



GULF STATES UTILITIES COMPANY

RIVER BEND STATION POST OFFICE BOX 220 ST. FRANCISVILLE, LOUISIANA 70775

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April 29, 1991
RBG- 34,910
File Nos. G9.5, G9.25.1.3

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

Gentlemen:

River Bend Station - Unit 1
Docket No. 50-458

Please find enclosed Licensee Event Report No. 91-006 for River Bend Station - Unit 1. This report is submitted pursuant to 10CFR50.73.

Sincerely,

W. H. Odell
Manager - Oversight
River Bend Nuclear Group

Mr. [unclear] [unclear] [unclear]
FAE/PDG/GAB/DCH/RCL/pj

cc: U.S. Nuclear Regulatory Commission
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 HRS. FORWARD CLAIMS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) RIVER BEND STATION										DOCKET NUMBER (2) 0 5 0 0 0 4 5 8 1 OF 0 3										PAGE (3) 3	
TITLE (4) PERSONNEL FAILURE TO REPLACE HIGH RADIATION AREA BARRIER																					
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					DOCKET NUMBERS							
04	01	91	191	006	000	04	29	91						0 5 0 0 0							
OPERATING MODE (9) 1			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																		
POWER LEVEL (10) 1,900			20.402(b)				20.406(e)				50.73(a)(2)(iv)				73.71(b)						
			20.406(a)(1)(i)				50.36(a)(1)				50.73(a)(2)(v)				73.71(c)						
			20.406(a)(1)(ii)				50.36(a)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
			20.406(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(viii)(A)										
			20.406(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)										
			20.406(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)										
LICENSEE CONTACT FOR THIS LER (12)												TELEPHONE NUMBER									
NAME L. A. England, Director - Nuclear Licensing												AREA CODE 5 0 4 3 8 1 - 4 1 4 5									
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																					
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC								CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC					
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)				MONTH	DAY	YEAR			
YES (If yes, complete EXPECTED SUBMISSION DATE)												X NO									

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1530 hours on 4/1/91 with the reactor in Operational Condition 1 (Power Operation) an operations engineering cooperative student, having about 3 months of experience, failed to replace a high radiation area (HRA) rope barricade. The rope was located at the doorway between the residual heat removal (RHR) 'A' pump room and the low pressure core spray (LPCS) pump room. The event occurred during valve operability surveillance testing. Technical Specification (TS) 6.12.1 requires that high radiation areas be barricaded. This report is submitted pursuant to 10CFR50.73(a)(2)(i)(B) as operation prohibited by the Technical Specifications.

As an interim measure, a standing order was issued to all operations personnel to require permission of the Shift Supervisor/Control Operating Foreman and escort by radiation protection personnel prior to entry into high radiation areas and very high radiation areas. These requirements are in addition to those in the Technical Specifications.

During the period that the barrier was down, no unauthorized personnel entered the HRA. Therefore, this event did not have an adverse impact on the safe operation of River Bend Station or the health and safety of the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

EXPIRES 8/31/88

FACILITY NAME (1) RIVER BEND STATION	DOCKET NUMBER (2) 0 5 0 0 0 4 5 8	LER NUMBER (8)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 1	0 0 6	0 0 0	2 OF	0 3	

TEXT (if more space is required, use additional NRC Form 305A's) (17)

REPORTED CONDITION

At 1530 hours on 4/1/91 with the reactor in Operational Condition 1 (Power Operation) an operations engineering cooperative student having about three months of experience, failed to replace a high radiation area (HRA) rope barricade. The rope was located at the doorway between the residual heat removal (RHR) 'A' pump room and the low pressure core spray (LPCS) pump room. Technical Specification (TS) 6.12.1 requires that high radiation areas be barricaded. This report is submitted pursuant to 10CFR50.73(a)(2)(i)(B) as operation prohibited by the Technical Specifications.

INVESTIGATION

During the performance of a valve operability surveillance test, the cooperative student was acting as a communicator at the doorway between the two pump rooms to relay instructions on valve positioning to one operator, while another operator monitored flow rates. This required passing through the rope barricade at frequent intervals. After 5 to 6 trips through the barricade, the cooperative student placed the rope on a hook leaving the doorway unsecured. At the completion of the test, the cooperative student closed the watertight door between the two pump rooms, but failed to replace the rope barricade. During an end-of-shift HRA barrier inspection, radiation protection (RP) personnel discovered the unsecured barricade and took the appropriate actions to secure the high radiation area.

The root cause of this event was personnel error in that the personnel involved failed to replace the HRA barrier rope. In addition, a contributing factor was that there was a lack of clear direction to the operators and the cooperative student concerning their interface.

A review of previous LERs has identified two previous reports concerning the improper restoration of radiation area barriers. LER 90-010 reported an event in which an operator entered an HRA after placing a rope barricade to one side, and left the barricade in that condition while in the HRA. LER 90-042 reported five instances in which Technical Specification required radiation area barriers were not properly secured. These incidents resulted in the formation of a task force and the implementation of several corrective actions to address radiation protection barrier issues. These corrective actions were provided in Revision 2 to LER 90-042.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) RIVER BEND STATION	DOCKET NUMBER (2) 0 5 0 0 0 4 5 8	LER NUMBER (6)			PAGE (3)		
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TEXT (if more space is required, use additional NRC Form 305A's) (17)

CORRECTIVE ACTION

As interim corrective action, a standing order was issued to all operations personnel to require permission of the Shift Supervisor/Control Operating Foreman and escort by radiation protection personnel prior to entry into high radiation areas and very high radiation areas. These requirements are in addition to those in the Technical Specifications.

Counseling was provided for the three individuals involved. In the future, the following additional actions will be taken:

- . Emphasis on task accountability including self checking and the team concept within the Operations Department.
- . Improvement in the definition of the interface between operations engineering cooperative students and other plant staff personnel.
- . Reinforcement of plant staff standards and expectations for operations personnel.
- . New procedural requirements to replace high radiation entrance barriers immediately upon each passage through the barrier or pass the barrier hand-to-hand during multiple entries.

Note that the particular radiation barrier in this case is to be modified under Modification Request (MR) 91-0005. This modification is to relocate the rope barrier to a permanent fixture. This MR was initiated as corrective action for prior radiation area boundary problems.

SAFETY ASSESSMENT

During the testing process, test personnel were within 2-3 feet of the HRA entrance and no other personnel entered the HRA. Security records for entries into the auxiliary building were reviewed for the period between the completion of the test and the time of discovery of the unsecured rope barrier. During this time, only the radiation protection personnel who discovered the misplaced barrier entered the high radiation area. The cooperative student left the area at about 1530. During an end-of-shift HRA inspection, the unsecured barrier was discovered at 1628. Note that this inspection activity was a part of GSU's corrective action for past HRA boundary problems. Based on these considerations, the operational impact of this event was insignificant and the health and safety of the public were not adversely affected.