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James J. Fisicaro
Director
Nuclear Safety

February 12, 1996

U.S. Nuclear Regulatory Commission
Document Control Desk
Mail Stop P1-37
Washington, D.C. 20555

Subject: River Bend Station - Unit 1
Docket No. 50-458
License No. NPF-47
Licensee Event Report 50-458/96-004-00
File Nos. G9.5, G9.25.1.3

RBG-42379
RBF1-96-0026

Gentlemen:

In accordance with 10CFR50.73, enclosed is the subject report.

Sincerely,

JJF/JHM/kvm
enclosure

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Licensee Event Report 50-458/96-004-00
February 12, 1996
RBG-42379
RBF1-96-0026
Page 2 of 2

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

NRC Sr. Resident Inspector
P. O. Box 1051
St. Francisville, LA 70775

INPO Records Center
700 Galleria Parkway
Atlanta, GA 30339-3064

Mr. C. R. Oberg
Public Utility Commission of Texas
7800 Shoal Creek Blvd., Suite 400 North
Austin, TX 78757

Louisiana Department of Environmental Quality
Radiation Protection Division
P.O. Box 82135
Baton Rouge, LA 70884-2135
ATTN: Administrator

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: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO
THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING
BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (IT-6 F33),
U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, 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)

05000-458

PAGE (3)

1 OF 3

TITLE (4)

CONTAINMENT ISOLATION OF VARIOUS BALANCE OF PLANT (BOP) VALVES DUE TO INATTENTION TO DETAIL
(HUMAN ERROR)

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 NAME	DOCKET NUMBER
1	15	96	96	-- 004	-- 00	2	12	96	NA	NA
									FACILITY NAME	DOCKET NUMBER
									NA	NA
									FACILITY NAME	DOCKET NUMBER
									NA	NA

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
5		20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
	-0-	20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	X 50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME

David Lorring-Supervisor, Licensing

TELEPHONE NUMBER (Include Area Code)

(504) 381-4157

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)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO	EXPECTED SUBMISSION	MONTH	DAY	YEAR

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

At 0908 CST on January 15, 1996, with the plant in Refueling (Mode 5), a containment isolation of various balance-of-plant (BOP) valves occurred when logic test switches were (incorrectly) moved to the "Test" position during prerequisite steps being performed for surveillance test procedure, "Containment & Drywell Manual Isolation Actuation 18 Month LSFT & Channel Functional Test." A lead instrumentation & control (I&C) technician should have read a prerequisite step to say: "Verify the following switches are in the 'Norm' position." Instead, the lead I&C technician misread the step and conveyed to the nuclear control operator "Verify the following switches are in the 'Test' position." The root cause of the event was that the lead I&C technician demonstrated inattention to detail and inadequate self-checking during the performance of the surveillance test procedure. The lead I&C technician has been counseled and assigned to less critical work for the remainder of the Refueling Outage 6 (RF-6). The plant was undergoing core alterations with reactor water level greater than 23 feet above reactor pressure vessel flange. All systems isolated as designed. Shutdown cooling was unaffected. This event, therefore, was of minimal safety significance. An earlier licensee event report (LER) describes a similar event whereby a Division I balance of plant containment isolation signal was generated during replacement of a relay base. The signal resulted in closure of several containment isolation valves in various systems. The root cause of that event, however, differed from the current event being reported.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
RIVER BEND STATION	05000-458	96	-- 004 --	00	2 OF 3

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

REPORTED CONDITION:

At 0908 CST on January 15, 1996, with the plant in Refueling (Mode 5), a containment isolation of various balance-of-plant (BOP) valves occurred when logic test switches in multiple divisions were (incorrectly) moved to the "Test" position during prerequisite steps being performed for surveillance test procedure STP-058-4201, "Containment & Drywell Manual Isolation Actuation 18 Month LSFT & Channel Functional Test." The STP was being performed as a functional retest for a preventative maintenance task to replace an isolation relay. The containment isolation constitutes an engineered safety feature (ESF) actuation and is being reported pursuant 10CFR50.73 (a)(2)(iv).

INVESTIGATION:

It was determined that while performing the applicable portions of STP-058-4201 as a functional retest following installation of an isolation relay, the lead I&C technician requested a nuclear control operator (NCO) to change switch positions from "Norm" to "Test" for 16 key-lock switches. The NCO, having received the request, inserted the keys one at a time and operated the back panel switches one after the other until the isolations occurred.

The lead I&C technician informed the NCO in the main control room that STP-058-4201 needed to be partially performed to complete post maintenance testing. The lead I&C technician while preparing to perform the prerequisite step should have read "Verify the following switches are in the 'Norm' position." Instead, the lead I&C technician misread and conveyed to the NCO "Verify the following switches are in the 'Test' position."

The lead I&C technician and the NCO proceeded to implement the prerequisite step by placing the switches one-by-one in the "Test" position. They advanced through the steps of the procedure to the point that the isolation logic was completed and the isolation occurred. The lead I&C technician again reviewed the STP, reread the step and realized his error. The procedure was halted and the test switches were returned to their "Norm" position.

The procedure step was examined and determined to be accurate and otherwise acceptable. The prerequisite section of the procedure is structured to ensure that the four channels are in the normal position prior to beginning the STP steps, thereby minimizing the possibility of an inadvertent isolation. Following the prerequisite section, the procedure section has the test switches placed in the test position, then restored to normal for each channel in the procedure body. This feature of the procedure, however, did not prevent the lead I&C technician from misreading the step and the resultant incorrect action from being performed.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
RIVER BEND STATION	05000-458	96	-- 004	-- 00	3 OF 3

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

ROOT CAUSE:

The root cause of the event was inattention to detail on the part of the lead I&C technician when he failed to correctly read the procedure. He failed to self-check himself and consequently, the NCO was provided incorrect instructions.

A review of recent licensee event reports (LERs) indicated a similar event was reported in LER 94-014 dated July 5, 1994. LER 94-014 describes a Division I balance of plant containment isolation signal that was generated during replacement of the base of a relay, resulting in the closure of several containment isolation valves in various systems. The root cause of the earlier event differs from this LER in that an inadequate review of the job plan resulted in the human error occurring.

CORRECTIVE ACTIONS:Short Term

The lead I&C technician has been counseled and was removed from surveillance testing activities for the remainder of Refueling Outage (RF-6). The lead I&C technician was counseled on the requirements for performing procedures exactly as written, and the necessity of attention to detail when performing test procedures. Other I&C technicians were informed of the details of the event in a shop meeting on January 15, 1996.

Long Term

This event is being reviewed with Operations personnel to reinforce the need to maintain a questioning attitude and self-checking.

SAFETY ASSESSMENT:

The plant was in a refueling outage, undergoing core alterations with reactor water level greater than 23 feet above reactor pressure vessel flange. During the event, all systems isolated as designed. Residual heat removal (*BO*) pump "B" was in upper fuel pool cooling assist mode for shutdown cooling, and was unaffected. This event, therefore, was of minimal safety significance.

Note: Energy Industry Identification Codes are indicated in the text as (*XX*)