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SUBJECT: LER 98-001-00:on 980203,automatic start of HPCS EDG was noted.Caused by operator error.Operations crew stabilized plant at approximately 75% reactor power & investigation of event was initiated.W/980304 ltr.	C A
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March 4, 1998 GO2-98-044

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. 98-001-00

Transmitted herewith is voluntary Licensee Event Report No. 98-001-00 for WNP-2. This report is submitted in response to the recommendations contained in NUREG-1022.

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

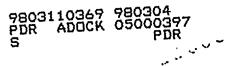
Respectfully, P./R Bernis

Vice President, Nuclear Operations Mail Drop PE23

Enclosure

cc: EW Merschoff, NRC RIV KE Perkins, Jr., NRC RIV, WCFO C Poslusny, Jr., NRR PD Robinson, Winston & Strawn

NRC Sr. Resident Inspector, MD927N (2) INPO Records Center - Atlanta, GA DL Williams, BPA, MD399



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LICENSE	E EVENT REPORT (TEXT CONTINUATION	LER)					
FACILITY NAME (1)	NAME (1) DOCKET NUMBER (2) LER NUMBER (6)						
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Washington Nuclear Plant - Unit 2	50-397	98	001	00	2	OF	4

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

Event Description

On February 3, 1998, while operating in Mode 1 at 100% power, control room personnel were making preparations to perform the Division 1 Emergency Diesel Generator semi-annual operability surveillance (OSP-ELEC-S701). In accordance with the surveillance procedure, the designated Control Room Operator (CRO2) had shifted the power source for electrical board SM-1 from transformer TR-N to transformer TR-S, with a second Control Room Operator (CRO3) acting as a peer checker for the evolution. As one of the final steps in the evolution, the procedure directed the control switch for breaker CB-N1/1, the normal supply breaker to electrical bus SM-1, to be placed in the TRIP position to ensure the switch escutcheon green flag is displayed.

Just prior to this step, CRO3 (the peer checker) responded to an unrelated control room annunciator, and CRO2 (the performer) momentarily turned away from the control panel to review the impending steps of the procedure. After reviewing the procedure, CRO2 returned his attention to the control panel and incorrectly selected and manipulated the control switch for breaker CB-N1/2, the normal supply breaker to bus SM-2. Upon manipulation of the handswitch, CB-N1/2 tripped, de-energizing SM-2. The selection and operation of the handswitch for CB-N1/2 was performed in error by CRO2.

De-energization of SM-2 caused automatic tripping of the pumps associated with the bus, i.e., condensate pump COND-P-1B, condensate booster pump COND-P-2B, and condenser circulating water pump CW-P-1B. The consequent reduction in reactor feedwater flow resulted in reactor water level lowering at a rate of about 25 inches per minute. Prompt action by the Operations crew to lower total core flow to approximately 60 million lb-mass/hr using the Reactor Recirculation system, thus reducing reactor power level, successfully stabilized the plant at approximately 75% power. Power was immediately returned to bus SM-2 by manual closure of the alternate supply breaker from transformer TR-S.

Additionally, the momentary loss of bus SM-2 caused the de-energization of electrical bus SM-4, which in turn resulted in automatic starting of the HPCS DG due to SM-4 undervoltage. Normal power was subsequently returned to bus SM-4 when the Operations crew re-closed the supply breakers from SM-2 and manually tripped the HPCS DG.

Because the HPCS DG is not considered an Engineered Safety Feature at WNP-2, this report is being voluntarily submitted per the recommendation of NUREG 1022. This event would otherwise require a mandatory report per the requirements of 10CF50.73(a)(2)(iv).

Immediate Corrective Action

A voluntary 4-hour report of the HPCS DG auto start was made in accordance with 10 CFR 50.72 (b)(2)(ii).

After the transient was stabilized, a Problem Evaluation Request was initiated and an Incident Review Board (IRB) was convened.

	EVENT REPORT (LER)				••••••••	
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Washington Nuclear Plant - Unit 2	50-397	98	001	00	3	OF	4
TEXT (If more space is required, use additional copies of NRC Form 3	66A) (17)			<u> </u>			
Root Cause							
The cause of the event was human error. After hav procedure, CRO2 incorrectly selected the handswit position without adequate self-checking.	•		•			IP	
A contributing cause of this event was failure to ob procedure using peer checks, CRO2 considered the discontinued obtaining peer checks prior to action s	e remaining portion of						
An additional contributing cause of this event was t communicated by Operations management.	that peer checking st	andard	s have not bee	n proper	ly		
Further Corrective Action							
Operations supervision will conduct and document error(s) associated with this event.	appropriate counsel	ing to a	ddress the hur	nan perf	orma	ince	
A station wide stand down was conducted on Febru human performance error initiated events.	uary 3, 1998, to revi	ew this	event as well	as other	rece	nt	
An entry into the Operations Night Orders was mad Operations Observation program, procedure usage,					gard	ling th	ne
Shift Managers will evaluate crew members for buy do not exhibit the proper use of self-checking techn techniques, emphasizing the value of self-checking.	iques will be given o			-		s that	
Operations management expectations regarding pee appropriate Operating Instruction(s).	er checks and self-ch	lecking	will be docum	ented in	the		
The Operations Observation program will be revise expectations for peer checks and self-checking.	d to provide instruc	tion to	reinforce mana	igement'	s		
Assessment of Safety Consequences							
The consequences of this event were minimized by resultant reactor water level transient. Additional power conditions such as this event. A review of bus SM-2 is a negligible contributor to the overall	ly, the design basis the WNP-2 Probab	of the ilistic S	plant envelope Safety Analysi	es loss o s shows	f ele that	ctrica loss c	

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION										
FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)	PAGE (3)		3)				
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

consequences of this event are considered minimal. However, it is recognized that personnel performance is critical to successful plant operations.

Similar Events

LER 96-002 documented an equipment operator opening a potential transformer fuse compartment, resulting in electrical bus SM-8 transferring to alternate power supply, and automatic starting of EDG-2.

LER 95-002 documents Operations personnel manipulation of the wrong lever on the main turbine front standard, resulting in a main turbine trip and reactor scram.