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SUBJECT: LER 95-003-00:on 940817,CR indication lost for PASS inboard CI valve & cycling for restoration erratic & showed continuous closed indication.Caused by unclear TS requirement.TS Bases will be revised.W/950215 ltr.

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February 15, 1995
GO2-95-033

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. 95-003, REVISION 0**

Transmitted herewith is Licensee Event Report No. 95-003 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)
Vice-President, Nuclear Operations

JMP
Enclosure

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IE22

LICENSEE EVENT REPORT (LER)

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

TITLE (4) FAILURE TO COMPLY WITH TECHNICAL SPECIFICATION ACTION STATEMENT WHEN ALLOWED OUTAGE TIME WAS EXCEEDED FOR A CONTAINMENT ISOLATION VALVE

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)
08	17	94	95	- 0 0 3 -	0 0	02	15	95	N/A	0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR: (11)

__ 20.402(b)	__ 20.405c	__ 50.73(a)(2)(iv)	__ 73.71(b)
__ 20.405(a)(1)(i)	__ 50.36(c)(1)	__ 50.73(a)(2)(v)	__ 73.71(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	TELEPHONE NUMBER AREA CODE	TELEPHONE NUMBER
James M. Pedro, Compliance Specialist	509	377-8418

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 January 18, 1995 following a surveillance of the Post Accident Sample System valves, control room indication for two inboard containment isolation valves failed to provide the required closed/not closed control room indication. A review showed that this condition had existed since August 17, 1994 for one of the valves with no compensatory action taken. The redundant outboard containment isolation valves were deactivated isolating the associated sample lines. The failure to comply with Technical Specification ACTION statement resulted from Technical Specification 3.3.7.5 not clearly identifying that control room indication was required to meet the LCO requirements. Contributing causes for the event involved a communications weakness between Operations and Licensing and a weakness in operator understanding of the indications required to meet Technical Specification 3.3.7.5. Corrective actions involve clarifying the Technical Specification Bases, improving communications between Operations and Licensing, and ensuring control room operators are aware of the need for control room indication to meet the requirements of Technical Specification 3.3.7.5. The event was determined to have negligible impact on plant safety because the containment isolation valve is a normally closed, fail closed valve and was capable of performing its safety function.

Event Description:

On January 18, 1995 the plant was in Operational Condition 1 at 100 percent power. At approximately 0900, while on a tour of the control room, the Resident Inspector questioned the operability of Post Accident Sample System (PASS)[KN] containment [CN] isolation valve PSR-V-X77A/1 [KN,V]. The attached deficiency tag hung on January 6, 1995 indicated that the control room indicator did not indicate properly during valve operations. Following a surveillance to verify operability of the PASS valves, control room indication was lost at 1050 hours for PASS inboard containment isolation valve PSR-V-X77A/3 [KN,V]. During cycling of the PASS valves at 1140 hours to verify the restoration of valve position indication for PSR-V-X77A/3, control room indication for PSR-V-X77A/3 was erratic. Local PASS panel indication for PSR-V-X77A/3 was normal. The valve cycling operation also revealed that control room indication for PASS inboard containment isolation valve PSR-V-X77A/1 showed continuous closed indication during valve cycling.

A review of past operating history for PSR-V-X77A/1 showed that the continuous closed indication had existed since August 17, 1994 with no compensatory action implemented. This is a violation of Technical Specification 3.3.7.5, "Accident Monitoring Instrumentation," Table 3.3.7.5-1 which requires one position indication channel per containment isolation valve to be operable in Operational Conditions 1 and 2. Indications required by this Technical Specification table are based on NRC Regulatory Guide 1.97, which recommends control room indication for plant variables required by the control room operators during accident conditions. The ACTION statement requires the inoperable channel to be returned to an OPERABLE status within 7 days or be in at least HOT SHUTDOWN within the next 12 hours.

Immediate Corrective Action:

The outboard containment isolation valves (PSR-V-X77A/2 and PSR-V-X77A/4) inline with PSR-V-X77A/1 and PSR-V-X77A/3 respectively were deactivated, isolating the associated PASS sample lines.

Further Evaluation:

Technical Specification 3.3.7.5, "Accident Monitoring Instrumentation," requires instrumentation necessary to ensure sufficient information is available to control room operators to monitor plant conditions following an accident. To meet this Technical Specification the recommendations of Regulatory Guide 1.97, "Instrumentation For Light-Water-Cooled Nuclear Power Plants To Access Plant and Environs Conditions During and Following An Accident," were implemented. The Regulatory Guide recommends closed/not closed control room indication for primary containment isolation valves.

Technical Specification 3.3.7.5 did not provide adequate detail on which sources of valve position indication could be credited with satisfying the Limiting Condition for Operation (LCO). The Technical Specification Bases states that accident monitoring instrumentation capability is consistent with the recommendations of Regulatory Guide 1.97 but does not specify that control room indication is required. The plant's FSAR specifies control room indication as the required Regulatory Guide 1.97 indication for containment isolation valve position indication. Since the requirement that only control room indication be used to satisfy the Technical Specification LCO was not explicitly specified in the Technical Specification or Bases, operators had incorrectly credited the local PASS panel indication with satisfying the LCO.

Position indications for PSR-V-X77A/1 are provided through the operation of four externally mounted reed switches [KN,33]. Control room indication for PSR-V-X77A/1 is provided by relay PSR-RLY-30 inline with one of the closed reed switches. With PSR-V-X77A/1 fully closed, the reed switch closes energizing PSR-RLY-30 [KN,RLY] and providing closed indication in the control room.

On August 17, 1994, during the performance of a PASS surveillance to verify system operability, control room open indication for PSR-V-X77A/1 was not obtained when the valve was opened. A work request was generated to investigate and repair the valve position indication in the control room.

On January 6, 1995 replacement of PSR-RLY-30 failed to restore control room open indication for PSR-V-X77A/1. When the PASS inboard containment isolation valves were opened to verify the open indication for PSR-V-X77A/1, the operators recorded in the control room log that control room indication for PSR-V-X77A/1 showed continuously closed while the other inboard valves indicated open. As the inboard valves were closed, PSR-V-X77A/1 momentarily indicated open then showed closed indication in the control room. Local PASS panel indication for PSR-V-X77A/1 was normal. During the valve cycling evolution, the control room operators questioned if Technical Specification 3.3.7.5 ACTION statement was applicable because position indication for PSR-V-X77A-1 was available at the local PASS panel during relay replacement. Technical Specifications required that one valve position indication channel be operable for each primary containment isolation valve.

The Shift Manager contacted the Licensing Department to determine if open indication was required for PSR-V-X77A/1. The Shift Manager failed to inform Licensing that he had continuous closed indication in the control room for PSR-V-X77A/1. Licensing informed the Shift Manager that the required indication was closed/not closed indication; but failed to inform him that it was a required control room indication. The Technical Specification 3.3.7.5 ACTION statement was exited based on the operators having reliable valve

position indication at the PASS panel. A work request was generated to adjust or repair the valve indicating reed switch which provides control room indication by energizing or de-energizing relay PSR-RLY-30.

The lack of detail in the Technical Specifications concerning the specific requirements of the LCO contributed to the control room operators making the operability decision consistent with previous determinations. Since the PASS panel is accessible post accident and valve operations are performed from the panel, the previous interpretations of the Technical Specification requirement for accident monitoring position indication had been that the local indication at the PASS panel was acceptable to meet the LCO.

Further evaluation of the electrical circuit for PSR-V-X77A/1 control room indication concluded that the continuous closed indication existed since August 17, 1994 when open indication was not available in the control room.

This event is reported per 10 CFR 50.73(a)(2)(i) as a condition prohibited by the Technical Specifications.

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

Root Cause:

The event resulted from Technical Specifications not clearly identifying that control room indication was required to meet the LCO. Contributing causes for this event involved a communications weakness between Operations and Licensing and a weakness in operator understanding of the indications required to meet the LCO requirements of Technical Specification 3.3.7.5.

Further Corrective Actions:

The Licensing staff has been advised of the need to investigate related documentation and to clearly communicate all information when determining Technical Specification LCO applicability.

The Technical Specification Bases will be revised by June 30, 1995 to clarify Technical Specification 3.3.7.5.

Control room operators will be instructed by April 30, 1995 to clearly communicate all information when determining a Technical Specification LCO applicability.

Control room operators will be advised by April 30, 1995 to investigate available and referenced documents, such as the FSAR, when determining Technical Specification LCO applicability.

Control room operators will review this LER and be briefed on the need for control room indication to meet Technical Specification 3.3.7.5 by April 30, 1995.

Safety Significance:

The accident monitoring instrumentation provides information required by the control room operator during accident conditions. This information is used by the operators to assess plant conditions and take appropriate actions. The PASS containment isolation valves are normally closed and fail closed on a loss of power. The valves can not be controlled from the control room and normal operation is limited to surveillance testing.

Failure of the control room indication for PSR-V-X77A/1 had minimal impact on plant safety. The valve position indication failure did not affect the ability of the valve to close or remain closed. Local indication was available at the only panel where the valve can be operated and control room indication for the redundant isolation valve was unaffected by this problem.

Previous Similar Events:

A review of LERs for similar root cause, failure, or sequence of events did not identify any similar LERs.

EIIS Information

Text Reference	EIIS Reference System	Component
Containment	CN	
Isolation valve		ISV
Post Accident Sample System	KN	
PSR-V-X77A/1	KN	V
PSR-V-X77A/3	KN	V
PSR-RLY-30	KN	RLY