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Rick J. King
Director
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November 20, 2001

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 / 01-003-00

File Nos. G9.5, G9.25.1.3

RBG-45881
RBF1-01-0242

Ladies and Gentlemen:

In accordance with 10CFR50.73, enclosed is the subject Licensee Event Report.
Commitments are identified on the included Commitment Identification Form.

Sincerely,

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

RJK/dhw
enclosure

JE 22

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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

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

La. Department of Environmental Quality
Office of Environmental Compliance
Surveillance Division
P. O. Box 82215
Baton Rouge, LA 70884-2215
Attn: Prosanta Chowdhury

Commitment Identification Form

COMMITMENT	ONE-TIME ACTION	CONTINUING COMPLIANCE
Guidelines will be implemented to provide a clear visual identification of components that have been verified to be correctly positioned for the test. (Scheduled completion date 4/1/03)		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 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose 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
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TITLE (4) Unplanned Automatic Start of Standby Service Water System During Surveillance Testing Due to Inadequate Control of Test Configuration

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
09	24	2001	2001	- 003 -	00	11	20	2001	FACILITY NAME	DOCKET NUMBER
										05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9) 5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)											
	20.2201(b)			20.2203(a)(3)(ii)			50.73(a)(2)(ii)(B)			50.73(a)(2)(ix)(A)		
POWER LEVEL (10) 0	20.2201(d)			20.2203(a)(4)			50.73(a)(2)(iii)			50.73(a)(2)(x)		
	20.2203(a)(1)			50.36(c)(1)(i)(A)			X 50.73(a)(2)(iv)(A)			73.71(a)(4)		
	20.2203(a)(2)(i)			50.36(c)(1)(ii)(A)			50.73(a)(2)(v)(A)			73.71(a)(5)		
	20.2203(a)(2)(ii)			50.36(c)(2)			50.73(a)(2)(v)(B)			OTHER Specify in Abstract below or in NRC Form 366A		
	20.2203(a)(2)(iii)			50.46(a)(3)(ii)			50.73(a)(2)(v)(C)					
	20.2203(a)(2)(iv)			50.73(a)(2)(i)(A)			50.73(a)(2)(v)(D)					
	20.2203(a)(2)(v)			50.73(a)(2)(i)(B)			50.73(a)(2)(vii)					
	20.2203(a)(2)(vi)			50.73(a)(2)(i)(C)			50.73(a)(2)(viii)(A)					
	20.2203(a)(3)(i)			50.73(a)(2)(ii)(A)			50.73(a)(2)(viii)(B)					

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)					EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).					X NO				

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

On September 24, 2001, at approximately 4:55 p.m. CDT with the plant in a refueling outage, an unplanned automatic actuation of the Division II standby service water system occurred during Division I integrated emergency core cooling systems testing. This event is being reported in accordance with 10CFR50.73(a)(2)(iv)(A) as an event that resulted in the automatic actuation of a safety system.

The actuation of Division II standby service water occurred as a result of an incorrect alignment of two motor-operated valves in the system. After plant conditions were established to support starting the test, the required service water valve alignment was not properly established prior to commencement of the test. When the test was initiated, a low pressure condition was momentarily induced in the standby service water system. The Division II standby service water system responded as designed to the low pressure condition. After an initial assessment, the system was restored to its standby configuration, and the test proceeded.

This event was of minimal significance with respect to the health and safety of the public. The reactor was in cold shutdown at the time of the event, and the Division II standby service water system responded as designed. No loss of safety function occurred.

LICENSEE EVENT REPORT (LER)

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

EVENT DESCRIPTION

On September 24, 2001, the station was in a refueling outage, and scheduled surveillance testing of the Division I emergency core cooling systems (ECCS) was being conducted. Prior to 6:00 a.m. CDT, the service water supply to the drywell unit coolers (**CLR**) was secured, realigning the systems to a chilled water supply to improve habitability for workers in the area until the ECCS test could be performed. Setup for the ECCS test continued while the system was in this configuration.

As part of the test setup, an operator was required to verify the position of four motor-operated service water valves. Two Division I valves (**ISV**) were to be verified open, and two Division II valves were to be verified closed. This test alignment separates the two divisions of service water through this cross-tie. When the operator initially performed this verification, all four motor-operated valves were closed due to the chilled water lineup. The operator verified the two Division II valves closed and flagged the two Division I valves so that verification could be performed when the service water lineup was restored just prior to the actual test initiation.

When plant conditions supported performance of the ECCS test, the operating crew realigned service water to the drywell coolers using the system operating procedure to restore the system. At the completion of this realignment, the two Division I valves were verified to be open as required by the ECCS test procedure. The test director did not recognize that the two Division II valves that had previously been verified closed were reopened as part of this operation. As a result, all four motor-operated valves were open, and the service water system cross-tied through the drywell unit coolers when other automatic valve actions occurred as expected during the test. When the test was initiated at approximately 4:55 p.m., a low pressure condition was momentarily induced in the standby service water system. The Division II standby service water system responded as designed to the low pressure condition. After an initial assessment, it was restored to its correct configuration, and the ECCS test proceeded.

CAUSAL ANALYSIS AND IMMEDIATE CORRECTIVE ACTION

The surveillance test procedure is extensive, and is written to allow performance in a number of various plant configurations. The test procedure itself contains no detailed provisions for tracking changes to affected plant components once their pre-test configuration is set. The test director relied on active monitoring of crew activities to identify configuration changes that could impact test conditions, and missed these two valves. No tool was used to identify verified test components so that all operators manipulating could assist in maintaining the appropriate test configuration.

The lessons learned from the Division I test were incorporated into the crew briefing for the Division II test conducted later in the outage.

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

CORRECTIVE ACTION TO PREVENT RECURRENCE

The ECCS test is a complex test that requires several hours to prepare and involves a broad cross-section of plant components. This complexity and the extended time duration of the test create a unique error-likely situation for operators and test participants. Recognizing this, the following action will be taken to prevent recurrence:

- Guidelines will be implemented to provide a clear visual identification of components that have been verified to be correctly positioned for the test.

This action is scheduled to be completed by April 1, 2003, and will provide a mechanism to alert operating personnel when plant operations require these components to be manipulated. They can then ensure that the component is restored in accordance with plant procedures and that the impact on test activities is appropriately evaluated.

PREVIOUS OCCURRENCES

A search of River Bend's Licensee Event Reports since January 1995 found no similar previous events.

SAFETY SIGNIFICANCE

This event was of minimal significance with respect to the health and safety of the public. The reactor was in cold shutdown at the time of the event, and the Division II standby service water system responded as designed. No loss of safety function occurred.

(Note: Energy Industry Identification codes are annotated in the text as (**XXX**).)