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Eric W. Olson Site Vice President

RBG-47545

February 19, 2015

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

Subject: Licensee Event Report 50-458 / 2014-006-00 River Bend Station – Unit 1 Docket No. 50-458 License No. NPF-47

RBF1-15-0136

Dear Sir or Madam:

In accordance with 10 CFR 50.73, enclosed is the subject Licensee Event Report. This document contains no commitments. If you have any questions, please contact Mr. Joseph Clark at 225-381-4177.

Sincerely,

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EWO/dhw

Enclosure

LE22 NKK

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cc: U. S. Nuclear Regulatory Commission Region IV 1600 East Lamar Blvd. Arlington, TX 76011-4511

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

INPO (via ICES reporting)

Central Records Clerk Public Utility Commission of Texas 1701 N. Congress Ave. Austin, TX 78711-3326

Department of Environmental Quality Office of Environmental Compliance Radiological Emergency Planning and Response Section Ji Young Wiley P.O. Box 4312 Baton Rouge, LA 70821-4312

NRC FO (02-2014)	RM 366		U.S. N	UCLE/	AR REG	ULATOF	RY COMM	IISSION	APPROV	ED BY OMB: NO.	3150-0104		E	XPIRES:	01/31/2017	
LICENSEE EVENT REPORT (LER) (See Page 2 for required number of digits/characters for each block)								iR)	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 and Information Collections Branch (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.							
1. FACIL		ME							2. DOC	KET NUMBER		3. P/	AGE			
River Bend Station - Unit 1						05000	05000 458 1 OF 4					4				
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NRC FORM 366A (02-2014)	U.S. NUCLEAR REGULA CENSEE EVENT RE CONTINUATION	PORT (LER)	APPROVED BY OMB: NO. 3150-0104 EXPIRES: 0 Estimated burden per response to comply with this mandatory collection request Reported lessons learned are incorporated into the licensing process and fed back Send comments regarding burden estimate to the FOIA, Privacy and Information Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555- internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of and Regulatory Affairs, NEOB-10202, (3150-0104). Office of Management an Washington, DC 20503. If a means used to impose an information collection does n currently valid OMB control number, the NRC may not conduct or sponsor, and a pur required to respond to, the information collection.						uest: 80 hours. back to industry. ation Collections 555-0001, or by e of Information nt and Budget, es not display a
1. FACIL		2. DOCKET		6. LER NUMB	BER			3. PAGE	
River Bend Station - Unit	: 1	05000 458	YEAR 2014	SEQUENTIA NUMBER		REV NO.	2	OF	4
event resulted from the lo existing half-scram on Di Approximately four minu pump (**SJ**) to trip. A feedwater pump "C," but reactor water level decrea automatic control, the val was put back into service in a second scram signal. This event is being report primary containment isol INVESTIGATION and II The Division 1 half-scram failure of an instrumentat significant aspects of the Loss of Division 2 RPS E Power was lost when the cause of the output break replaced, and the MG wa remain in service carrying recurrence of this probler Misoperation of the Start The operation of the start operator's manual input. "automatic" function of t normal, and this was con Additionally, Engineering and its control logic are d the closed position, there	at 0836 CST, a reactor scram pass of power on the Division ivision 1. The loss of Division intes after the scram, reactor as reactor water level decreas its supply breaker failed to ased to the point at which the leve failed to open. Attempts by that time, reactor wate ted in accordance with 10 C ation logic (**JM**). MMEDIATE ACTIONS in had been inserted two day tion channel on the no. 2 material event, as follows: Bus output breaker on the RPS is a tested and returned to a star g the bus until completion of n.	a 2 reactor protection ion 2 RPS power als water level increase used back through th close. Main feedwater is sto open it with a m er level had decrease FR 50.73(a)(2)(iv)(. 's prior to the event, ain turbine control van motor-generator (Mu ailure of the MG fiel andby condition as a of a modification to of o determine why it w iscovered a failed ci- correctly in the post- ableshooting.	<ul> <li>a system ( o resulted</li> <li>d to the Lie</li> <li>e normal of ter pump</li> <li>regulating</li> <li>anual inpud</li> <li>d slightly</li> <li>A) as an a</li> <li>in compliance</li> <li>in compliance</li> <li>a) in the I</li> <li>d flash can</li> <li>backup p</li> <li>d flash can</li> <li>backup p</li> <li>d flash can</li> <li>card scram env</li> <li>the valve</li> <li>the valve</li> <li>the valve</li> </ul>	RPS) (**JD in a Divisio evel 8 setpoi operating rar "A" was sub valve (FRV at signal wer below the L utomatic act ance with Te ns were form Division 2 sur rd due to a d ower supply he field flash onsive to eit in the "manu- ironment on was consisted hen the valv	**) b on 2 c int, cange, c bsequ () sho re uns evel uatio uatio echni med t ubsys degra /. Th h card ther thual" s ince rec ow a	us, in c containing ausing t operator lently re- build hav success: 3 RPS a n of the ical Spe o invest tem trip ded cap e altern d as a p he autor side of t eactor w tith its d	onjunction ment isola the runnin rs attemp eturned to ve opened ful, and the actuation e RPS system cification tigate the oped. The pacitor. The pacitor. The pacitor. The pacitor is system the value vater leve	on with a ation sign ing main fi- ted to re-so o service. I to establi- he "C" m setpoint, stem and the is, follow e separate e mostly the capac er supply source of atroller or controlle I had retu teria. The 'open" sig	pre- al. eedwater start main As lish ain FRV resulting the the likely itor was will the r. The rned to e valve gnal from

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## LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

U.S. NUCLEAR REGULATORY COMMISSION

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#### NARRATIVE

The procedural guidance to isolate the main FRVs and use the startup FRV in a scram recovery was developed in 2010 to mitigate the effects of any seat leakage through the main FRVs. At that time, Operations developed the procedure change and validated its feasibility in the training simulator. However, no cross-discipline review by Engineering was requested. The investigation of December 25 event found that the simulator model does not accurately reflect the actual operating characteristics of the startup FRV, in that the simulated performance of the valve is more responsive than the actual valve. An Engineering review could have brought the actual operating characteristics to light. This factor, in conjunction with the simulator performance, reinforced the concept that the startup FRV was capable of controlling reactor water level in the post-scram transient condition.

Malfunction of Main Feedwater Pump "C"

The failure of main feedwater pump "C" was found to have been was caused by an "over-racked" condition of its supply breaker (that is, the breaker racking mechanism had slightly over-travelled the last time the breaker was returned to service). This caused the limit switches that detect the position of the breaker mechanism within the cabinet to give the control logic circuit a false indication that the breaker was not connected to the bus. Interim instructions have been implemented to have electricians verify the condition of all similar breakers each time they are racked in.

### CORRECTIVE ACTION TO PREVENT RECURRENCE

The following corrective actions are planned, and will be tracked and documented in the corrective action program:

Loss of Division 2 RPS Bus

A design modification will be installed to eliminate the potential for a failure in the field flash card to affect the operation of the MG set once it is loaded.

Misoperation of the Startup FRV

Operating procedures have been revised to direct that, in the scram recovery environment, one of the main FRVs will remain in service. The startup FRV is not to be used in that condition.

The main FRVs are on the schedule of work items for the upcoming refueling outage. Valve seat leakage is one of the deficiencies to be addressed.

Malfunction of "C" Main Feedwater Pump

Guidance on racking the main feedwater pump breakers (and those of similar design) will be incorporated into the pertinent operating procedures.

Additionally, the deficiency that necessitated the insertion of the Division 1 half-scam on December 23 was corrected prior to plant startup.

#### PREVIOUS OCCURRENCE EVALUATION

River Bend Station previously reported an event that occurred on December 6, 2014, in which the Division 2 RPS bus de-energized unexpectedly. That condition resulted in a Division 2 containment isolation and a half-scram. The investigation did not conclusively determine the cause of the trip of the Division 2 RPS motor-generator (MG) output breaker, which initiated the event. Repairs were made to the MG control circuits to address the most likely causes of the trip, and the MG was load tested for approximately 30 hours prior to being placed back into service. It was postulated that another intermittent failure was occurring in the field flash

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#### NARRATIVE

circuit card, and a design modification is being developed to mitigate that failure, but that remains a future activity. As described above, the source of the MG output breaker trip on December 25 has not been conclusively identified, so it is not certain whether the corrective actions for the December 6 event should have precluded the December 25 event.

### SAFETY SIGNIFICANCE

No plant parameters requiring the actuation of any standby diesel generators or the emergency core cooling systems were exceeded. No reactor safety-relief valves actuated. All reactor control rods properly inserted at the scram signal. This event was, thus, of minimal significance to the health and safety of the public.

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