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**Rick J. King**  
Director  
Nuclear Safety Assurance

September 11, 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 / 00-011-00

File Nos. G9.5, G9.25.1.3

RBG-45486  
RBF1-00-0196

Ladies and Gentlemen:

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

Sincerely,

A handwritten signature in black ink, appearing to read "Rick J. King".

RJK/dhw  
enclosure

IE22

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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

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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

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.

**LICENSEE EVENT REPORT (LER)**

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

FACILITY NAME (1)

River Bend Station

DOCKET NUMBER (2)

05000-458

PAGE (3)

1 of 3

TITLE (4)

Secondary Containment Inoperable Due to Failure of Auxiliary Building Door Opening Device

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
08	11	2000	2000	011	00	09	11	2000	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)			
1	100%	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)	50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	X 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

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
	<input checked="" type="checkbox"/>				

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

On August 10, 2000, at 2250 hours with the plant in Mode 1 (Power Operation) at 100 percent power, a secondary containment door leading into the auxiliary building became blocked open such that it caused secondary containment to be inoperable for a short period of time. This event is being reported in accordance with 10CFR50.73(a)(2)(v) as a condition that alone could have prevented the fulfillment of a safety function needed to control the release of radioactive material.

Three secondary containment doors used for routine personnel access into the auxiliary building are equipped with assist devices that ease the opening of the door against the differential pressure created by operation of the standby gas treatment system (GTS). The door involved in this event was opened for routine access while the GTS system was running for a surveillance test. The door assist device malfunctioned, causing the door to be blocked open approximately eight inches. The door remained in this condition for approximately eighteen minutes before the assist device was reset to allow the door to be closed.

During the period the door was blocked open, the plant continued to operate normally. There was no actual safety significance to the health and safety of the public. If a design-basis accident had occurred while the door was blocked open, evaluations have shown that the exclusion area boundary thyroid dose would have remained within the limits defined by 10CFR100.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

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River Bend Station	05000-458	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		00	-- 011 --	00	

**REPORTED CONDITION**

On August 10, 2000, at 2250 hours with the plant in Mode 1 (Power Operation) at 100 percent power, a secondary containment door (\*\*DR\*\*) leading into the auxiliary building became blocked open such that it caused secondary containment to be inoperable for a short period of time. This event is being reported in accordance with 10CFR50.73(a)(2)(v) as a condition that alone could have prevented the fulfillment of a safety function needed to control the release of radioactive material.

The door leading into the auxiliary building was opened for routine access while GTS was running for a surveillance test. The door assist device malfunctioned, causing the door to be blocked open approximately eight inches. The door remained in this condition for approximately eighteen minutes before the assist device was reset to allow the door to be closed.

**INVESTIGATION**

Three secondary containment doors used for personnel access to the auxiliary building during power operations are equipped with assist devices that ease the opening of the door against differential pressure. The ventilation system draws a slight negative pressure in the building when operating normally, and in this condition, the doors may be opened manually without the use of the assist devices. When the GTS system is operating, the differential pressure is greater, such that the doors are difficult to open. The assist device incorporates a gear-operated jack that opens far enough to allow the door to be fully opened by hand.

At the time of the event, the GTS system was running for a surveillance test, causing the differential pressure across the doors to be higher than normal. At 2250 hours, the door was opened using the assist device. An internal failure of the assist device caused the jack to stick in the extended position. The jack could not be retracted, thus the door could not be fully closed. Approximately eighteen minutes later, the assist device was reset, and the door was successfully closed.

The design of the charcoal filters in the GTS trains is based on a specific upper limit of air flow through the system. With the door blocked open approximately eight inches, air flow would likely have been too high to maintain the required efficiency of the charcoal filters. In this condition, the system's ability to perform its design function of limiting the release of radioactive material to the atmosphere may have been degraded. Also, it is unclear that required negative pressure in secondary containment could have been achieved.

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**CAUSE ANALYSIS AND IMMEDIATE CORRECTIVE ACTIONS**

An examination of the assist device found that a jam nut was missing from the mechanism that resets the jack after the door is opened. It could not be determined why or for how long the jam nut was missing.

The design of the assist device includes a feature that allows the jack to be manually reset in the event of a failure internal to the device. The person using the door attempted to reset the jack, but encountered more resistance in the mechanism than expected. He made no further attempt to reset the jack, to avoid causing further damage. Removal of an external access cover on the device revealed that resetting the jack could be performed without causing any damage. The door was secured within approximately eighteen minutes, and the integrity of secondary containment was re-established.

A review of the training video used to familiarize plant personnel with the operation of the assist devices found that it did not clearly discuss the amount of force required to manually reset the jack.

**CORRECTIVE ACTION TO PREVENT RECURRENCE**

Preventive maintenance procedures for the assist devices will be evaluated for enhancements that would facilitate the detection of missing components or components that have become worn or misadjusted.

The assist devices on the other two auxiliary building doors were inspected and found to be operating correctly.

**PREVIOUS OCCURRENCE EVALUATION**

A search of the Condition Report database found no previous occurrences of the failure of a door assist device causing door to be blocked open.

**SAFETY SIGNIFICANCE**

During the period the door was blocked open, the plant continued to operate normally. There was no actual safety significance to the health and safety of the public. If a design-basis accident had occurred while the door was blocked open, evaluations have shown that the exclusion area boundary thyroid dose would have remained within the limits defined by 10CFR100.

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