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Rick J. King
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February 22, 2000

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

Subject: River Bend Station
Docket No. 50-458
License No. NPF-47
Licensee Event Report 50-458 / 00-001-00

File Nos. G9.5, G9.25.1.3

RBG-45265
RBF1-00-0039

Ladies and Gentlemen:

In accordance with 10CFR50.73, enclosed is the subject Licensee Event Report. There are no commitments in this document.

Sincerely,

Rick J King

RJK/dhw
enclosure

IE22

cc: U. S. Nuclear Regulatory Commission
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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION
(6-1998)

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
River Bend Station	05000-458	1 of 3

TITLE (4)
Automatic Isolation of the Reactor Core Isolation Cooling System During Surveillance Testing Due to Procedure Implementation 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
01	22	2000	2000	01	00	02	22	2000	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1
POWER LEVEL (10)	31%

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

	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)
	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	TELEPHONE NUMBER (Include Area Code)
D. N. Lorfing, Supervisor - Licensing	225-381-4157

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE).	✓ NO				

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

On January 22, 2000, with the plant in Mode 1 (Power Operation) at 31 percent power, an automatic isolation of the reactor core isolation cooling (RCIC) system occurred during surveillance testing. The purpose of the regularly scheduled surveillance test was to perform a channel functional test of the automatic isolation of the Division I steam supply isolation valve in the RCIC system as would occur with a low pressure condition in the steam supply line. The test technician misread a procedure step, which caused him to omit instructions to lift a circuit lead in order to block the isolation signal to the motor operated steam supply valve. When subsequent steps were performed, an isolation signal generated by the trip unit being tested was sent to the valve, which responded as designed. The isolation signal was reset, and the RCIC system was restored to its normal standby status approximately twenty-six minutes after the event.

This event is being reported in accordance with 10CFR50.73(a)(2)(iv) as an event that resulted in the automatic actuation of an engineered safety feature. The RCIC steam supply valve is a primary containment isolation valve.

The RCIC steam supply valve responded as designed to the isolation signal. The high pressure core spray system was operable at the time. This event had minimal effects on the health and safety of the public.

REPORTED CONDITION

On January 22, 2000, with the plant in Mode 1 (Power Operation) at 31 percent power, an automatic isolation of the reactor core isolation cooling (RCIC) system occurred during surveillance testing. The test technician misread a procedure step, which caused him to omit instructions to lift a circuit lead in order to block the isolation signal to the motor operated steam supply valve (**ISV**). When subsequent steps were performed, an isolation signal generated by the trip unit being tested was sent to the valve, which responded as designed.

INVESTIGATION

The purpose of the regularly scheduled surveillance test was to perform a channel functional test of the automatic isolation of the Division I steam supply isolation valve in the RCIC system as would occur with a low pressure condition in the steam supply line. At one point in the procedure, the technician is directed to observe the status of an indicating light for the presence of an isolation signal at the trip unit being tested. If an isolation signal is present, the technician is directed to lift a circuit lead which will disable the automatic isolation function of the valve, allowing the test to continue. The technician misread the procedure step regarding the indicator light, which caused him to omit the instructions to lift a circuit lead. When subsequent steps were performed, an isolation signal generated by the trip unit being tested was sent to the valve, and it responded as designed.

Two technicians were involved in performing the surveillance test. The second technician who was not signing procedure steps did not observe the indication that a trip signal was present, and was not involved in the erroneous decision to skip the step directing the lifting of the circuit lead. The technicians had been trained to use the "peer checking" process of error reduction only in cases involving tool / equipment manipulation, and that technique did not apply at the step in the procedure which the isolation signal was generated.

ROOT CAUSE ANALYSIS AND IMMEDIATE CORRECTIVE ACTIONS

The root cause of this event was that the technician did not apply error reduction practices, in that he did not apply self-checking to ensure that the intended action was correct. Additionally, while a pre-job briefing was performed before the test, the practice of defining critical elements found within the procedure was not adequate.

After the automatic isolation was recognized, the trip signal was reset and the RCIC system was restored to its normal standby status.

CORRECTIVE ACTION TO PREVENT RECURRENCE

The qualifications of the technicians involved to perform surveillance testing were suspended pending the completion of a program of remedial training regarding procedure use, independent verification, and the conduct of maintenance.

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PREVIOUS OCCURRENCE EVALUATION

A review of LERs submitted by River Bend Station since January 1997 found no other events in which a human performance error caused an isolation of the RCIC system.

SAFETY SIGNFICANCE

The RCIC steam supply valve responded as designed to the isolation signal. The high pressure core spray (HPCS) system was operable at the time. The RCIC system was restored to its normal standby configuration approximately twenty-six minutes after the event. This event had minimal effects on the health and safety of the public.

The RCIC system is not part of the emergency core cooling systems. The RCIC system is designed to operate either automatically or manually following a reactor pressure vessel (RPV) isolation accompanied by a loss of coolant flow from the feedwater system to provide adequate core cooling and control of RPV water level. Under these conditions, the HPCS and RCIC systems perform similar functions. Should a design basis control rod drop accident occur, the RCIC system can be used in conjunction with the HPCS system to meet the single failure criteria in mitigating the consequences of the event. This event is not considered to be a safety system functional failure.

(Note: Energy industry component identification codes are annotated in the text as (**XXX**).)