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 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 94-011-00: on 940624, determined that weekly manual scram channel functional test had not been performed. Caused by inadequate communication between operations SRO personnel. Programmatic change & counseling personnel. W/940728 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 8
 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 • 3000 George Washington Way • Richland, Washington 99352

July 28, 1994
GO2-94-178

Docket No. 50-397

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

Subject: NUCLEAR PLANT WNP-2, OPERATING LICENSE NPF-21
LICENSEE EVENT REPORT NO. 94-011

Transmitted herewith is Licensee Event Report No. 94-011 for the WNP-2 Plant. This report is submitted in response to the reporting requirements of 10CFR50.73 and discusses the items of reportability, corrective action taken, and action taken to preclude recurrence.

Should you have any questions or desire additional information, please call me or D.A. Swank at (509) 377-4563.

Sincerely,



J. V. Parrish (Mail Drop 1023)
Assistant Managing Director, Operations

JVP/CDM/my
Enclosure

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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 4

TITLE (4)

FAILURE TO COMPLETE WEEKLY MANUAL SCRAM SURVEILLANCE REQUIREMENTS WITHIN THE ALLOWED TECHNICAL SPECIFICATION INTERVAL DUE TO INADEQUATE COMMUNICATION

EVENT DATE (5)

LER NUMBER (6)

REPORT DATE (7)

OTHER FACILITIES INVOLVED (8)

MONTH			DAY			YEAR			YEAR			SEQUENTIAL NUMBER			REVISION NUMBER			MONTH			DAY			YEAR			FACILITY NAMES			DOCKET NUMBERS(S)		
0	6	2	4	9	4	9	4	0	1	1	0	0	0	7	2	8	9	4							0	5	0	0	0			

OPERATING MODE (9)

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)	50.73(a)(2)(iv)	77.71(b)
			20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.73(c)
			20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
			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

C.D. Mackaman, Licensing Engineer

TELEPHONE NUMBER

AREA CODE

5 0 9 3 7 7 - 4 4 5 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

YES (If yes, complete EXPECTED SUBMISSION DATE) X NO

ABSTRACT (16)

On June 30, 1994, with WNP-2 in Mode 5 (Refueling) at 0% power, it was determined that the weekly manual scram channel functional test had not been performed within the Technical Specification (TS) allowed interval. As a result, the TS operability requirements had not been met for all four Reactor Protection System (RPS) manual scram trip channels during a 3.4 day period from 2103 hours on June 24, 1994 until 0541 hours on June 28, 1994. Since this condition was not identified until June 30, 1994, all TS required actions had not been performed.

No immediate corrective actions were necessary because at the time of discovery all four manual scram trip channels were operable.

The root cause for this event was inadequate communication between Operations Senior Reactor Operator (SRO) support personnel and the Control Room staff. Corrective actions included a programmatic change and counseling of responsible personnel.

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

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION							
FACILITY NAME (1) Washington Nuclear Plant - Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 9 7	LER NUMBER (8)			PAGE (3)		
		Year	Number	Rev. No.			
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TITLE (4) FAILURE TO COMPLETE WEEKLY MANUAL SCRAM SURVEILLANCE REQUIREMENTS WITHIN THE ALLOWED TECHNICAL SPECIFICATION INTERVAL DUE TO INADEQUATE COMMUNICATION							

Event Description

On June 30, 1994, with WNP-2 in Mode 5 (Refueling) at 0% power, it was determined that the weekly manual scram channel functional test (CFT) had not been performed within the Technical Specification (TS) allowed interval. Surveillance Procedure 7.4.3.1.1.22, "Manual Scram Functional Test - CFT," satisfies Technical Specification Surveillance (TSS) Requirement 4.3.1.1 for all four Reactor Protection System (RPS) manual scram trip channels. The surveillance was due at 2103 hours on June 24, 1994 but was not completed until 0541 hours on June 28, 1994. As a result, the TS 3.3.1 surveillance requirements had not been met for the four manual scram trip channels for a 3.4 day period. The condition of the overdue surveillance and the missed action requirements was not identified until June 30, 1994. For the entire 3.4 days of inoperability, no core alterations were in progress and all control rods remained fully inserted. The TS action statement requirements to manually trip one channel and have the mode switch locked in shutdown were not met.

Immediate Corrective Actions

No immediate corrective actions were necessary because at the time of discovery all four manual scram trip channels were operable.

Further Evaluation

This event is reportable pursuant to the requirements of 10CFR50.73(a)(2)(i)(B) as "Any operation or condition prohibited by the plant's Technical Specifications. . . ."

The manual scram CFT surveillance was delivered to Operations Senior Reactor Operator (SRO) support personnel for performance scheduling on June 22, 1994. At the time, the Control Rod Drive (CRD) System outage was in progress and the system was Clearance tagged out of service. Because the CRD System is actuated by the RPS manual scram function, the Control Room support SRO mistakenly concluded that the surveillance could not be performed until after the CRD System was returned to service. Therefore, the surveillance was not sent to the Control Room for performance but was placed on hold in the Operations Production Center. The Control Room support SRO notified the Operations post maintenance testing (PMT) coordinator (responsible for surveillance tracking) that several surveillances, including the manual scram CFT surveillance, would have to be performed after the CRD System outage. Although the manual scram CFT surveillance was due and could have been performed, neither the Control Room support SRO or the PMT coordinator notified the Control Room of the decision to postpone the surveillance. The surveillance was subsequently sent to the Control Room and performed on June 28, 1994.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION															
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TITLE (4) FAILURE TO COMPLETE WEEKLY MANUAL SCRAM SURVEILLANCE REQUIREMENTS WITHIN THE ALLOWED TECHNICAL SPECIFICATION INTERVAL DUE TO INADEQUATE COMMUNICATION															

During the initial setup and establishment of the Operations Production Center prior to the refueling outage in April 1994, Operations Division management stressed on several occasions that effective communications and coordination were the key to successful conduct of work in and out of the Control Room. In this case, it was the Control Room support SRO's responsibility to discuss with the Control Room the decision to postpone the surveillance and to assist the Control Room staff in determining actions necessary to support that decision. Control Room personnel were unaware of the need to enter TS Action Statement 3.3.1 and were not given the opportunity to evaluate the decision to postpone the surveillance.

A plant surveillance Late Report lists surveillances that are "late" and approaching the end of their TS allowed interval. This report is presented daily to department managers at the morning Plan of the Day (POD) meeting to ensure prompt management attention. The manual scram CFT surveillance mentioned as being "late" during the June 23, 1994 POD meeting presentation apparently due to an oversight. Currently, in addition to the daily POD meeting presentations, the Late Report is available on the plant work control computer system for each department manager's review.

Root Cause

The root cause for this event was inadequate communication between Operations SRO support personnel and the Control Room staff.

Further Corrective Action

All Operations surveillances are now sent to the Control Room for scheduling and performance as was the policy before the establishment of the Operations Production Center in April 1994.

Responsible personnel were counseled concerning their failure to keep the Control Room staff adequately informed of the postponement of the manual scram CFT surveillance. Further personnel actions will be evaluated as appropriate.

Safety Significance

There was negligible safety significance associated with this event. The successful completion of the manual scram CFT surveillance on June 28, 1994 with no discrepancies demonstrated that the four manual scram trip channels were capable of performing their safety functions during the 3.4 day period the surveillance was delinquent. Furthermore, during this period, the plant was in the Refueling Mode with the reactor mode switch locked in the "Refuel" position such that plant design restrictions on control rod withdrawal were activated. These restrictions limit control rod movement to one rod at a time to maintain reactor shutdown margin above the TS 3.1.1 limits to preclude inadvertent criticality. Therefore, this event was deemed to have posed no threat to the health and safety of either the public or plant personnel.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION														
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TITLE (4) FAILURE TO COMPLETE WEEKLY MANUAL SCRAM SURVEILLANCE REQUIREMENTS WITHIN THE ALLOWED TECHNICAL SPECIFICATION INTERVAL DUE TO INADEQUATE COMMUNICATION														

Similar Events

Other events involving surveillances not performed within the TS allowed interval are listed below. LERs 93-010 and 93-026 addressed the generic aspects of these previous events through the implementation of the Technical Specification Improvement Project (TSSIP) and Plant Manager sponsored cultural, accountability, and programmatic changes. These efforts have resulted in a significant reduction in the numbers of backlogged and "late" surveillances and increased attention to the timeliness of surveillance reviews. In addition, there has been a downward trend in personnel error related missed and delinquent surveillances. Based on the positive results of previous actions to prevent recurrence, this event is considered to be an isolated incidence.

LER 91-005	LER 92-023
LER 91-013	LER 92-038
LER 91-027	LER 92-046
LER 91-028	LER 93-010
LER 91-036	LER 93-026

EIIS Information

Text Reference

Reactor Protection System (RPS)
Control Rod Drive (CRD) System

EIIS Reference

<u>System</u>	<u>Component</u>
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JC	---
AA	---