



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

June 12, 2000

Randal K. Edington, Vice President - Operations
River Bend Station
Entergy Operations, Inc.
P.O. Box 220
St. Francisville, Louisiana 70775

SUBJECT: CORRECTION TO NRC REPORT INSPECTION REPORT NO. 50-458/00-09

Dear Mr. Edington:

NRC Inspection Report 50-458/00-09 was issued on May 18, 2000, with an error in the actual decrease in reactor cavity level. Since this error could lead to confusion, we are issuing a corrected page. Please replace page 4 of the "Report Details" section with the revised page 4 included with this letter. We regret any inconvenience this may have caused.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

William D. Johnson, Chief
Project Branch B
Division of Reactor Projects

Docket No.: 50-458
License No.: NPF-47

Enclosure:
As stated

Entergy Operations, Inc.

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RITS Coordinator (**NBH**)

Only inspection reports to the following:

D. Lange (**DJL**)

NRR Event Tracking System (**IPAS**)

RBS Site Secretary (**PJS**)

R:_RB\RB2000-09RP-COR.wpd

RIV:SRI	C:DRP/B			
TWPruett;df	WDJohnson			
E - WDJohnson	/RA/			
6/12/00	6/12/00			

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Valve E12-F064A opened in less than 8 seconds even though the minimum flow of 1100 gpm had been reached. Because the flow was above the setpoint, Valve E12-F064A received an immediate signal to close during the opening stroke. As a result, when Valve E12-F064A reached the full open position, it immediately attempted to close. The sudden reversal of the voltage applied to the valve motor resulted in a current value which exceeded the normal inrush current and caused the breaker for Valve E12-F064A to trip open. With Valve E12-F064A failed open, a flow path existed which resulted in a loss of approximately 3 inches (6,000 gallons) of water inventory from the reactor cavity to the suppression pool.

Following the event, the licensee initiated Condition Report (CR) 1999-0784. The licensee determined the root cause to be that the original design was inadequate in that the RHR minimum flow valve 8 second time delay was not an adequate time to establish flow before the minimum flow valve opened. A contributing cause was determined to be an inadequate review associated with a change in operations practices. Specifically, changes in the operational philosophy regarding the use of human performance tools resulted in more deliberate operation of equipment and the changes were not assessed in relation to specific time sensitive plant evolutions.

On June 26, 1999, the following corrective actions were developed and approved by the licensee:

- Increase the minimum flow valve 8 second time delay to 30 seconds, per Engineering Request (ER) 99-0349, to provide additional time for operations personnel to increase RHR flow,
- Install a 1 second time delay in the electrical circuit for Valve E12-F064A, per ER 99-0450, to prevent sudden motor reversal and a subsequent breaker trip,
- Revise operations standards and expectations to ensure prejob briefs included time sensitive actions, and
- Provide training to operations personnel on breaker trips due to sudden motor reversal.

On March 19 and 20, 2000, Valve E12-MOVF064A again opened (when it should have remained closed) while starting RHR Pump A in the shutdown cooling mode of operation. Valve E12-F064A received an automatic signal to close during each event; however, the valve breaker did not trip even though there was a sudden reversal of voltage. Since Valve E12-F064A closed, the loss of inventory from the reactor vessel to the suppression pool only lasted a few seconds. Consequently, there was not a notable decrease in reactor vessel level. Engineering personnel stated that the sudden reversal in voltage resulted in the potential for a trip of the breaker for Valve E12-F064A and that the breaker could have tripped during the event. Had the breaker for Valve E12-F064A tripped, the loss in inventory from the vessel would have continued until an operator closed Valve E12-F064A, as was the case during the April 30, 1999, event.