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AUTH. NAME AUTHOR AFFILIATION
HUGO, B.R. Washington Public Power Supply System
PARRISH, J.V. Washington Public Power Supply System
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 94-014-00: on 940706, ESF actuation occurred due to
lineup error. Caused by noncompliance w/testing procedures.
Improper lineup was corrected. W/940805 ltr.

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

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August 5, 1994
GO2-94-184

Docket No. 50-397

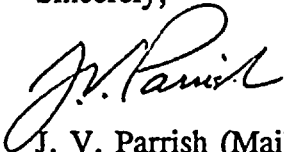
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Washington, D.C. 20555

Subject: NUCLEAR PLANT WNP-2, OPERATING LICENSE NPF-21,
LICENSEE EVENT REPORT NO. 94-014, REVISION 0

Transmitted herewith is Licensee Event Report No. 94-014 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/BRH
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
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TITLE (4) **Engineered Safety Feature Actuation Due to Test Lineup Error Caused by Noncompliance with Testing Procedure**

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 NUMBER(S)						
07	06	94	94	-	0	1	4	-	0	0	08	05	94	N/A				0 5 0 0 0			
																0 5 0 0 0					

OPERATING MODE (9) 4		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR: (11)											
		<input type="checkbox"/> 20.402(b) <input type="checkbox"/> 20.405c <input checked="" type="checkbox"/> 50.73(a)(2)(iv) <input type="checkbox"/> 73.71(b)											
POWER LEVEL (10) 0 0 0		<input type="checkbox"/> 20.405(a)(1)(i) <input type="checkbox"/> 50.36(c)(1) <input type="checkbox"/> 50.73(a)(2)(v) <input type="checkbox"/> 73.71(c)											
		<input type="checkbox"/> 20.405(a)(1)(ii) <input type="checkbox"/> 50.36(c)(2) <input type="checkbox"/> 50.73(a)(2)(vii) <input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)											
		<input type="checkbox"/> 20.405(a)(1)(iii) <input type="checkbox"/> 50.73(a)(2)(i) <input type="checkbox"/> 50.73(a)(2)(viii)A											
		<input type="checkbox"/> 20.405(a)(1)(iv) <input type="checkbox"/> 50.73(a)(2)(ii) <input type="checkbox"/> 50.73(a)(2)(viii)B											
		<input type="checkbox"/> 20.405(a)(1)(v) <input type="checkbox"/> 50.73(a)(2)(iii) <input type="checkbox"/> 50.73(a)(2)(x)											

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
Bruce R. Hugo, Compliance Engineer		AREA CODE 509	377-8593

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)				EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (if yes, complete EXPECTED SUBMISSION DATE)				<input checked="" type="checkbox"/> NO				

ABSTRACT (16)

At 1236 hours on July 6, 1994, Instrumentation and Control (I&C) technicians were back filling instrument lines to support excess flow check valve testing. Due to a lineup error, the differential pressure sensed by in-service reactor vessel level detectors was increased creating an invalid low level indication which caused several automatic actions including a low pressure core spray system actuation and injection. The control room operator secured the injection after verifying no actual low level condition existed. The cause of the event was the failure of the technicians to follow the back fill procedure. Corrective actions include counseling the technicians, discussing the event with the I&C shop, and developing and delivering further training to I&C technicians. This event had negligible safety significance since plant safety systems responded as designed, no actual low level condition existed, and the stresses induced by the injection were small due to the small differential temperatures and pressures involved.

LICENSED EVENT REPORT (LER) TEXT CONTINUATION

Washington Nuclear Plant - Unit 2	0 5 0 0 0 3 9 7	94	-	0 1 4	-	0 0	2	OP	4
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TEXT (17)

Event Description:

At 1236 hours on July 6, 1994, with WNP-2 in Operational Condition 4 at 0 percent power, Instrumentation and Control (I&C) technicians were back filling instrument lines to support excess flow check valve [V] testing. Due to a lineup error, the differential pressure sensed by in-service reactor vessel [AD, RCT] level detectors [LI] was increased creating an invalid low level indication. This caused the following automatic actions: reactor pressure vessel low level half scram, low pressure core spray (LPCS) system [BM] actuation, low pressure coolant injection (LPCI) [BO] 'A' system actuation signal, and emergency diesel generator [EK, DG] 1 automatic start.

Due to the residual heat removal (RHR) system being in a shutdown cooling lineup, no LPCI injection to the reactor pressure vessel (RPV) occurred via the RHR system. Injection into the RPV from the suppression chamber did occur due to the LPCS actuation. This injection, which increased RPV level by 20 inches, was secured by the control room operator after he verified using two independent indications that no actual low level condition existed.

By 1327 hours on July 6, 1994, the component actuations and trips resulting from the invalid low level indication had been reset.

Immediate Corrective Action:

The improper lineup that caused the invalid level signal was corrected.

Excess flow check valve testing was stopped pending an investigation of the cause of this event.

Further Evaluation:

This event is reported per 10 CFR 50.73(a)(2)(iv) as an actuation of an Engineered Safety Feature. This event was also reported via the Emergency Notification System at 1354 hours on July 6, 1994.

There were no structures, systems, or components that were inoperable at the start of the event that contributed to the event.

Root Cause:

The cause of the improper lineup was the failure of the technicians to follow the back filling procedure. The technicians had previously completed a similar back filling operation successfully, and were performing this operation with the procedure in hand up to the point where an attachment identified the back fill pump connection point and valves to be operated. The technicians

LICENSED EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR		SEQUENTIAL NUMBER		REVISION NUMBER			

TEXT (17)

incorrectly assumed that this attachment was similar to the one used previously. They then attempted to perform the rest of the operation based on their knowledge of the previous back fill operations and by tracing piping runs to identify the valves to be operated and back fill pump connection point. This resulted in an incorrect lineup to in-service level instruments when they identified the wrong isolation valve.

Further Corrective Actions:

An Incident Review Board was convened with the technicians involved as participants. Extensive discussions were held with the crew involved and the oncoming crew regarding the inappropriate actions taken and the lessons learned from the event.

The technicians were counseled by the Maintenance Production Manager on the importance of strict procedural compliance. The individuals acknowledged their responsibility to meet these requirements.

The Maintenance Production Manager also met with I&C shop personnel to review this event and its causes. The meeting emphasized strict procedural adherence and the importance of self-checking for component identification.

Attention to Detail and Self-checking training is being developed for I&C technicians. This training is scheduled for completion by October 31, 1994.

Safety Significance:

This event had negligible safety significance. Plant safety systems responded as designed to the indicated low RPV level, and no actual low level condition existed. Plant operators secured the unneeded RPV injection after determining that the initiating signal was invalid.

The LPCS system design usage factor assumes 10 occurrences of 40 degree F fluid injection into a 470 degree F, 500 psig RPV. The actual injection temperature was 70 degree F with the RPV at 130 degree F and 106 psig, producing significantly less stress than assumed in the design usage factor calculation.

LICENSED EVENT REPORT (LER) TEXT CONTINUATION

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		94		0 1 4		0 0			

TEXT (17)

Previous Similar Events:

LER 93-025 documents an event in which a procedural deficiency caused a Nuclear Steam Supply Shutoff System [JM] isolation during a surveillance test. Corrective actions included changing the procedure and upgrading other Electrical shop surveillance procedures with the same weakness.

LER 89-025 documents three Engineered Safeguards Feature actuations during excess flow check valve testing. Corrective actions included specifying pressure control bands and valve numbers in the test procedure, and caution tagging out of service instruments.

These corrective actions would not be expected to have prevented the event described in this report.