



Entergy Operations, Inc.  
River Bend Station  
5485 U.S. Highway 61N  
St. Francisville, LA 70775  
Tel 225-381-4157

Marvin L. Chase  
Director – Regulatory & Performance  
Improvement

RBG-47694

July 25, 2016

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

Subject: Licensee Event Report 50-458 / 2016-007-00  
River Bend Station – Unit 1  
Docket No. 50-458  
License No. NPF-47

RBF1-16-0084

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 Ms. Kristi Huffstatler at 225-378-3305.

Sincerely,

A handwritten signature in black ink, appearing to read "Marvin L. Chase".

MLC / 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

INPO  
(via ICES reporting)

JE22  
NRR

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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)

(See NUREG-1022, R.3 for instruction and guidance for completing this form  
<http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr1022/r3/>)

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 e-mail to [Infocollects.Resource@nrc.gov](mailto: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.

<b>1. FACILITY NAME</b> River Bend Station - Unit 1	<b>2. DOCKET NUMBER</b> 05000 458	<b>3. PAGE</b> 1 OF 3
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**4. TITLE**  
Operations Prohibited by Technical Specifications Due to Failure to Implement Required Actions Within Completion Time

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
05	25	2016	2016	007	00	07	25	2016		05000
										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)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)
100	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> 73.77(a)(1)
	<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)(D)	<input type="checkbox"/> 73.77(a)(2)(i)
	<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)(vii)	<input type="checkbox"/> 73.77(a)(2)(ii)
	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> OTHER	Specify in Abstract below or in NRC Form 366A	

**12. LICENSEE CONTACT FOR THIS LER**

LICENSEE CONTACT Kristi Huffstatler, Manager - Regulatory Assurance (acting)	TELEPHONE NUMBER (Include Area Code) (225) 378-3305
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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
na									

**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 May 25, 2016, it was determined that there had been a violation of Technical Specifications during a recent planned maintenance outage of the Division 1 diesel generator (DG). During that outage, three material deficiencies of various subcomponents were discovered while conducting maintenance tasks. The initial operability screening of each deficiency determined that the as-found condition did not, by itself, cause the DG to be inoperable. However, the associated condition report for each item was flagged as "inoperable." These determinations should have, thus, caused the operators to invoke the requirements of the TS to perform common cause evaluations to assure that the same conditions did not exist on the operable Division 2 DG. This action was not performed. Human performance evaluations of the operators involved in the condition report screening concluded that a cognitive, undocumented decision was made that the individual deficiencies did not meet the threshold of requiring a common cause evaluation. This event constituted operations prohibited by Technical Specifications, and is being reported in accordance with 10 CFR 50.73 (a)(2)(i)(B). Approximately four days following the discovery of the air leaks and the governor drive coupling configuration, DG system engineers documented operability evaluations which concluded that none of these conditions posed any potential challenge to the ability of the DG to fulfill its safety function. It was confirmed that no similar conditions were present on the Division 2 DG. The air leaks were repaired and the governor drive coupling assembly was corrected prior to restoration of the Division 1 DG to an operable status. This event had no significance with respect to the health and safety of the public.



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

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<b>1. FACILITY NAME</b>		<b>2. DOCKET NUMBER</b>		<b>3. LER NUMBER</b>		
River Bend Station - Unit 1		05000- 458		<b>YEAR</b>	<b>SEQUENTIAL NUMBER</b>	<b>REV NO.</b>
				2016	007	00

**NARRATIVE**

**REPORTED CONDITION**

On May 25, 2016, it was determined that there had been a violation of Technical Specifications during a recent planned maintenance outage of the Division 1 diesel generator (DG)[EK]. During that outage, three material deficiencies of various subcomponents were discovered while conducting maintenance tasks. These discoveries should have caused the operators to invoke the requirements of the TS to perform common cause evaluations to assure that the same conditions did not exist on the operable Division 2 DG. This action was not performed.

This condition constituted operations prohibited by Technical Specifications, and is being reported in accordance with 10 CFR 50.73 (a)(2)(i)(B).

**INVESTIGATION**

The material deficiencies found during the DG outage involved two minor air leaks on pressure switches in the engine air start subsystem and a DG governor drive coupling that was not in compliance with design drawings. Condition Reports were initiated in accordance with the corrective action program, and these CRs underwent the initial operability assessment. The CRs were individually flagged by the operations shift managers (OSM) as conditions that would cause the DG to be inoperable. Since the DG was already inoperable for the planned maintenance outage, the CRs were added to the work tracking system to assure that the conditions would be corrected prior to restoring the DG to an operable status.

Limiting Condition for Operation (LCO) 3.8.1 was already in effect for the maintenance outage. One of the Required Actions of this LCO specifies that a common cause evaluation will be performed for material defects discovered to potentially have an adverse effect on the operability of the DG. This evaluation is meant to assure that the same condition does not exist on the other DG. The TS requires that this evaluation be completed within 24 hours. Although there were discussions between OSM and the maintenance staff at the time, there was no documentation of the conclusions.

Human performance evaluations were conducted with the OSMs involved in the processing of the Condition Reports written on each of the deficiencies. Following are the conclusions:

- With regard to the air leaks, the OSM reasoned that the leaks had likely been induced by the maintenance activities, since the system had been depressurized and then restored to normal pressure prior to discovery of the leak. No leakage had been reported prior to this activity.
- Regarding the condition of the DG governor drive coupling, the initial assessment concluded that the coupling had been in the as-found configuration since the DGs were installed during plant construction. This was seen as significant evidence that the as-found condition did not adversely affect the ability of the DG to perform its design safety function.

**CORRECTIVE ACTIONS TO PREVENT RECURRENCE**

The causal analysis of this event has been reviewed as operational experience by each of the active OSMs. A training analysis is being conducted to define and correct knowledge gaps that contributed to this event.



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CONTINUATION SHEET**

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1. FACILITY NAME River Bend Station - Unit 1	2. DOCKET NUMBER 05000-458	3. LER NUMBER		
		YEAR 2016	SEQUENTIAL NUMBER 007	REV NO. 00

**NARRATIVE**

**PREVIOUS OCCURRENCE EVALUATION**

In the last three years, River Bend Station has reported the following incidents of operations prohibited by Technical Specifications:

- LER 050-458 / 2016-03-00 (report date 3/17/16) – This event involved a postulated malfunction in a reactor control rod drive mechanism, not a human performance deficiency. The investigation of this event will be completed during the next refueling outage.
- LER 050-458 / 2015-06-00 (report date 9/14/2015) – This event involved the use of superseded vendor manual data in the initial troubleshooting of an abnormal system response during surveillance testing. Later analysis confirmed that the affected subcomponent should have been declared inoperable at the time of discovery.
- LER 050-458 / 2015-03-00 (report date 7/9/2015) – This event involved the mis-positioning of a manual valve in the Division 2 containment penetration leakage control system. The investigation found that operators failed to adequately apply configuration control requirements regarding that valve.
- LER 050-458 / 2015-01-00 (report date 4/16/2015) – This event involved a deficient surveillance test procedure.
- LER 050-458 / 2014-03-00 (report date 8/11/2014) – This event involved the concurrent inoperability of redundant channels of an RPS trip function due to a common cause malfunction in channels containing a certain type of relay.

While the second and third items above were related to human performance deficiencies, neither of them were attributed to a root cause involving errors in the application of Technical Specifications requirements.

**SAFETY SIGNIFICANCE**

Approximately four days following the discovery of the air leaks and the governor drive coupling configuration, DG system engineers documented operability evaluations which concluded that none of these conditions posed any potential challenge to the ability of the DG to fulfill its safety function. It was confirmed that no similar conditions were present on the Division 2 DG. The air leaks were repaired and the governor drive coupling assembly was corrected prior to restoration of the Division 1 DG to an operable status. This event had no significance with respect to the health and safety of the public.

(NOTE: Energy Industry Identification System component function identifier and system name of each component or system referred to in the LER are annotated as (\*\*XX\*\*) and [XX], respectively.)