

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)						DOCKET NUMBER (2) 0   5   0   0   0   3   9   7   1   OF   0   2									PAGE (3) 1											
TITLE (4) <b>RPS Actuation During Surveillance Testing</b>																										
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)													
0	1	7	8	5	8	5	-	0	0	5	-	0	0	0	2	1	5	8	5	0	5	0	0	0		
																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)																							
4			20.402(b)				20.406(c)				X	50.73(a)(2)(iv)				73.71(b)										
POWER LEVEL (10)			0   0   0				20.406(a)(1)(i)					50.73(a)(2)(v)				73.71(c)										
			20.406(a)(1)(ii)				50.38(a)(2)					50.73(a)(2)(vi)				X OTHER (Specify in Abstract below and in Text: NRC Form 366A)										
			20.406(a)(1)(iii)				50.73(a)(2)(i)					50.73(a)(2)(vii)(A)				50.72(b)(2)(ii)										
			20.406(a)(1)(iv)				50.73(a)(2)(ii)					50.73(a)(2)(viii)(B)														
			20.406(a)(1)(v)				50.73(a)(2)(iii)					50.73(a)(2)(ix)														
LICENSEE CONTACT FOR THIS LER (12)																										
NAME										TELEPHONE NUMBER																
R. L. Koenigs, Compliance Engineer										5   0   9   3   7   7   -   2   5   0																
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13) Ext. 2279																										
CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS																
A	TIG	-	-	-	N																					
SUPPLEMENTAL REPORT EXPECTED (14)																										
YES (If yes, complete EXPECTED SUBMISSION DATE)										NO			EXPECTED SUBMISSION DATE (15)			MONTH	DAY	YEAR								
										X																
ABSTRACT Limit to 400 spaces, i.e., approximately fifteen single-space typewritten lines (16)																										

On 1/17/85, during surveillance testing prior to a reactor startup, the incorrect APRM channel was inadvertently placed in "Standby". Upon realizing that a mistake had been made, this channel was returned to operation and the correct APRM channel placed in "Standby" prior to resetting the Division II Half Scram signal. This resulted in a Reactor Protection System (RPS) actuation.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Washington Nuclear Plant - Unit 2	0500039785	—	005	—	00	02	OF 02

TEXT (If more space is required, use additional NRC Form 365A's) (17)

Plant Conditions

- a) Power Level - 0%
- b) Plant Mode - 4

Event

During surveillance testing of APRM channel "A" prior to a reactor startup, APRM channel "B" was inadvertently placed in "Standby" causing a full RPS trip. The technicians involved were performing their second shift of the surveillance testing that was required for Plant startup.

The two Plant Technicians were in communication by sound powered phones. The party at the Reactor Operator's Console had the procedure and the second party at the APRM panel had a copy of the procedure. The individual at the Reactor Operator's Console was reading each step of the procedure out loud as the procedure was performed.

The individual at the APRM panel was told to place APRM channel "A" in the "Standby" mode. The individual at the APRM panel inadvertently placed APRM channel "B" in "Standby", realized his mistake, returned channel "B" to operate and placed APRM channel "A" in "Standby" before the Division II Half SCRAM could be reset.

Immediate Corrective Action

The RPS actuation signal was immediately reset, and surveillance testing continued.

Further Corrective Action

- o The Technicians involved were counseled as to using proper care in the performance of surveillance testing procedures.
- o All I&C shop personnel shall be instructed as to the necessity for determining the consequences prior to taking action to correct mistakes incurred during the performance of surveillance procedures.
- o Use of these technicians for two consecutive shifts of surveillance testing was in accordance with Plant procedures. However, to the extent possible, WNP-2 will avoid the use of Instrument & Control Technicians for two consecutive shifts of critical surveillance testing in the future.
- o Since confusing identification labels may have contributed to this event, new labels will be provided to more positively identify the APRM channels.

Safety Significance

There is no safety significance associated with this event as all equipment operated correctly to cause a full RPS actuation.

## Washington Public Power Supply System

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

Docket No. 50-397  
February 15, 1985

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

Subject: NUCLEAR PLANT NO. 2  
LICENSEE EVENT REPORT NO. 85-005

Dear Sir:

Transmitted herewith is Licensee Event Report No. 85-005 for WNP-2 Plant. This report is submitted in response to the report requirements of 10CFR50.73 and discusses the item of reportability, corrective action taken, and action taken to preclude recurrence.

This is the follow-up report to the verbal notification given at 2135 hours on January 17, 1985.

Very truly yours,

*J. D. Martin for*  
J. D. Martin (M/D 927M)  
WNP-2 Plant Manager

JDM:mm

Enclosure:  
Licensee Event Report No. 85-005

cc: Mr. John B. Martin, NRC - Region V  
Mr. A. D. Toth, NRC - Site (901A)  
Ms. Dottie Sherman, ANI  
INPO Records Center - Atlanta, GA

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