

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Washington Nuclear Plant - Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 9 7 1	PAGE (3) 1 OF 0 2
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TITLE (4)
 Inadvertent Initiation of CR Emergency Filtration Unit

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															
0	6	2	0	8	4	8	4	4	0	6	6	0	0	0	7	1	2	8	4	0	5	0	0	0

OPERATING MODE (9) 2

POWER LEVEL (10) 0 0 1

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)

20.402(b)	<input checked="" type="checkbox"/>	80.73(a)(2)(iv)	<input type="checkbox"/>	73.71(b)
20.406(a)(1)(i)	<input type="checkbox"/>	80.73(a)(2)(v)	<input type="checkbox"/>	73.71(c)
20.406(a)(1)(ii)	<input type="checkbox"/>	80.73(a)(2)(vi)	<input checked="" type="checkbox"/>	OTHER (Specify in Abstract below and in Text: NRC Form 366A)
20.406(a)(1)(iii)	<input type="checkbox"/>	80.73(a)(2)(vii)	<input type="checkbox"/>	50.72(b)(2)(ii)
20.406(a)(1)(iv)	<input type="checkbox"/>	80.73(a)(2)(viii)(A)	<input type="checkbox"/>	
20.406(a)(1)(v)	<input type="checkbox"/>	80.73(a)(2)(viii)(B)	<input type="checkbox"/>	
20.406(a)(1)(vi)	<input type="checkbox"/>	80.73(a)(2)(ix)	<input type="checkbox"/>	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
C.M. Powers, Reactor Engineering Supervisor	510 931 7171-12151011

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13) Ext. 2996

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPD'S	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPD'S
A	I L	- R A	K 0 2 0	N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if you complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 400 spaces - e. approx. sixty fifteen single-space typewritten lines) (16)

A Control Room emergency filtration unit (an ESF System) was inadvertently actuated due to a spike on the corresponding radiation monitor. The spike was associated with corrective maintenance being performed on the Control Room outside air chlorine analyzer.

After verifying that radiation and chlorine levels were not above normal background levels, the radiation monitors and emergency filtration units were reset and returned to a normal lineup.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

TEXT (If more space is required, use additional NRC Form 388A's) (17)

Plant Conditions

- a). Plant Mode 2
- b) Power Level 1%

Event

A Control Room emergency filtration unit (WMA-FN-54A) was automatically actuated on 6/20/84 by a high-high radiation alarm originating from a Control Room outside air intake monitor (WOA-RIS-31A).

Immediate Corrective Action

Normal background radiation levels were observed at radiation monitors 31A and 32A. The associated radiation recorder (WOA-RR-31) revealed that monitor 31A had received a spike of sufficient magnitude to trip the high-high alarm causing automatic actuation of the Control Room emergency filtration unit. Monitor 32A had spiked sufficiently to trip the high alarm, and the Control Room chlorine analyzer (WOA-SR-15) had also spiked to 0.37 ppm (trip occurs at 0.5 ppm) as observed on its respective recorder (WOA-XR-1). Normal chlorine levels were observed at WOA-SR-15. The alarms were promptly reset and the Control Room emergency HVAC system was secured.

Further investigation attributed the cause of the incident to be Instrument Technicians performing maintenance on a Control Room outside air chlorine analyzer (WOA-SR-15). The Technicians had not de-energized the chlorine analyzer as required by Plant procedures prior to replacing light bulb indicators.

Notification was given to the NRC in accordance with the requirements of 10CFR50.72(b)(2)(ii).

Long Term Corrective Action

Investigation and resolution of noise problems are continuing on the radiation monitoring and interfacing systems.

A training session will be held to discuss the procedure applicable to this event with emphasis placed on the importance of following procedures.

Safety Significance

There were no safety consequences associated with this event and all plant systems performed as required.

Washington Public Power Supply System

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

Docket No. 50-397

July 12, 1984

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

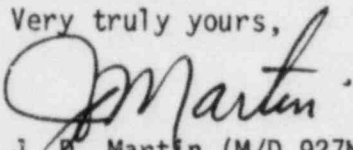
Subject: NUCLEAR PLANT NO. 2
LICENSEE EVENT REPORT NO. 84-066

Dear Sir:

Transmitted herewith is Licensee Event Report No. 84-066 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 1401 hours on June 20, 1984.

Very truly yours,



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

JDM:mm

Enclosure:

Licensee Event Report No. 84-066

cc: Mr. John B. Martin, Administrator
Region V, Office of Inspection and Enforcement
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Walnut Creek, California 94596
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