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February 17, 2005

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

Subject: River Bend Station – Unit 1
Docket No. 50-458
License No. NPF-47
Licensee Event Report 50-458 / 04-003-01

File Nos. G9.5, G9.25.1.3

RBG-46401
RBF1-05-0026

Ladies and Gentlemen:

In accordance with 10CFR50.73, enclosed is the subject Licensee Event Report. This is a supplement to the initial report submitted on December 28, 2004. This document contains no commitments.

Sincerely,

A handwritten signature in black ink that reads "David N. Lorfing".

David N. Lorfing
Manager – Licensing (acting)

DNL/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

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Office of Environmental Compliance
Surveillance Division
Radiological Emergency Planning & Response Unit
P.O. Box 4312
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LICENSEE EVENT REPORT (LER)

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

Estimated burden per response to comply with this mandatory 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 and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@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 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.

1. FACILITY NAME River Bend Station, Unit 1	2. DOCKET NUMBER 05000 458	3. PAGE 1 of 3
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4. TITLE
Unplanned Automatic Start of Standby Diesel Generator Due to Loss of Division 1 Switchgear

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV. NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	31	2004	2004	- 003 -	01	2	17	2005		05000
									FACILITY NAME	DOCKET NUMBER
										05000

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

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME David N. Lorfing, Manager – Licensing (acting)	TELEPHONE NUMBER (Include Area Code) 225-381-4157
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

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

14. SUPPLEMENTAL REPORT EXPECTED	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO			

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

On October 31, 2004, at approximately 10:36 p.m. CST, an automatic start of the Division 1 emergency diesel generator (DG) occurred as a result of the loss of the Division 1 standby switchgear. The plant was in cold shutdown for a refueling outage at the time of the event. The normal feeder breaker to the Division 1 4160kv bus tripped during the installation of test jumpers in preparation for surveillance testing. Due to inadequate use of error prevention practices, the technician inadvertently contacted an adjacent terminal, generating a trip signal to the feeder breaker. The diesel generator started as designed on a bus low voltage condition, and its output breaker automatically closed, restoring power to the bus. At the time of the event, the reactor cavity was flooded to greater than 23 feet. The reactor water cleanup system was in service and the Division 2 residual heat removal system was operating in the shutdown cooling mode. These systems were unaffected by this event and continued to provide alternate means of coolant circulation. For the remainder of the surveillance test being performed, all work involving lifted leads and jumpers was monitored directly by the test director. This event is being reported in accordance with 10CFR50.73(a)(2)(iv)(A) as an event that resulted in the automatic actuation of the Division 1 DG. This event was of minimal safety significance.

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FAILURE CONTINUATION

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REPORTED CONDITION

On October 31, 2004, at approximately 10:36 p.m. CST, an automatic start of the Division 1 emergency diesel generator (DG) (**DG**) occurred as a result of the loss of the Division 1 4160kv standby bus. The plant was in cold shutdown for a refueling outage at the time of the event. The normal feeder breaker to the Division 1 4160kv bus tripped during the installation of test jumpers in preparation for surveillance testing. The technician inadvertently contacted an adjacent terminal, generating a trip signal to the feeder breaker. The diesel generator started as designed on a bus low voltage condition, and its output breaker automatically closed, restoring power to the bus.

At the time of the event, the reactor cavity was flooded to greater than 23 feet. The reactor water cleanup system was in service, and the Division 2 residual heat removal system was operating in the fuel pool cooling assist mode. These systems were unaffected by this event and continued to provide alternate means of coolant circulation. The Division 1 residual heat removal system was operating in the shutdown cooling mode prior to the event, but tripped upon loss of the switchgear. It was restored to service approximately 40 minutes later. The Division 1 DG was returned to the standby condition at 2:06 a.m. the following day.

INVESTIGATION AND CAUSAL ANALYSIS

A detailed review of the event and root cause was conducted. The test jumper was installed inside a relay case in the auxiliary cubicle of the Division 1 4180 volt switchgear. The relay had been removed in accordance with procedure to provide access to the necessary terminals. The alligator clips on the jumper were plastic-coated to provide electrical insulation. Following installation of the jumper, the technicians attempted to close the cubicle door. However, the jumper was partially obstructing the door. During attempts to rearrange the jumper to clear the door, one of the alligator clips contacted an adjacent terminal, resulting in the trip signal to the switchgear feeder breakers. The switchgear was de-energized, and the Division 1 DG automatically started as designed.

Although the alligator clips on the jumper were insulated by the plastic coating, this was not effective in preventing inadvertent contact inside the cramped relay case. Station maintenance procedure directs technicians to evaluate work conditions in sensitive or high risk tasks for potential applicability of error reduction techniques. In this case, it would have been appropriate to shield the adjacent terminals with electrical tape. However, the technician felt confident he could accomplish the task without doing so.

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CORRECTIVE ACTIONS TO PREVENT RECURRENCE

A briefing was held with all Instrumentation & Control technicians and electricians to discuss the use of tape to cover exposed terminals when installing test connections on critical circuits in congested areas.

For the remainder of the surveillance test being performed, all work involving lifted leads and jumpers was monitored directly by the test director.

Additional training on expectations regarding evaluation of critical steps and use of error prevention techniques is being developed. This action will be tracked in the station corrective action program.

PREVIOUS OCCURRENCE EVALUATION

A review of reportable events at River Bend for the previous three years found no similar occurrences.

SAFETY ANALYSIS

The Division 1 DG started as designed and restored power to its standby switchgear. At the time of the event, the reactor cavity was flooded to greater than 23 feet. The reactor water cleanup system was in service and the Division 2 residual heat removal system was operating in the shutdown cooling mode. These systems were unaffected by this event and continued to provide alternate means of coolant circulation and decay heat removal. Thus, this event was of minimal safety significance.

(NOTE: Energy Industry Component Identification codes are annotated as (**XX**).)