ENERGY NORTHWEST

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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

IE22

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION
(6-2004)

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.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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 INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER 0500
March	21	2007	2007	- 001 -	00	May	15	2007	FACILITY NAME	DOCKET NUMBER 0500

9. OPERATING MODE
Mode 1

10. POWER LEVEL
100%

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: *(Check all that apply)*

☐ 20.2201(b)	☐ 20.2203(a)(3)(i)	☐ 50.73(a)(2)(i)(C)	☐ 50.73(a)(2)(vii)
☐ 20.2201(d)	☐ 20.2203(a)(3)(ii)	☐ 50.73(a)(2)(ii)(A)	☐ 50.73(a)(2)(viii)(A)
☐ 20.2203 (a)(1)	☐ 20.2203(a)(4)	☐ 50.73(a)(2)(ii)(B)	☐ 50.73(a)(2)(viii)(B)
☐ 20.2203(a)(2)(i)	☐ 50.36(c)(1)(i)(A)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(ix)(A)
☐ 20.2203(a)(2)(ii)	☐ 50.36(c)(1)(ii)(A)	☐ 50.73(a)(2)(iv)(A)	☐ 50.73(a)(2)(x)
☐ 20.2203(a)(2)(iii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(v)(A)	☐ 73.71(a)(4)
☐ 20.2203(a)(2)(iv)	☐ 50.46(a)(3)(ii)	☐ 50.73(a)(2)(v)(B)	☐ 73.71(a)(5)
☐ 20.2203(a)(2)(v)	☐ 50.73(a)(2)(i)(A)	☐ 50.73(a)(2)(v)(C)	☐ OTHER
☐ 20.2203(a)(2)(vi)	☒ 50.73(a)(2)(i)(B)	☐ 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME	TELEPHONE NUMBER *(Include Area Code)*
Fred A. Schill	509 377-2269

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
☐ YES *(If yes, complete 15. EXPECTED SUBMISSION DATE)* ☐ NO				

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.

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

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]