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David N. Lorfing
Manager-Licensing

August 23, 2005

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

Subject: Licensee Event Report 50-458 / 05-002-00
River Bend Station – Unit 1
Docket No. 50-458
License No. NPF-47

File Nos. G9.5, G9.25.1.3

RBG-46472
RBF1-05-0137

Ladies and Gentlemen:

In accordance with 10CFR50.73, enclosed is the subject Licensee Event Report.
This document contains no commitments.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Lorfing".

David N. Lorfing
Manager – Licensing

DNL/dhw
Enclosure

TE22

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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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Public Utility Commission of Texas
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Austin, TX 78711-3326

Mr. Ronnie Wascom
Louisiana Department of Environmental Quality
Office of Environmental Compliance
P.O. Box 4312
Baton Rouge, LA 70821-4312

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 Actuation of Standby Service Water Due to Procedure Error

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
06	24	2005	2005	- 002 -	00	08	23	2005		05000
									FACILITY NAME	DOCKET NUMBER
										05000

9. OPERATING MODE
4

10. POWER LEVEL
0

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)
<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

14. SUPPLEMENTAL REPORT EXPECTED
 YES (If yes, complete 15. EXPECTED SUBMISSION DATE) NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

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

On June 24, 2005, at approximately 1:13 a.m. CDT, an unplanned automatic start of a Division 2 standby service water pump occurred. The plant was in cold shutdown at the time. This event is being reported in accordance with 10CFR5073(a)(2)(iv) as a condition that resulted in the automatic initiation of an emergency service water system. The Division 2 subsystem was being aligned to support diagnostic testing of a motor-operated valve in the system. The other Division 2 pump had already been started in accordance with the system operating procedure, and the subsequent steps directed the operator to open the inlet valve to the standby cooling tower. At this point, the pressure in the normal service water supply header decreased momentarily below the trip setpoint of the Division 2 automatic start circuitry. The second Division 2 pump started as designed. The causal analysis determined that the system operating procedure was inadequate for the alignment being performed, as it did not preserve sufficient margin in the normal service water supply pressure to avoid actuation of the low pressure trip units that start the standby system. The system operating procedure has been changed to correct this deficiency. No loads being supplied by service water were adversely affected by the actuation of the second Division 2 standby service water pump. Thus, this event was of minimal safety significance.

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REPORTED CONDITION

On June 24, 2005, at approximately 1:13 a.m. CDT, an unplanned automatic start of the "D" standby service water (SSW) pump (**P**) occurred. The plant was in cold shutdown at the time. This event is being reported in accordance with 10CFR5073(a)(2)(iv) as a condition that resulted in the automatic initiation of an emergency service water system.

The SSW system consists of two pumps in each of two independent subsystems. The "B" and "D" pumps supply the Division 2 subsystem. The Division 2 subsystem was being realigned to support diagnostic testing of a motor-operated valve (**ISV**) in the system. The "B" pump had already been started in accordance with the system operating procedure, and the subsequent steps directed the operator to open the inlet valve to the standby cooling tower. At this point, the pressure in the normal service water (NSW) supply header decreased momentarily below the trip setpoint of the Division 2 automatic start circuitry. The "D" pump started as designed. Normal service water flow in the plant was not interrupted.

IMMEDIATE ACTIONS and CAUSAL ANALYSIS

The Division 2 standby service water subsystem was operating normally following the automatic actuation of the "D" pump. This alignment was subsequently maintained to allow the scheduled testing of the motor operated valve.

The causal analysis determined that the system operating procedure was inadequate for the realignment being performed, as it did not preserve sufficient margin in normal service water supply pressure to avoid actuation of the low pressure trip units that start the SSW system. In the operation being conducted, the system was momentarily in a configuration in which the operating pumps were not supplying adequate flow for the loads that were in service, resulting in a drop in supply header pressure.

This event is similar to an event that occurred in April 1999, in which the system was being restored to normal alignment following surveillance testing. The procedure steps put the system in such an alignment that allowed a momentary drop in header pressure. The corrective action for that event included the revision of numerous surveillance test procedures, but did not include the system operating procedure. It could not be determined why that omission occurred.

CORRECTIVE ACTIONS TO PREVENT RECURRENCE

An engineering evaluation of the standby service water system was performed to develop a number of potential changes for the system operating procedure. The optimum solution was selected, involving a change in the alignment of the supply to the reactor plant

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component cooling water (CCP) heat exchangers. The CCP system heat exchangers are the major load on the system in its normal alignment. The system operating procedure has been revised to implement this change.

A separate broad-scope review of the normal and standby service water systems is being conducted to identify commonality between equipment, procedural, organizational, and programmatic issues associated with automatic actuations of the SSW system over the last 15 years. This review will examine all actuations regardless of cause, with the purpose of developing comprehensive corrective actions to prevent a recurrence of these types of events. The results of that review will be documented in the station corrective action program.

PREVIOUS EVENTS EVALUATION

This event is similar to an event that occurred in April 1999, in which the system was being restored to normal alignment following surveillance testing. The procedure steps put the system in such an alignment that allowed a momentary drop in header pressure. The corrective action for that event included the revision of numerous surveillance test procedures, but did not include the system operating procedure. It could not be determined why that omission occurred.

SAFETY ANALYSIS

No loads being supplied by service water were adversely affected by the actuation of the "D" standby service water pump, and the plant was in cold shutdown at the time. Thus, this event was of minimal safety significance.

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