



**Entergy Operations, Inc.**  
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**Rick J. King**  
Director  
Nuclear Safety Assurance

August 15, 2003

U. S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, DC 20555

Subject: Licensee Event Report 50-458 / 03-007-00  
River Bend Station Unit 1  
Docket No. 50-458  
License No. NPF-47

File Nos. G9.5, G9.25.1.3

RBG-46157  
RBF1-03-0154

Ladies and Gentlemen:

In accordance with 10CFR50.73, enclosed is the subject Licensee Event Report.  
Commitments are summarized on the Commitment Identification Form.

Sincerely,

A handwritten signature in cursive script, appearing to read "Rick J. King".

RJK/dhw  
enclosure

IE22

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August 15, 2003  
RBG-46157  
Page 2 of 3

cc: U. S. Nuclear Regulatory Commission  
Region IV  
611 Ryan Plaza Drive, Suite 400  
Arlington, TX 76011

NRC Sr. Resident Inspector  
P. O. Box 1050  
St. Francisville, LA 70775

INPO Records Center  
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Mr. Jim Calloway  
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Mr. Prosanta Chowdhury  
Louisiana Department of Environmental Quality  
Office of Environmental Compliance  
Surveillance Division  
Radiological Emergency Planning & Response Unit  
P.O. Box 4312  
Baton Rouge, LA 70821-4312

Commitment Identification Form

COMMITMENT	ONE-TIME ACTION*	CONTINUING COMPLIANCE*
The procedure for breaker racking will be revised to add a specific requirement to confirm the proper identity of the breaker prior to any racking operations.	X	

\*Check one only

## LICENSEE EVENT REPORT (LER)

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

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 Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NE08-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose 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

River Bend Station Unit 1

## 2. DOCKET NUMBER

05000 458

## 3. PAGE

1 OF 3

## 4. TITLE

High Pressure Core Spray Pump Inadvertently Disabled Due to Personnel Error During  
Installation of Clearance Order

## 5. EVENT DATE

MO DAY YEAR  
06 17 2003

## 6. LER NUMBER

YEAR SEQUENTIAL  
NUMBER  
2003 - 007 - 00

## 7. REPORT DATE

MO DAY YEAR  
08 15 2003

## 8. OTHER FACILITIES INVOLVED

FACILITY NAME DOCKET NUMBER  
05000  
FACILITY NAME DOCKET NUMBER  
050009. OPERATING  
MODE

1

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

10. POWER  
LEVEL

100

20.2201(b)

20.2203(a)(3)(ii)

50.73(a)(2)(ii)(B)

50.73(a)(2)(ix)(A)

20.2201(d)

20.2203(a)(4)

50.73(a)(2)(iii)

50.73(a)(2)(x)

20.2203(a)(1)

50.36(c)(1)(i)(A)

50.73(a)(2)(iv)(A)

73.71(a)(4)

20.2203(a)(2)(i)

50.36(c)(1)(ii)(A)

50.73(a)(2)(v)(A)

73.71(a)(5)

20.2203(a)(2)(ii)

50.36(c)(2)

X

50.73(a)(2)(v)(B)

OTHER

20.2203(a)(2)(iii)

50.46(a)(3)(ii)

50.73(a)(2)(v)(C)

Specify in Abstract below or in

20.2203(a)(2)(iv)

50.73(a)(2)(i)(A)

50.73(a)(2)(v)(D)

NRC Form 366A

20.2203(a)(2)(v)

50.73(a)(2)(i)(B)

50.73(a)(2)(vii)

20.2203(a)(2)(vi)

50.73(a)(2)(i)(C)

50.73(a)(2)(viii)(A)

20.2203(a)(3)(i)

50.73(a)(2)(ii)(A)

50.73(a)(2)(viii)(B)

## 12. LICENSEE CONTACT FOR THIS LER

## NAME

J.W. Leavines, Manager - Licensing

## TELEPHONE NUMBER (Include Area Code)

225-381-4642

## 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 EXPECTED SUBMISSION DATE).

X

NO

15. EXPECTED  
SUBMISSION  
DATE

MONTH

DAY

YEAR

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

On June 17, 2003, at approximately 4:20 p.m., with the plant operating at 100 percent power, the feeder breaker for the high pressure core spray (HPCS) pump was racked out inadvertently during placement of equipment clearance tags. This condition is being reported in accordance with 10CFR50.73(a)(2)(v)(B) as a condition that could have prevented the fulfillment of the safety function of the HPCS system. Actions were immediately taken to restore the pump to its standby configuration. The HPCS pump was inoperable for approximately 16 minutes. All other emergency core cooling systems were operable during this event. Thus, this event was of minimal significance to the health and safety of the public.

LICENSEE EVENT REPORT (LER)  
FAILURE CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
River Bend Station Unit 1	05000-458	2003	- 007	- 00	2 OF 3

## REPORTED CONDITION

On June 17, 2003, at approximately 4:20 p.m., with the plant operating at 100 percent power, the feeder breaker (\*\*BKR\*\*) for the high pressure core spray (HPCS) (BG) pump was racked out inadvertently during placement of equipment clearance tags. This condition is being reported in accordance with 10CFR50.73(a)(2)(v)(B) as a condition that could have prevented the fulfillment of the safety function of the HPCS system.

## INVESTIGATION AND IMMEDIATE CORRECTIVE ACTIONS

At the time of the event, an equipment clearance order was being implemented to remove the Division 3 standby service water pump (SWP-P2C) from service for maintenance. The feeder breakers for the HPCS pump (\*\*P\*\*) and SWP-P2C are both in the Division 3 4160 volt switchgear, separated by one cabinet.

Two Operators performed a preparatory walkdown for the job, and found that additional personal protective equipment was needed. The equipment was retrieved from a different building in the plant. When the Operator later donned the required equipment to proceed with the task, he did not use self-checking and peer-checking techniques to assure he was at the correct breaker. He opened the breaker cabinet door and proceeded to rack the HPCS pump breaker out, which disabled the pump. An alarm simultaneously actuated in the main control room indicating trouble with the HPCS pump, and actions were immediately taken to restore the pump to service. The HPCS pump was restored to an operable status after approximately 16 minutes.

## CAUSAL ANALYSIS

When the Operator completed preparations to rack out the breaker, he turned to the cabinet door and opened it without self-checking the information on the clearance tag to the label on the door. Also, the second Operator did not provide a "peer check" to verify and assure the proper equipment and manipulations. With the cabinet opened, there is no HPCS system labeling inside to uniquely identify the breaker or the load it serves.

A pre-job brief for this task had been conducted by senior personnel in the work management center, and included a discussion of human performance and error avoidance techniques. After the event, both the Operators assigned to the task stated they left the briefing with a clear understanding of the job. They knew of no reason for failing to carry out all the techniques discussed in the briefing.

**LICENSEE EVENT REPORT (LER)**  
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**CORRECTIVE ACTIONS TO PREVENT RECURRENCE**

Following the event, the clearance tagging qualifications for the Operators were removed. The Operators have since completed a remediation plan to restore their clearance tagging qualification. Operations management conducted stand-down briefings with all shift crews to reinforce the use of human performance tools and techniques.

The procedure for breaker racking will be revised to add a specific requirement to confirm the proper identity of the breaker prior to any racking operations.

**PREVIOUS OCCURRENCE EVALUATION**

A review of reportable events at River Bend since January 2000 found no occurrences of safety systems having been inadvertently disabled due to component misidentification.

**SAFETY SIGNIFICANCE**

The HPCS pump was inoperable for approximately 16 minutes. All other emergency core cooling systems were operable during this event. Thus, this event was of minimal significance to the health and safety of the public.

(NOTE: Energy Industry Component Identification codes are annotated as (\*\*XX\*\*).)