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RBG-47616

September 14, 2015

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

Subject: Licensee Event Report 50-458 / 2015-006-00
River Bend Station – Unit 1
Docket No. 50-458
License No. NPF-47

RBF1-15-0140

Dear Sir or Madam:

In accordance with 10 CFR 50.73, enclosed is the subject Licensee Event Report. This document contains no commitments. If you have any questions, please contact Mr. Joseph Clark at 225-381-4177.

Sincerely,

A handwritten signature in black ink that reads "N. Todd Brumfield".

NTB / dhw

Enclosure

cc: U. S. Nuclear Regulatory Commission
Region IV
1600 East Lamar Blvd.
Arlington, TX 76011-4511

NRC Sr. Resident Inspector
P. O. Box 1050
St. Francisville, LA 70775

IE22
NRK

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INPO
(via ICES reporting)

Central Records Clerk
Public Utility Commission of Texas
1701 N. Congress Ave.
Austin, TX 78711-3326

Department of Environmental Quality
Office of Environmental Compliance
Radiological Emergency Planning and Response Section
Ji Young Wiley
P.O. Box 4312
Baton Rouge, LA 70821-4312



LICENSEE EVENT REPORT (LER)
(See Page 2 for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@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

4. TITLE

Operations Prohibited by Technical Specifications Due to Error in Initial Operability Evaluation

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
7	17	2015	2015	006	00	09	14	2015	FACILITY NAME	DOCKET NUMBER 05000

9. OPERATING MODE	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)			
1	<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	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input 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 checked="" 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

LICENSEE CONTACT Joseph A. Clark, Manager - Regulatory Assurance	TELEPHONE NUMBER (Include Area Code) (225) 381-4177
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
n/a									

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 July 17, 2015, with the plant operating at 92 percent power, it was determined that an operability evaluation previously performed for a safety-related instrument in the primary containment isolation circuitry was in error, which resulted in the failure to take actions required by the Technical Specifications. On July 8, 2015, a scheduled surveillance test was performed on one channel of the primary containment isolation logic. During the test, an error message was displayed on the associated trip unit. The operators and technicians researched the vendor manual, consulted the cognizant engineers, and determined that the error message was not indicative of any inability of the system to perform its design safety function. Subsequent review found that the first operability determination on the condition report was in error, and that the trip channel was not actually capable of performing as designed. The trip unit was declared inoperable, and taken out of service to be replaced. The channel was again declared operable on July 18 at 2:44 a.m. The elapsed time between the receipt of the error message on July 8 and the restoration to an operable status exceeded the allowable outage time of Technical Specifications. The cause of the error in the first operability determination was the use of an outdated vendor manual for the initial troubleshooting. This condition is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B) as operations prohibited by Technical Specifications. During the time that the trip unit was inoperable, redundant channels in the isolation logic remained capable of performing the safety function. This event was, thus, of minimal safety significance to the health and safety of the public.



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

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@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.

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NARRATIVE

REPORTED CONDITION

On July 17, 2015, with the plant operating at 92 percent power, it was determined that an operability evaluation previously performed for a safety-related instrument in the primary containment isolation circuitry was in error, which resulted in the failure to take actions required by the Technical Specifications. That initial evaluation performed on July 8 had determined that the affected circuitry was operable, when in fact it was not actually capable of performing its design function. This condition existed for longer than the allowable outage time, and is, thus, being reported in accordance with 10 CFR 50.73(a)(2)(i)(B) as operations prohibited by Technical Specifications.

INVESTIGATION AND IMMEDIATE CORRECTIVE ACTIONS

On July 8, 2015, a scheduled surveillance test was performed on one channel of the primary containment isolation logic. The channel is part of the logic that automatically isolates the reactor water cleanup (RWCU) system if the area temperature in the RWCU heat exchanger room exceeds operating limits. If this channel is found to be inoperable, the channel must be placed in the tripped condition within 24 hours, or else the affected primary containment path must be isolated within one hour.

During the test, an error message was displayed on the associated trip unit. The operators and technicians researched the vendor manual, consulted the cognizant engineers, and determined that the error message was not indicative of any inability of the system to perform its design safety function. A condition report was written to document the situation and provide for further review. The surveillance test was deemed a success, and the trip channel was restored to an operable status.

Subsequent review found that the first operability determination on the condition report was in error, and that the trip channel was not actually capable of performing as designed. The trip unit was declared inoperable, and taken out of service to be replaced. The channel was again declared operable on July 18 at 2:44 a.m. The elapsed time between the receipt of the error message on July 8 and the restoration to an operable status exceeded the allowable outage time of Technical Specifications.

CAUSAL ANALYSIS

The cause of the error in the first operability determination was the use of an outdated vendor manual for the initial troubleshooting. The trip unit is of a slightly different design than the original, having been installed in the past as part of a system modification. The vendor manual for the old trip unit is still available in the document control system as a reference. This investigation determined that the operators' understanding of the process for retrieving controlled documents was deficient, in that they did not know the correct method of differentiating the status of an historical document versus a current controlled document. The similarity between the old and new trip unit led others involved in the initial troubleshooting to think they were using the correct manual. It was during the engineers' follow-up evaluation of the first operability determination that the error was discovered.

Contributing to this event was the inappropriately lengthy amount of time allowed the engineers for performance of their follow-up evaluation. That is, a more timely due date for that review could have resulted in the error being discovered prior to the expiration of the Technical Specification required actions. Sufficient guidance existed in the governing procedure that should have resulted in a due date commensurate with the significance of the situation.

**LICENSEE EVENT REPORT (LER)
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NARRATIVE

CORRECTIVE ACTIONS to PREVENT RECURRENCE

These actions were taken (or are planned) to address the direct causes of this event, and are documented in the corrective action program:

- Senior operators were briefed on the proper use of the document control operating system.
- A user's guide was developed for the document control operating system.
- Senior operators will be briefed regarding expectations for timeliness of due dates on operability evaluations.

PRIOR OCCURRENCE EVALUATION

No previous similar events have been reported at River Bend Station in the last three years.

SAFETY SIGNIFICANCE

During the time that the trip unit was inoperable, redundant channels in the isolation logic remained capable of performing the safety function. This event was thus of minimal safety significance to the health and safety of the public.