

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Wolf Creek Generating Station										DOCKET NUMBER (2) 0 5 0 0 0 4 8 2										PAGE (3) 1 OF 013									
TITLE (4) Inadvertent ESF Actuation - Safety Injection Initiation																													
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 5 0 0 0											
0 4		1 9		8 5		8 5		0 1 2		0 0 0 5		1 7 8		5				0 5 0 0 0											
OPERATING MODE (9) 4						THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																							
POWER LEVEL (10) 0.010						20.402(b)						20.405(c)						<input checked="" type="checkbox"/> 50.73(a)(2)(iv)						73.71(b)					
						20.405(a)(1)(i)						50.38(c)(1)						50.73(a)(2)(v)						73.71(c)					
						20.405(a)(1)(ii)						50.38(c)(2)						50.73(a)(2)(vi)						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)(vii)(A)											
						20.405(a)(1)(iv)						50.73(a)(2)(ii)						50.73(a)(2)(vii)(B)											
20.405(a)(1)(v)						50.73(a)(2)(iii)						50.73(a)(2)(x)																	
LICENSEE CONTACT FOR THIS LER (12)																													
NAME Merlin G. Williams - Superintendent of Regulatory, Quality, and Administrative Services																TELEPHONE NUMBER AREA CODE 311 16 316 141-18181311													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																													
CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC		CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC											
B		B I		2101		L 21010		N																					
SUPPLEMENTAL REPORT EXPECTED (14)																													
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)																<input checked="" type="checkbox"/> NO						EXPECTED SUBMISSION DATE (15)							
																						MONTH DAY YEAR							

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1619 CST on April 19, 1985, an inadvertent train 'B' Safety Injection (SI) occurred. The plant was in Mode 4 prior to initial criticality with the Reactor Coolant System (RCS) at 369 PSIG and 212 degrees F at the time of the event.

The Safety Injection was initiated during performance of a surveillance test when a Reactor Operator inadvertently unblocked a Steamline Low Pressure SI signal. All engineered safety features equipment required to actuate with the plant in Mode 4 responded properly with one exception. Valve EF-HV-60, a motor-operated Essential Service water isolation valve did not fully close (approximately 3 percent open). Subsequent to the event, a loose limit switch lug was found in the valve motor operator and has been repaired.

The Safety Injection was terminated at 1628 and the plant was restored to a normal configuration in accordance with plant procedures at 1811.

At no time did conditions develop which posed a threat to the health and safety of the public.

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. LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1) Wolf Creek Generating Station	DOCKET NUMBER (2) 0 5 0 0 0 4 8 2	LER NUMBER (6)			PAGE (3)		
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		8 5	- 0 1 2	- 0 0	0 2	OF	0 3

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

At 1619 CST on April 19, 1985, an inadvertent Train 'B' Safety Injection (SI) occurred. The plant was in Mode 4 prior to initial criticality with the Reactor Coolant System (RCS) at 369 psig and 212 degrees F and pressurizer level at approximately 25 percent prior to the event. The Residual Heat Removal (RHR) system was in operation and the reactor trip breakers were shut for performance of surveillance testing.

At the time of the event surveillance test procedure STS-IC-211A, "Actuation Logic Test - Train 'A' Solid State Protection System", was being performed. The I&C Technician performing the test requested the Reactor Operator to "Block" several train 'A' actuation signals which had been "RESET" (unblocked) to perform the test. While accomplishing this, the Reactor Operator inadvertently "Reset" the 'B' Train Steamline Pressure Safety Injection "Block" switch. This resulted in actuation of Train 'B' Safety Injection on low steamline pressure. This Engineered Safety Features Actuation System (ESFAS) trip function is normally blocked in Mode 4 as plant conditions are below the required trip setpoints.

The Reactor Trip breakers opened and all engineered safety features equipment required to actuate with the plant in Mode 4 responded properly with the exception of valve EF-HV-60 which did not fully close.

Water was injected into the RCS via the 'B' Centrifugal Charging Pump resulting in a maximum RCS pressure of 440 psig, minimum RCS temperature of 205 degrees F and a maximum pressurizer level of approximately 83 percent. Discharge into the RCS was terminated at 1628 and restoration of plant systems to a normal configuration in accordance with plant procedures was completed at 1811.

The Safety Injection Pumps and the Auxiliary Feedwater Pumps were not in service as allowed by Technical Specifications.

Subsequent to the Safety Injection, it was noted that valve EF-HV-60, a motor operated Essential Service Water valve which isolates normal cooling water from the 'B' Component Cooling Water Heat Exchanger, had double indication on the main control board (both open and closed lights were illuminated). The ESFAS status panel indicated that the valve had completed its required safety function and was closed.

Inspection of the valve revealed that it was approximately 3 percent open and that a lug in the valve operator 'close' limit switch circuit was loose allowing the 'close' circuit to be intermittent. This caused the valve to stop at the 3 percent position and resulted in the double position indication. A new lug was installed and the valve was tested to function properly. Although the cause of the loose lug has not been determined, an evaluation is being performed to recommend any appropriate corrective action.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

The cognitive personnel error which initiated this event has been reviewed by the Shift Supervisor with the operating personnel. The need to exercise greater caution in performing actions that could result in inadvertent actuations or in upsetting plant conditions was emphasized. In addition, this Licensee Event Report is included as required reading for all operating personnel.

At no time during this event did conditions develop which posed a threat to the health and safety of the public.



KANSAS GAS AND ELECTRIC COMPANY

GLENN L. KOESTER
VICE PRESIDENT - NUCLEAR

May 17, 1985

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

Mr. R.P. Denise, Director
Wolf Creek Task Force
U.S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011

KMLNRC 85-117
Re: Docket No. STN 50-482
Subj: Licensee Event Report 85-012-00

Gentlemen:

The enclosed Licensee Event Report is submitted pursuant to 10 CFR 50.73 (a) (2) (iv) concerning an Engineered Safety Feature Actuation.

If you have any questions concerning this matter, please contact me or Mr. Otto Maynard of my staff.

Yours very truly,

Glenn L. Koester
Vice President - Nuclear

GLK:dab

xc: PO'Connor (2), w/a
JCummins, w/a

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