

## 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 02										
TITLE (4) Technical Specification Violation - Centrifugal Charging Pump 'A'																								
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	8	3	0	8	5	8	5	0	6	3	0	0	9	2	3	8	5	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)																						
3		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)										
POWER LEVEL (10)		20.405(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)										
0 0 1 0		20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 368A)										
		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 Merlin G. Williams - Superintendent of Regulatory, Quality and Administrative Services										TELEPHONE NUMBER														
										AREA CODE														
										3 1 1 6 3 1 6 4 1 - 1 8 1 8 3 1 1														
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																								
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs														
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 (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At approximately 2200 CDT, on August 31, 1985, with the plant in Mode 3, Hot Standby, a manual isolation valve on the "A" Centrifugal Charging Pump discharge line was found closed. This condition caused the Centrifugal Charging Pump to be inoperable in violation of Technical Specifications 3.1.2.4 and 3.5.2. The manual valve was opened immediately upon discovery returning "A" Centrifugal Charging Pump to operable status.

The "A" Centrifugal Charging Pump had been taken out of service on August 27 for maintenance. Following completion of the maintenance, a surveillance test demonstrated proper pump performance and the pump was declared operable on August 30, 1985.

A personnel error in the performance of the post maintenance surveillance test left the manual valve closed rather than in its required open position and a review of the completed surveillance procedure failed to identify the error. This resulted in the Centrifugal Charging Pump being inoperable for longer than the 72 hours allowed by Technical Specifications.

The surveillance test procedure has been revised to prevent future similar errors. Additional training on post test reviews is also planned.

There was no damage to plant equipment or release of radioactivity as a result of this event, and at no time did conditions develop which could have posed a threat to the health or 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)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Wolf Creek Generating Station	0 5 0 0 0 4 8 2	8 5	- 0 6 3	- 0 0	0 2	OF 0 2

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

At approximately 2200 CDT, on August 31, 1985, with the plant in Mode 3, Hot Standby, it was discovered that a Technical Specification violation had occurred involving Centrifugal Charging Pump "A" [CB-P]. Technical Specifications 3.1.2.4 and 3.5.2 action statements allow one Centrifugal Charging Pump to be out of service for a maximum of 72 hours before additional compensatory actions are required.

On August 27, at approximately 2112 CDT, Centrifugal Charging Pump (CCP) "A" was taken out of service for maintenance. Maintenance activities were completed on August 30, 1985, and following completion of surveillance test STS-BG-100A, "Centrifugal Charging System 'A' Train Inservice Pump Test", the CCP was declared operable at 2030 CDT on August 30, 1985. At that time, CCP "A" had been out of service for less than the 72 hours allowed by Technical Specifications.

On August 31, at approximately 2200 CDT, during routine operator inspections of the status of safety systems, it was discovered that manual valve BG-8485A [CB-ISV], the CCP "A" discharge isolation valve, was closed rather than in its required open position. This condition resulted in the CCP being inoperable. Valve BG-8485A was opened immediately upon discovery that it was not in the proper position, returning CCP "A" to operable status.

It was subsequently determined that a personnel error had occurred during the performance of surveillance test STS-BG-100A. The operator performing the surveillance test misinterpreted a caution statement in the test procedure regarding the position of valve BG-8485A in various plant modes, resulting in the valve being left in the closed (incorrect) position. As a consequence of this error, Centrifugal Charging Pump "A" had remained out of service from August 27, 1985, until August 31, 1985, exceeding the 72 hours allowed by Technical Specifications.

To prevent possible future errors, surveillance procedure STS-BG-100A, and its sister procedure STS-BG-100B have been revised to clearly state the required position of the CCP Discharge Isolation valves.

A management review of this event determined that an additional factor contributed to this event. Administrative procedures require a post test review of the completed surveillance procedure by the Shift Supervisor. In this case, the detailed post test review could have identified the error in performance of the test, but did not.

The apparent weakness in the post test review function has been addressed in writing to the Shift Supervisors reiterating the administrative requirements. Additionally, a training session for the Shift Supervisors is planned to review the post test review requirements and implementation responsibilities.

There was no damage to plant equipment or release of radioactivity as a result of this event, and at no time did conditions develop which could have posed a threat to the health or safety of the public.



KANSAS GAS AND ELECTRIC COMPANY

GLENN L. KOESTER  
VICE PRESIDENT - NUCLEAR

September 23, 1985

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

COPY FOR

Mr. R.P. Denise, Director  
Division of Reactor Safety and Projects  
U.S. Nuclear Regulatory Commission  
Region IV  
611 Ryan Plaza Drive, Suite 1000  
Arlington, Texas 76011

KMLNRC 85-218  
Re: Docket No. STN 50-482  
Subj: Licensee Event Report 85-063-00

Gentlemen:

The enclosed Licensee Event Report is submitted pursuant to  
10 CFR 50.72 (a) (2) (i) concerning a Technical Specification  
Violation.

Yours very truly,

*Glenn L. Koester*

GLK:bb  
Enc.  
xc:PO'Connor (2), w/a  
JCummins, w/a

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