CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9606040015 DOC.DATE: 96/05/24 NOTARIZED: NO DOCKET #
FACIL:50-397 WPPSS Nuclear Project, Unit 2, Washington Public Powe 05000397
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RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 96-001-00:on 960425,inadvertent ESF actuations occurred due to tripping of temporary power supply to IN-3.Caused by personnel error.Operations restored to IN-3 loads & reset ESF actuations.W/960524 ltr.

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CATEGORY 1 DOCUMENT

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05-397

WASHINGTON PUBLIC POWER SUPPLY SYSTEM

P.O. Box 968 • 3000 George Washington Way • Richland, Washington 99352-0968 • (509) 372-5000

May 24, 1996
GO2-96-110

Docket No. 50-397

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

Gentlemen:

Subject: **NUCLEAR PLANT WNP-2, OPERATING LICENSE NPF-21, LICENSEE EVENT REPORT NO. 96-001-00**

Transmitted herewith is Licensee Event Report No. 96-001-00 for WNP-2. This report is submitted in response to the reporting requirements of 10CFR73 and discusses the items of reportability, corrective action taken, and action taken to preclude recurrence.

Should you have any questions or desire additional information regarding this matter, please call me or Ms. Lourdes Fernandez at (509) 377-4147.

Respectfully,

P. R. Bemis (Mail Drop PE20)
Vice President, Nuclear Operations

Enclosure

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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 4

TITLE (4) INADVERTENT ESF ACTUATIONS DUE TO TRIPPING OF TEMPORARY POWER SUPPLY TO IN-3 BY OUTAGE ELECTRICIANS

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)
04	25	96	96	- 0 0 1 -	0 0	05	24	96	N/A	0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	5
POWER LEVEL (10)	0 0 0

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

__ 20.402(b)	__ 20.405c	X 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)	__ 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
Bill Pfitzer, Licensing Engineer	509	377-2419

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 Thursday, April 25, 1996, at 0835, with the plant defueled, two temporary plant electricians inadvertently opened the fused disconnect supplying the Uninterruptible Power Supply (UPS) inverter IN-3 loads, causing a loss of power to the loads. Deenergization of IN-3 loads resulted in Engineered Safety Feature (ESF) actuations and containment isolations which were reset without further incident by control room personnel. At the time, the IN-3 loads were being temporarily supplied through a disconnect switch located on Power Panel PP-7A that was labeled as a spare disconnect. The disconnect handle had a caution tag which identified the disconnect as ON and supplying temporary power to the IN-3 loads. Also written on the caution tag were instructions to contact the control room prior to operating the disconnect. The two electricians stated they did not read and understand the caution tag. They have been restricted from work in the power block for the remainder of the outage, and the importance of the administrative barriers reiterated to maintenance personnel.

Event Notification was made to the NRC pursuant to the requirements of 10 CFR 50.72(b)(2).

Event Description

On Thursday, April 25, 1996, at 0835, with the plant defueled, two temporary plant electricians inadvertently opened the fused disconnect supplying the Uninterruptible Power Supply inverter [UJX,INVT] IN-3 loads, causing a loss of power to the loads. At the time, the IN-3 loads were being temporarily supplied through a disconnect switch located on Power Panel [PL] PP-7A, and labeled as a spare disconnect. Deenergization of IN-3 loads resulted in the following ESF actuations:

- Start of Control Room Emergency Filtration system
- Start of Standby Gas Treatment system [BH]
- Isolation of Reactor Building Ventilation system [VA]
- Isolation of the following containment valves:
  - CSP-V-1 [VB,V] and CEP-V-1A [VB,V] (containment purge and exhaust)
  - RCC-V-5 and RCC-V-21 [CC,V] (containment cooling supply and return)
  - EDR-V-395 [V] and FDR-V-220 [V] (reactor building sump discharges to radwaste)

At the time of the incident, the personnel involved were walking down Work Order Task DS34-01 in preparation for replacing the disconnect switch. Their intent was to take photographs of the disconnect fuse clips, and while attempting to open the cabinet door to take the photos they inadvertently opened the disconnect.

Immediate Corrective Action

Operations restored power to IN-3 loads and reset the ESF actuations without further incident.

Event Notification was made to the NRC pursuant to the requirements of 10 CFR 50.72(b)(2).

The temporary electricians involved were restricted from performing work in the power block.

Management expectations concerning equipment clearance requirements and the appropriate approvals needed prior to entering panels, components or systems, were reiterated during briefings with plant and contractor maintenance personnel regarding this event.

Further Evaluation

The two electricians stated they assumed the disconnect was open because the work instructions identified the disconnect as a spare, and the instructions made no mention of the disconnect being the temporary power supply to IN-3. Furthermore, they found the breaker handle in the mid-position between OPEN and CLOSED. The electricians did not question this condition because the work instructions described the problem as, "cubicle will not close properly and has missing parts."

The main barrier in place to prevent this occurrence was a caution order on the disconnect handle which stated the status as ON. The back side of the card read, "Caution tag the temporary power supply breaker to PP-7A-A per 10.25.1 step 6.1.14. Do not operate without CRS/Shift Manager permission." The electricians stated they failed to notice the status ON indication on the front of the card, and did not read the information on the back of the card. An additional barrier was provided by direction given in procedure PPM 1.3.7G which specifically disallows opening of panels by craftsmen performing walkdown of work instructions.

Root Cause

The primary root cause of this event was personnel error. The electricians involved did not read and follow the instructions on the caution tag. Additionally, the electricians did not follow the requirements of PPM 1.3.7G which specifically disallows opening of panels by craftsmen performing walkdown of work instructions. Contributing causes were lack of a questioning attitude and inexperience using Supply System procedures.

Further Corrective Action

Revise PPM 10.25.1 to include the requirement to provide field identification of spare disconnects which are providing temporary power.

Revise applicable maintenance lesson plans regarding clearance orders (PPM 1.3.8) and opening of panels by maintenance personnel (PPM 1.3.7G) to include lessons learned from this event.

Assessment of Safety Consequences

The safety consequences of this event are minimal because the plant was defueled in Mode 5. All expected actuations and isolations occurred, and the affected systems were restored by control room personnel without further incident.

Previous Similar Events

Previous LERs documenting personnel error resulting in ESF or RPS actuation are as follows:

- LER 95-002 involved Operations personnel operating the wrong lever during a main turbine test resulting in turbine trip and reactor scram.
- LER 93-024 involved personnel error and failure to self check during restoration of the Containment Instrument Air (CIA) system. Improper restoration resulted in actuation of the CIA backup nitrogen bottle programmer.
- LER 93-002-01 involved painters inadvertently actuating Reactor Feedwater Pump Room "A" fire protection deluge system which ultimately led to the trip of Reactor Feedwater Pump "A" trip and reactor scram.