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Rick J. King
Director
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June 19, 2000

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

Subject: Licensee Event Report 50-458 / 00-009-00
River Bend Station
Docket No. 50-458
License No. NPF-47

File Nos. G9.5, G9.25.1.3

RBG-45381
RBF1-00-0138

Ladies and Gentlemen,

In accordance with 10CFR50.73, enclosed is the subject Licensee Event Report. The commitments contained in this document are identified on the Commitment Identification Form.

Sincerely,

A handwritten signature in cursive script that reads "J. Leavines for".

RJK/dhw
attachment
enclosure

RGN-001

IE22

Licensee Event Report 50-458 / 00-009-00
June 19, 2000
RBG-45381
RBF1-00-0138
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
E-Mail

Mr. Jim Calloway
Public Utility Commission of Texas
1701 N. Congress Ave.
Austin, TX 78711-3326

Mr. Prosanta Chowdhury
Program Manager – Surveillance Division
Louisiana DEQ
Office of Radiological Emergency Planning and Response
P. O. Box 82215
Baton Rouge, LA 70884-2215

Attachment

Commitment Identification Form

Subject: Licensee Event Report 50-458 / 00-009-00

June 19, 2000

RBG-45381

RBF1-00-0138

Page 1 of 1

COMMITMENT	ONE-TIME ACTION	CONTINUING COMPLIANCE
Meetings will be conducted with control room supervisory personnel emphasizing key roles and responsibilities, the importance of procedural compliance, and adherence to communications standards.	x	
The plant startup procedure will be revised to remove the multiple action steps.	x	
The monthly surveillance procedure will be revised to clarify the acceptance criteria for the proper isolation of the drywell purge valves.	x	

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 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-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. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)

River Bend Station

DOCKET NUMBER (2)

05000-458

PAGE (3)

1 of 3

TITLE (4)
Noncompliance with Technical Specifications for Drywell Purge Valve Configuration During Power Operations Due to Personnel 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
05	19	2000	2000	009	00	06	19	2000	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
1	100%	20.2201(b)	20.2203(a)(2)(v)	X	50.73(a)(2)(i)
		20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)
		20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)
		20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)
		20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)

LICENSEE CONTACT FOR THIS LER (12)

NAME
J. W. Leavines, Manager - Licensing

TELEPHONE NUMBER (Include Area Code)
225-381-4642

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)

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

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

On May 19, 2000, at approximately 0357 hours, plant operators discovered that four air-operated valves (AOV's) in the drywell ventilation system were not sealed shut as required by Technical Specification Surveillance Requirement 3.6.5.3.1. The AOV's are part of the drywell pressure boundary, and are required to be sealed shut by Technical Specifications (TS) and plant procedures when the plant is not in cold shutdown. The valves were closed, but were not sealed as defined by the TS bases. The plant was started up on April 8, 2000, without meeting this requirement, and a subsequent surveillance test intended to verify the valves are isolated did not discover the noncompliance. This condition is being reported in accordance with 10CFR50.73(a)(2)(i)(B) as operation prohibited by Technical Specifications.

The cause of this event was inadequate communications between a shift superintendent and the control room supervisor implementing the plant startup procedure.

Although the requirements of the Technical Specification were not satisfied, the administrative controls established by tagging the valve control switches and locking the actuator handwheels provided sufficient barriers to prevent inadvertent operator actuation of the valves. Additionally, the operating procedure for the drywell purge system contains a precaution that prohibits opening of the drywell purge valves when the plant is not in cold shutdown. Therefore, this event had minimal potential to affect the health and safety of the public.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET (2) NUMBER (2)	LER NUMBER (6)			PAGE (3)
River Bend Station	05000-458	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		00	-- 009 --	00	

REPORTED CONDITION

On May 19, 2000, at approximately 0357 hours, plant operators discovered that four air-operated valves (AOV's) in the drywell ventilation system were not sealed shut as required by Technical Specification Surveillance Requirement 3.6.5.3.1. The AOV's are part of the drywell pressure boundary, and are required to be sealed shut by Technical Specifications (TS) and plant procedures when the plant is not in cold shutdown. The valves were closed, but were not sealed as defined by the TS bases. The plant was started up on April 8, 2000, without meeting this requirement, and a subsequent surveillance test intended to verify the valves are isolated did not discover the noncompliance.

This condition is being reported in accordance with 10CFR50.73(a)(2)(i)(B) as operation prohibited by Technical Specifications.

INVESTIGATION AND IMMEDIATE CORRECTIVE ACTION

The AOV's are 24-inch butterfly valves (**V**), and are opened as required to purge the drywell atmosphere in support of personnel access during plant shutdown. The valves require pressurized air to open, and are closed by spring pressure. The valve actuator has a manual handwheel that may be used to open the valve. The drywell purge system has one inlet into and one outlet from the drywell. The AOV's are arranged in redundant pairs on each leg of the purge flowpath, such that all four AOV's must be opened to operate the system. The electrical controls to the valves are powered in a paired arrangement from opposite divisions of safety-related power sources. The purge inlet valves are powered from opposite electrical divisions, as are the purge outlet valves.

The AOV's are required by TS to be sealed closed when the plant is not in cold shutdown. This requirement is defined by the TS bases to mean that the motive power to the valve actuator is removed, either by de-energizing the source of electrical power or by closing the air supply. This requirement is normally met by closing and tagging the air supply valve at each AOV actuator, in addition to tagging the control switches in the main control room.

River Bend returned to power operations on April 8, 2000, following a refueling outage. The plant startup procedure has a step requiring the AOV's to be sealed closed. When this step was reached during preparation for plant startup, it was signed as complete by a shift superintendent based on verbal communication with the control room supervisor whom had been assigned to actually complete the task.

On May 19, 2000, the valves were discovered to not be properly sealed. The AOV control switches in the main control room were verified to be properly tagged to prevent operation. The actuator handwheel was verified to be locked to prevent local manual operation. The control switch tags and handwheel locks were verified to have been in position since plant startup on April 8, 2000. The actuator air supply valves were closed and tagged on May 19, 2000.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET (2) NUMBER (2)	LER NUMBER (6)			PAGE (3)
River Bend Station	05000-458	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3
		00	-- 009 --	00	

CAUSAL ANALYSIS AND CORRECTIVE ACTION TO PREVENT RECURRENCE

The cause of this event was inadequate communications between a shift superintendent and the control room supervisor implementing the plant startup procedure. The plant startup procedure was deficient in that the step directing the isolation of the drywell purge system contained more than one action under a single signature block. This is not consistent with proper formatting of operational procedures. Additionally, the monthly surveillance procedure intended to verify the valves are sealed does not direct the operator to check the position of the air supply valve to the AOV actuator.

Meetings will be conducted with control room supervisory personnel emphasizing key roles and responsibilities, the importance of procedural compliance, and adherence to communications standards. The plant startup procedure will be revised to remove the multiple action steps. The monthly surveillance procedure will be revised to clarify the acceptance criteria for the proper isolation of the drywell purge valves.

PREVIOUS OCCURRENCE EVALUATION

A review of River Bend Condition Reports found no previous occurrence of this condition.

SAFETY SIGNIFICANCE

Although the requirements of the Technical Specification were not satisfied, the administrative controls established by tagging the valve control switches and locking the actuator handwheels provided sufficient barriers to prevent inadvertent operator actuation of the valves. Additionally, the operating procedure for the drywell purge system contains a precaution that prohibits opening of the drywell purge valves when the plant is not in cold shutdown.

The only postulated scenario with the potential to cause spurious opening of the valves is a main control room fire. A main control room fire causing circuit failures in both electrical divisions could have caused both valves in one or both branches of the purge path to open, since the source of operating air was not isolated. NRC Branch Technical Position APSCB 9.5.1 states that no other design basis events need be postulated concurrent with a main control room fire. In the absence of any other failure, there would be no consequence of opening this drywell penetration during power operations. Therefore, this event had minimal potential to affect the health and safety of the public.

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