared inoperable and the appropriate Primary Containment [NH] Technical Specification actions were entered. The ball valve isolates the TIP system from primary containment when the system is not in use. Following troubleshooting efforts on June 15, 1998 at 0007 hours, plant personnel were unable to isolate TIP-V-2 due to the inability to withdraw the detector cabling. Accordingly, control room operators made preparations for the initiation of a plant shutdown in accordance with the Technical Specifications.

On June 15, 1998 at 1000 hours, control room operators manually scrammed the reactor as part of the controlled shutdown process and entered Operational Mode 3 as required by the Technical Specifications. On June 15, 1998 at 1947 hours, Operational Mode 4 was entered when reactor coolant temperature became less than 200 degrees Fahrenheit, well within the time frame required by the Technical Specifications.

The problem was traced to work that was performed during the recently-completed outage. During the outage, a work order had been initiated for Local Power Range Monitor (LPRM) [IG] replacements. As part of the work order, one of the tasks included TIP tube removal and replacement. However, during removal and replacement efforts, the tube was inadvertently re-installed in the reverse direction and not adequately tightened.

This resulted in the fittings becoming loose and separating from the LPRM dry tube. When the TIP detector was inserted, the cabling spooled out onto the floor and then would not retract.

Immediate Corrective Action

There was no additional immediate corrective action other than control room operators taking appropriate and timely action to maneuver the plant to a shutdown condition as required by the Technical Specifications.

Further Evaluation

This event is reportable in accordance with 10 CFR 50.73(a)(2)(i)(A) as the completion of any nuclear plant shutdown required by the Technical Specifications. Technical Specification 3.6.1.3, "Primary Containment Isolation Valves (PCIV)," requires each PCIV, except reactor building-to suppression chamber vacuum breakers, to be operable during Operational Modes 1, 2 and 3. In the event that a PCIV is inoperable and the associated conditions and actions cannot be met, Technical Specification 3.6.1.3 directs that the plant be in Operational Mode 3 within 12 hours and Operational Mode 4 within 36 hours.

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

Root Cause

The cause of this event was improper installation of the TIP tubing due to inadequate self-checking. Upon further investigation, it was determined that the tubing had been installed in the reverse direction and not adequately tightened during the recently-completed maintenance and refueling outage.

This resulted in the fittings in becoming loose and separating from the LPRM dry tube. The other end of the tubing at the under-vessel wall was found to be loosely connected. When the TIP detector was inserted, the cabling spooled out onto the floor and then would not retract.

Further Corrective Action

1. An inspection of the fittings was performed and no damage was observed. The associated tubing was then correctly re-attached.

2. The other TIP tubing was checked for proper installation with a second verifier and no additional discrepancies were identified. All connections were verified to be correctly installed.

3. This event and the importance of self-checking were discussed with the individuals involved and the maintenance organization in general.

Assessment of Safety Consequences

The safety consequences associated with this event were low. Appropriate and timely action was taken to maneuver the plant to a shutdown condition well within the time-frame allowed by the Technical Specifications. Furthermore, associated TIP Isolation Shear Valve TIP-V-8 [ISV] was operable during the event period and maintained a containment isolation function. Therefore, this event had minimal impact on the health and safety of either the public or plant personnel.

Similar Events

There have been no recent similar events.