

Entergy Operations, Inc.
River Bend Station
5485 U. S. Highway 61
P.O. Box 220
St. Francisville, LA 70775
Tel 504 336 6225
Fax 504 635 5068

Rick J. King
Director
Nuclear Safety & Regulatory Affairs

November 27, 1996

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

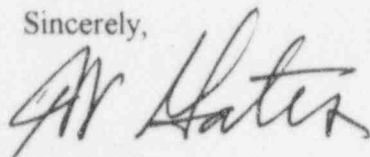
Subject: River Bend Station - Unit 1
Docket No. 50-458
License No. NPF-47
Licensee Event Report 50-458/96-015-00
File Nos. G9.5, G9.25.1.3

RBG-43500
RBF1-96-0434

Ladies and Gentlemen:

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

Sincerely,

 FOR RJK
RJK/JPO/kvm
enclosure

060032

IE221

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PDR ADQCK 05000458
S PDR

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RBG-43500
RBF1-96-0434
Page 2 of 2

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
700 Galleria Parkway
Atlanta, GA 30339-3064

Mr. G. Dishong
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

NRC FORM 366 (5-92)				U.S. NUCLEAR REGULATORY COMMISSION				APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95			
LICENSEE EVENT REPORT (LER)								ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MN88 7714), 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) 01 of 03	
TITLE (4) Inadvertent Bumping of Recently Installed Power Supply Fuse Resulting in Isolation Valve Closure											
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	
10	30	96	96	015	00	11	27	96	N/A	05000	
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more (11))								
1			20.402(b)			20.405(c)			x		50.73(a)(2)(iv)
POWER LEVEL (10)			20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)		73.71(b)
100			20.405(a)(1)(ii)			50.36(c)(2)			50.73(a)(2)(vii)		73.71(c)
			20.405(a)(1)(iii)			50.73(a)(2)(i)			50.73(a)(2)(viii)(A)		(Specify in abstract below and in text, NRC Form 366A)
			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 David Lorfing, Supervisor - Nuclear 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 NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		
SUPPLEMENTAL REPORT EXPECTED (14)						EXPECTED SUBMISSION DATE (15)		MONTH		DAY	
YES (If yes, complete EXPECTED SUBMISSION DATE)				X NO							
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16) <p>On October 30, 1996 at 0149, with the reactor in Operational Condition 1 (Power Operation) at 100 percent power, a Division 1 Reactor Core Isolation Cooling (RCIC) system isolation of a containment penetration isolation valve occurred when an I&C technician inadvertently bumped the fuse holder for an inverter/power supply (E21A-PS1) with his knee while performing a surveillance procedure. This event is reportable as an engineered safety feature actuation pursuant 10CFR50.73(a)(2)(iv).</p> <p>The root cause was determined to be that the risks and consequences associated with depressing the surface-mounted fuse holder cap on the new power supply installed during a recent outage were not identified or considered in the change process.</p> <p>The corrective actions included adding caution labels, informing appropriate people of the need for caution when working around this component and a walkdown of other control room cabinets to identify similarly installed fuse holders.</p> <p>Upon receipt of the trip signal, the RCIC system isolated as designed. Plant personnel verified the high pressure core spray system (HPCS) was operable and available at the time of the occurrence. This isolation did not compromise the ability of the plant to mitigate the consequences of an accident.</p>											

NRC FORM 366A (5-92)	U. S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/96	
<p align="center">LICENSEE EVENT REPORT (LER) TEXT CONTINUATION</p>		<p>ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MN88 7714), 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</p>	
		FACILITY NAME (1) River Bend Station	DOCKET NUMBER (2) 05000-458

Reported Conditions:

At 0149 on 10/30/96, with the plant at 100% power, steady state operations, a Division 1 Reactor Core Isolation Cooling (RCIC) (*BN*) system isolation of a containment penetration isolation valve occurred when a technician inadvertently bumped the fuse holder for inverter/power supply E21A-PS1 with his knee while performing a surveillance procedure. This event is reportable as an engineered safety feature actuation (ESF) pursuant to 10CFR50.73(a)(2)(iv).

Investigation:

E21A-PS1 is located in a main control room panel. The fuse holder is surface mounted through a hole in the power supply face plate and is located approximately 17 inches above the floor. While restoring from performance of a Surveillance Test Procedure (STP), the technician turned toward panel H13-P629 to get out of a chair and inadvertently depressed the fuse holder on the inverter/power supply with his knee, causing a momentary loss of power to numerous trip units which resulted in a Division 1 RCIC isolation.

While seismic requirements were appropriately met, continuity across the fuse holder terminals was repeatedly broken when the fuse cap was depressed during testing after the isolation.

The floor area beneath E21A-PS1 is marked with black/yellow barrier tape, which was previously installed to heighten awareness to sensitive relays which are also located on H13-P629, Bay A (above the location of the inverter/power supply). During an investigation interview, the I&C technician indicated that he was aware of the caution tape while performing the STP. He knew that the tape was to make personnel aware of the sensitive relays on the cabinet. He had taken precautions to ensure that the chair and the table on which he placed his test instruments were not within the caution tape boundary.

Investigation revealed four other similar inverter/power supply installations on which a similar style fuse holder is surface mounted. These inverter/power supplies were installed under a modification request (MR) during Refueling Outage 6 in January, 1996. The previous inverter/power supplies had internally mounted fuse blocks.

Root Cause:

Change Management -- The risks and consequences associated with depressing the surface-mounted fuse holder cap on the new power supply installed during a recent outage were not identified or considered in the change process. The location/placement of the fuse makes it vulnerable to being inadvertently depressed.

Three previous RCIC isolations were identified over the last two years. Two of the previous events were due to equipment issues and one was most probably linked to work with test leads on the inside of the panel. The event described in this report involves the bumping of a recently installed fuse on the exterior of the panel.

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Corrective Actions:

Immediate Corrective Actions:

The RCIC system was returned to its standby configuration at 0328 on 10/30/96. Caution labels have been attached to the panels warning of the sensitive fuses. The need for a high level of awareness when working near control room panels was discussed with the technician involved.

Long Term Corrective Actions:

Appropriate plant staff are being informed of the need for caution when working near similar fuse holders. A solution to prevent the subject fuse holders on effected power supplies from being inadvertently bumped by personnel or equipment will be evaluated.

Corrective Actions addressing Generic Concerns

A walk down was performed of Main Control Room cabinets, the Auxiliary Control Room cabinets, and the Division 1 & 2 remote shutdown panels. Four other inverter/power supplies also installed during the same period have surface mounted fuse holders that are susceptible to inadvertent contact such as bumping. Corrective actions for these components will be performed in a similar manner as for E21A-PS1. No other similar of fuseholders were identified.

An evaluation of the plant's response to potential bumping hazards will be conducted.

Safety Significance:

Upon receipt of the invalid trip signal, the RCIC system isolated as designed. Plant personnel verified the high pressure core spray system (HPCS) (*BG*) was operable and available at the time of the occurrence. This isolation did not compromise the ability of the plant to mitigate the consequences of an accident. No structures, systems, or components were inoperable at the start of the event that contributed to the event. The health and safety of the public was not compromised at any time during this event.

Note : Energy Industry Identification codes are identified in the text as (*XX*)