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May 15, 2007 GO2-07-085

10 CFR 50.73

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555-0001

Subject:

COLUMBIA GENERATING STATION, DOCKET NO. 50-397

LICENSEE EVENT REPORT NO. 2007-001-00

Dear Sir or Madam:

Transmitted herewith is Licensee Event Report No. 2007-001-00 for Columbia Generating Station. This report is submitted pursuant to 10 CFR 50.73(a)(2)(i)(B). The enclosed report discusses items of reportability and corrective actions taken.

There are no commitments being made to the NRC by this letter. If you have any questions or require additional information, please contact Mr. GV Cullen at (509) 377-6105.

Respectfully,

WS Oxenford

Vice President, Technical Services

Mail Drop PE04

Enclosure:

Licensee Event Report 2007-001 -00

cc: BS Mallett – NRC RIV CF Lyon – NRC NRR INPO Records Center

NRC Sr. Resident Inspector – 988C (2)

RN Sherman – BPA/1399 WA Horin – Winston & Strawn CE Johnson – NRC RIV/fax

IEDA

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION (6-2004) LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)						Es re ar FC DC Oi M ini nc cc	APPROVED BY OMB NO. 3150-0104 EXPIRES 6/30/2007 Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.									
1. FACILITY NAME							2. DOCKET NUMBER					3. PAGE				
Columbia Generating Station							05000397				1 OF 3					
4. TITLE																
Automatic Depressurization System Logic Signal Instrument Inadvertantly Disabled																
5. EVENT DATE				6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES			TIES IN	NVOLVED		
MONTH	DAY	YEA	R YEAR	SEQUENTIAL NUMBER	REV NO	МОМ	ГН	DAY	YEAR	FACILITY	NAME			DOCKET NUMBER 0500		
March	21	2007	20	007 - 001 - 00		Máy		15	2007	FACILITY	NAME		D		T NUMBER	
21 2007 2001 - 00			1,14,					0500								
9. OPERATING MODE Mode 1 10. POWER LEVEL 100%			☐ 20.2: ☐ 20.2: ☐ 20.2: ☐ 20.2: ☐ 20.2: ☐ 20.2: ☐ 20.2:	☐ 20.2201(d) ☐ 20.2203 (a)(1) ☐ 20.2203 (a)(2)(i) ☐ 20.2203(a)(2)(ii) ☐ 20.2203(a)(2)(iii) ☐ 20.2203(a)(2)(iv) ☐ 20.2203(a)(2)(v) ☐ 20.2203(a)(2)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)			0.2203(a)(3)(i)			50.73(a)(2 50.73(a)(2 50.73(a)(2 50.73(a)(2 50.73(a)(2 50.73(a)(2 50.73(a)(2 50.73(a)(2 50.73(a)(2	2)(i)(C) 2)(ii)(A) 2)(ii)(B) 2)(iii) 2)(iv)(A) 2)(v)(A) 2)(v)(B) 2)(v)(C)		50.73 50.73 50.73 50.73 50.73 50.73 73.71 73.71 OTHE Specif	(a)(2)(\(a)(2)(\(a)(2)(\(a)(2)(\(a)(2)(\(a)(4)(a)(5))\) R y in Abs	vii) viii)(A) viii)(B) x)(A)	
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FACILITY NAME Fred A. Schill TELEPHONE NUMBER (Include Area 509 377-2269									ea Code)							
13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT																
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14. SUPPLEMENTAL REPORT EXPECTED 15. EXPECTED MONTH DAY YEAR									YEAR							
☐ YES (If	yes, com	plete 1	5. EXPECTE	ED SUBMISSIO	N DATE)		NO		SUBMISSIC DATE	M					
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)																

On March 21st, 2007, at approximately 0214, it was determined that a pressure sensing instrument had been isolated and out of service during the time it was required to be operable by plant Technical Specifications. The instrument provides a low pressure Emergency Core Cooling System (ECCS) pump running permissive signal for initiation of the Automatic Depressurization System (ADS). The instrument was discovered isolated during surveillance testing and maintenance records indicate it had potentially been isolated for as long as 32 days. This is longer than the 8-day Completion Time allowed for Required Action G.2 of Technical Specifications Limiting Condition for Operation (LCO) 3.3.5.1 to restore the channel to operable status. This event meets the criteria for reporting pursuant to § 50.73(a)(2)(i)(B). During the entire time the instrument was out of service, redundant instruments were operable to maintain initiation capability of both ADS subsystems. No safety consequences are associated with this event.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION (1-2001)LICENSEE EVENT REPORT (LER) 1. FACILITY NAME 2. DOCKET 6. LER NUMBER 3. PAGE SEQUENTIAL REVISION YEAR NUMBER NUMBER 05000397 2 OF 3 Columbia Generating Station 2007-001-00

17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

Plant Conditions

At the time of discovery, Columbia Generating Station was operating in mode 1 at 100% power. There were no other structures, systems, or components inoperable at the time that contributed to the condition.

Event Description

On March 21st, 2007, at approximately 0214, it was discovered that a pressure sensing instrument [PS] had been isolated and out of service during the time it was required to be operable by plant Technical Specifications. The instrument provides a low pressure Emergency Core Cooling System (ECCS) [BO] pump running permissive signal for initiation of Division I of the Automatic Depressurization System (ADS) and is specified in Function 4.e of Table 3.3.5.1-1 in Technical Specifications Limiting Condition for Operation (LCO) 3.3.5.1. The instrument was discovered isolated during surveillance testing and maintenance records indicate it had potentially been isolated for as long as 32 days. This is longer than the 8-day Completion Time allowed for Required Action G.2 of Technical Specifications LCO 3.3.5.1 to restore operable status.

Immediate Corrective Action

The pressure instrument was promptly restored to service upon discovery of the condition. Correct pressure instrument valve configuration was verified for all channels in both divisions of ADS.

Cause

Several instances associated with surveillance testing were identified which presented opportunities for the instrument to be isolated by plant technicians or operators. However, no specific evidence or interview information could exclude or identify the specific instance when the inadvertent isolation occurred. Because of this, further cause analysis to identify the specific human error and its causes is not possible.

The cause of the required pressure sensing instrument being inadvertently isolated and out of service is considered to be related to human performance. A discussion pursuant to § 50.73(b)(2)(ii)(J) to support understanding of human performance factors to the extent they apply is provided.

Procedural deficiencies associated with the mispositioned valve included an inservice test procedure that had human factor deficiencies because it did not provide specific valve manipulation instructions or specify a location for connecting and disconnecting a test gauge used for measuring pump discharge pressure. Additionally, a surveillance procedure was found to have human factor deficiencies in that the noun identifier in the procedure for the instrument isolation valve was different

LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET		6. LER NUMBER	3. PAGE		
Columbia Congreting Station	05000397	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3	
Columbia Generating Station			2007-001-00	3 OF 3		

than the one used on the valve identification tag.

A minor human-system interface deficiency was noted in that the mis-positioned isolation valve had two labels. One label displayed the valve number and one displayed the noun name of the valve. This creates an additional step when applying the touch-read-read error prevention tool.

Circumstantial aspects of this event are that the personnel involved are non-licensed equipment operators and instrument technicians and there was no indication of any time or situational pressures involved with the testing activities.

Assessment of Safety Consequences

There were no safety consequences associated with this event.

During the entire time the pressure instrument was inadvertently isolated and out of service, redundant instruments were operable to provide initiation capability of both ADS subsystems.

Further Corrective Actions

Actions will be taken to correct the human factor deficiencies in the procedures and the human-system interface deficiency associated with the valve labeling.

Previous Similar Events

There have been no previous similar events in which an instrument providing an input to the ECCS system actuation logic had been inadvertently valved out of service for a period of time that exceeded Technical Specifications requirements.

EIIS Information (Denoted as [XX])

Emergency Core Cooling System [BO] Pressure Switch [PS]