GULF STATES UTILITIES COMPANY

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

AREA CODE 504 635 6094 346 8651

July 12, 1991
RBG- 35310
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 Supplement 1 to Licensee Event Report No. 90-023 for River Bend Station - Unit 1. This supplemental report is submitted to provide a status on the corrective action for this event.

Sincerely,

J. W. Leavines for

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

LAE/PDG/GAB/DCH/kvm

cc: U.S. Nuclear Regulatory Commission
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NRC FORM 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104

EXPIRES: 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS 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)	DOCKET NUMBER (2)	PAGE (3)
RIVER BEND STATION	0 5 0 0 0 4 5 8	1 OF 0 3

TITLE (4): Standby Gas Treatment and Annulus Mixing Systems not Initiated due to Failed Radiation Monitor Sample Pump and Flow Switch

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 NUMBER(S)
0 5	2 3	9 0	9 0	0 2 3	0 1					0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

	20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)
	20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
	20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
	20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

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 approximately 0730 on 05/23/90, with the plant at 100 percent power (Operational Condition 1), the Auxiliary Building Operator discovered that the annulus ventilation radiation monitor, 1RMS*RE11A was inoperative. The operator reported this discovery to control room personnel who observed that the control room indication of 1RMS*RE11A erroneously indicated that it was operable. Following this discovery, the operating logs were reviewed and it was determined that the annulus mixing and standby gas treatment (SGTS) systems had not been initiated within the time period (1 hour) required by Technical Specification (TS) 3.3.2, table 3.3.2.1-1.2.d, action 29. Therefore, this report is submitted pursuant to 10CFR50.73(a)(2)(i)(b) as operation prohibited by the Technical Specifications.

The root cause of this event was the failure of the radiation monitor sample pump and the failure of the sample pump flow switch to actuate. The failure of the flow switch denied the control room operators the indication needed to confirm the operability status of the sample pump.

During the period of time that 1RMS*RE11A was out of service, a redundant radiation monitor was available. Therefore, this event did not adversely affect the health and safety of the public.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

REPORTED CONDITION

At approximately 0730 on 05/23/90 with the plant at 100 percent power (Operational Condition 1), the Auxiliary Building Operator discovered that the annulus ventilation radiation monitor (*RA*) 1RMS*RE11A was inoperative. The Operator reported this discovery to control room personnel who observed that control room indication of 1RMS*RE11A erroneously indicated that it was operable. This was due to the failure of the sample pump flow switch (*FIS*) to actuate. The erroneous indication was corrected when an operator tapped the sample pump flow switch. Following the discovery of the erroneous control room indication, the operating logs were reviewed. This review showed that 1RMS*RE11A was last operable on 05/20/90. Log entries for 05/21/90 and 05/22/90 indicated that the instrument was inoperable, according to local indication. Technical Specification 3.3.2, table 3.3.2.1-1.3.d, action 29 requires that the annulus mixing and standby gas treatment (SGTS) (*BH*) systems be started within one hour of the failure of 1RMS*RE11A. Therefore, this report is submitted pursuant to 10CFR50.73(a)(2)(i)(b) as operation prohibited by the Technical Specifications.

INVESTIGATION

The investigation revealed three conditions which contributed to the failure to implement the TS actions. First, the flow switch failed to actuate, resulting in the erroneous reading in the control room. Second, two Operators, one on each of two separate days, 05/21/90 and 05/22/90, did not notify the Unit Operator or Control Operating Foreman (COF) upon detection of the off-normal readings. Third, the off-normal readings which were recorded and circled in red on the logs by the Operators, were not noticed by the COFs who reviewed the logs. Note that review by the COF usually occurs late in the shift, approximately 8 to 10 hours after the equipment is checked. Therefore, it is not likely that review by the COFs would have prevented this event. However, if either COF had identified the inoperable equipment, the duration of the non-compliance with the TS could have been shortened.

The root cause of this event was the failure of the radiation monitor sample pump and the failure of the sample pump flow switch to actuate. The failure of the flow switch denied the control room operators the indication needed to confirm the operability status of the sample pump.

A similar event involving different radiation monitors was reported in LER 85-015. In this case the sample pumps for both of the control room ventilation local intake radiation monitors (*RA*) (1RMS*RE13A&B) tripped due to an electrical transient. Technical Specification table

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

3/4.3.7.1-1.1.a requires the initiation of the control room ventilation system (*VI*) in its emergency mode within one hour of the loss of the minimum number of channels required for operability of the radiation monitors. In this event both sample pumps remained off for about 17 hours.

The subject event of this LER bears a superficial similarity to two additional LERs, 88-013 and 88-028. In both events, the operator did not recognize the requirement to initiate the annulus mixing and standby gas treatment (SGTS) (*BH*) systems as required by TS 3.3.2. This LER, while addressing the same TS requirement has a different root cause. In this case, the Unit Operator never had an opportunity to enter the action statement because he was not aware of the inoperable status of the radiation monitor.

CORRECTIVE ACTION

The Operation Section Procedure, OSP-012, "Daily Log Report", has been revised to identify important plant equipment with an asterisk. If an out of specification or off-normal reading is noted, the Operator is required to immediately contact the COF.

Modifications to address Technical Specification - related monitor operability are not warranted at this time. A modification request (MR) 88-0293 has been initiated and may be considered in the future should an enhancement be warranted.

SAFETY ASSESSMENT

During the period of time that 1RMS*RE11A was out of service, a redundant radiation monitor was available. Therefore, this event did not adversely affect the health and safety of the public.

NOTE: Energy Industry Identification System Codes are identified in the text as (*XX*).