ENERGY NORTHWEST

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September 20, 2012
GO2-12-130

10 CFR 50.73(a)(2)(v)(C)
10 CFR 50.73(a)(2)(v)(D)

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. 2012-003-00

Dear Sir or Madam:

Transmitted herewith is Licensee Event Report No. 2012-003-00 for Columbia Generating Station. This report is submitted pursuant to 10 CFR 50.73(a)(2)(v)(C) and 10 CFR 50.73(a)(2)(v)(D).

There are no commitments being made to the NRC by this letter. If you have any questions or require additional information, please contact Mr. ZK Dunham at (509) 377-4735.

Respectfully,

Plant Manager Acting UPOPS

WG Hettel
Vice President, Operations

Attachment: Licensee Event Report 2012-003-00

cc: NRC Region IV Administrator
NRC NRR Project Manager
NRC Senior Resident Inspector/988C
AJ Rapacz – BPA/1399
WA Horin – Winston & Strawn

IE22
NRR

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION
(10-2010)

APPROVED BY OMB NO. 3150-0104 EXPIRES 10/31/2013

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@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)

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4. TITLE

Secondary Containment Pressure Exceeded During Plant Maintenance

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 05000
07	24	2012	2012	– 003	– 00	09	20	2012	FACILITY NAME	DOCKET NUMBER 05000

9. OPERATING 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)*
Richard M Garcia, Principal Licensing Engineer	(509)377-8463

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

☐ **YES** *(If yes, complete 15. EXPECTED SUBMISSION DATE)* ☒ **NO**

15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR

ABSTRACT *(Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)*

On July 24, 2012, secondary containment pressure exceeded technical specification allowable limits for a period of approximately four and a half minutes. The pressure excursion was due to an inadvertent trip of reactor building fans ROA-FN-1B and REA-FN-1B. The trip occurred during ongoing maintenance on the Standby Gas Treatment (SGT) system. While technical specification limits were exceeded, the resulting pressure excursion was bounded by analytical results, and thus there were no safety consequences for this event. The investigation concluded that there was no direct evidence that a human performance error caused this event. The cause for the event was determined to be that operations does not have guidance on swapping to redundant lineups when work is to be performed on the SGT or reactor building HVAC . Corrective actions will revise standard operating procedures and Instrument Master Data Sheets by adding a note about reactor building fan trip risk.

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Plant Conditions:

At the time of event, the plant was operating in Mode 1 at 100% power. There were no structures, systems or components that were inoperable at the start of the event that contributed to the event. SGT Train B was out of service for planned maintenance and work performed as part of the maintenance contributed to the initiation of this event.

Event Description:

On July 24, 2012, at 11:22, the main control Room received both DIV 1 and DIV 2 RB HVAC board R trouble alarms indicating high secondary containment pressure and that both reactor building fans were off. In response to the alarms, operations started ROA-FN-1A and REA-FN-1A to recover reactor building ventilation. Plant data shows that for approximately 4 and a half minutes the secondary containment vacuum was less than -0.25 inches water vacuum.

The fans were noted to have tripped during maintenance on Standby Gas Treatment (SGT) system with alarms coming in shortly after reconnecting leads to a portion of the SGT system. No deficient maintenance practices were identified however it is possible that the work being performed caused the fans to trip.

This event is reportable as an event that could have prevented fulfillment of a safety function needed to control the release of radiation and mitigate the consequences of an accident per 10CFR50.73(a)(2)(v)(C) and 10CFR50.73(a)(2)(v)(D). An 8 hour event notification (48131) was previously made to the NRC based on meeting the reporting criteria of 10CFR50.72(b)(3)(v)(C) and 10CFR50.72(b)(3)(v)(D).

Extent of Condition:

Extent of condition is limited to the SGT system since it is the only safety related cross divisional system at Columbia. Normal maintenance work control practices ensure operability and functionality is maintained by components out of scope of the division being worked on. The preventive maintenance work orders for both A and B SGT loop calibrations have been revised to provide information that the ROA/REA fans need to be lined up on the correct division to eliminate future trips.

Immediate Corrective Action:

Maintenance planning revised all SGT preventive maintenance tasks, to ensure SGT loop logic and ROA/REA fan trip logic conflicts are clearly defined.

Cause:

The cause of the trip was that work control does not have guidance on swapping to redundant lineups when taking systems out of service.

Operating Experience & Previous Occurrences:

Searches in the INPO database and the Energy Northwest Corrective Action Program were not able to identify related issues or previous occurrences of this event. No specific internal or external related operating experience could be found that related to this issue. As a result of the searches performed there were no missed opportunities identified that could have prevented the event.

Further Corrective Actions:

Operations work control procedures will be revised to ensure that Operations reviews redundant lineups when

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work is to be performed on SGT or Reactor building fan. In addition, the Instrument Master Data Sheet for SGT is being revised to add a note about reactor building fan trip risk. An Operations support task and a note on all maintenance work orders related to SGT/RBHVAC work that will ensure a swap occurs to the alternate ROA/REA fans prior to commencing work are being added.

Assessment of Safety Consequences

This event resulted in an unplanned entry into TS 3.6.4.1 condition A. Secondary containment pressure was more than -0.25 inches water gauge for approximately four and a half minutes. The peak pressure was 0.06 inches water gauge. While the actual pressure is beyond the range allowed by technical specifications, the purpose of maintaining slight vacuum is to assist in drawdown of secondary containment to support accident response of the SGT system. Existing engineering analysis demonstrates that for this event, the drawdown credited in accident response could have been attained using the operational A train of SGT, thus there were no potential safety consequences. There were no actual safety consequences associated with this event since no events involving radiological hazards were experienced during the work activities.

Energy Industry Identification System (EIIS) Information

EIIS codes are bracketed [ ] where applicable in the narrative.