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September 4, 1992

RBG- 37, 455 File Nos. G9.5, G9.25.1.3

U.S. Nuclear Regulatory Commission Document Control Desk Washington, D.C. 20555

Gentlemen:

River Bend Station - Unit 1 Docket No. 50-458

Please find enclosed Licensee Event Report No. 92-015 for River Bend Station - Unit 1. This report is submitted pursuant 10CFR50.73.

Sincerely,

W. H. Odel

Manager - Oversight River Bend Nuclear Group

ME/POG/FRC/HM/FRH/pj

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cc: U.S. Nuclear Regulatory Commission 611 Ryan Plaza Drive, Suite 400 Arlington, TX 76011

> NRC Resident Inspector P.O. Box 1051 St. Francisville, LA 70775

INPO Records Center 1100 Circle 75 Parkway Atlanta, GA 30339-3064

Mr. C. R. Oberg Public Utility Commission of Texas 7800 Shoal Creek Blvd., Suite 400 North Austin, TX 78757

Louisiana Department of Environmental Quality Radiation Protection Division P.O. Box 82135 Baton Rouge, LA 70884-2135 ATTN: Administrator

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN FER RESPONSE TO COMPLY WITH THI INFORMATION COLLECTION REQUEST 500 HPS FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORD AND REPURTE MANAGEMENT BRANCH (F-530). U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20565, AND TOTHE PAPERWORK, REDUCTION PROJECT (3150-4104). OFFIC OF MANAGEMENT AND BUDGET WASHINGTON, DC 20561.

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At 1547 on August 8, 1992 with the unit shutdown (Operational Condition 5), a plant operator returned the reactor water clean-up (RWCU) bypass switches to the normal configuration following maintenance and, due to a failure of the RWCU backwash receiver high ambient temperature monitor, a RWCU system isolation occurred. Apparently, the RWCU backwash receiver high ambient temperature monitor, 1E31*TSN627B, failed during the period that the RWCU bypass switch was in BYPASS. The switch failure resulted in a common alarm in the main control room but did not give an alarm indication at the switch unit. The RWCU pumps were manually secured by plant operators.

The root cause of this event is a combination of personnel error and equipment failure. The personnel error is due to inadequate investigation and resultant incorrect assumption of the cause for the "RWCU BW RCVR HI AMBIENT OR DIFF TEMP" alarm. Although the specific failure mode of the temperature switch is not known at this time, the malfunctioning unit is being returned to the equipment vendor for an in depth analysis of the failure mechanism. The malfunctioning switch was replaced with a new unit and satisfactorily tested in accordance with STP-207-5233. Initiation of RWCU system isolation was based on an invalid isolation signal and had no adverse impact on plant safety. As a result, there was no impact on the health and safety of the public.

NRC FORM SEEA

U.S. NUCLEAR REGULATORY COMMISSION

U.S. NUCLEAR REGULATORY COMMISS

TEXT CONTINUATION

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST SOST HER FORWARD COMMENTS REGARDING SURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-530), U.S. NUCLEAR REGULATION FOOMMISSION WASHINGTON, DC 2056S. AND TO THE FAFERWORK REDUCTION PROJECT (3:50-5104). OFFICE DE MANAGEMENT AND SURGET WASHINGTON CO 2056S.

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REPORTED CONDITION

At 1547 on August 8, 1992 with the unit shutdown (Operational Condition 5), a plant operator returned the reactor water clean-up (*CE*) (RWCU) bypass switches to the normal configuration following maintenance and, due to a failure of the RWCU backwash receiver high ambient temperature monitor, 1E31*TSN627B, a RWCU system isolation occurred. The isolation of the RWCU system constitutes an engineered safety feature (ESF) actuation. Therefore, this event is reportable under 10CFR50.73 (a)(2)/iv).

INVESTIGATION

Following plant maintenance, the RWCU bypass switches were being returned to the normal configuration per SOP-0090. Apparently, the RWCU backwash receiver high ambient temperature monitor 1E31*TSN627B failed during the period that the RWCU bypass switch was in BYPASS. The switch failure resulted in a common alarm, "RWCU BW RCVR HI AMBIENT OR DIFF TEMP", at 1H13*P680 in the main control room but did not give an alarm indication at the switch unit, also located in the main control room. The plant operators thought that the alarm was due to a failed annunciator card since the switch unit was not in the alarm state. All isolation functions occurred as expected with the exception that the RWCU pumps did not trip due to jumpers being installed for the low flow trip function because of maintenance (MWOR-059199). The PWCU pumps were manually secured by plant operators.

The cause of the isolation signal was the failure of the monitor's temperature switch No. 1E31*TSN627B, Model 86 PEGF-EG. This switch was manufactured by The Riley Company. While troubleshooting, Maintenance personnel noted that the internal hermetically sealed output relay appeared to be stick but the specific cause of this failure is not known. For a description of earlier events involving Riley temperature switches, see LERs 85-009, 85-029, 85-031, 85-035, 85-037, 86-050, 86-051, 88-024, 90-019 and 90-046. The malfunctioning temperature switch was replaced and tested satisfactorily in accordance with STP-207-5233.

ROOT CAUSE

The root cause of this event is a combination of personnel error and equipment failure. The personnel error is due to inadequate investigation and resultant incorrect assumption of the cause for the "RWCU BW RCVR HI AMBIENT OR DIFF TEMP" alarm. Although the specific failure mode of the temperature switch is not known at this time, the malfunctioning unit is being returned to the equipment vendor for an in depth analysis of the failure mechanism. A review of NPRDS for similar failures (invalid alarm signals, not caused by use of the read/set switch) indicates 4 occurrences for Riley temperature switches system wide. None of the failures described are the same as the failure observed in this case. This failure rate is not considered to be excessive and, based on failure information currently available, no generic corrective action is being pursued at this time.

CORRECTIVE ACTION

The malfunctioning switch was replaced with a new unit and satisfactorily tested in accordance with STP-207-5233. The malfunctioning switch was returned to the vendor for failure analysis. No long term corrective action is necessary at this time as a result of this equipment failure.

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U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3160-0104 EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 500 HRS FORWARD COMMENTS REGARDING SURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT SERVICE (F. 1500 10 S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20565, AND TO THE FAPERWORK REDUCTION PROJECT (3150 0104), OFFICE OF MANAGEMENT AND SUDGET WASHINGTON, DC 20503.

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A night order was impleme led to remind control room operators of the need to use extreme caution when restoring a system to service following an extended shutdown for maintenance and the need to use all available sources to determine the cause of an alarm.

SAFETY ASSESSMENT

The plant was shutdown for refueling and the status of the RWCU was operating normally. Initiation of RWCU system isolation was based on an invalid isolation signal and had no adverse impact on plant safety. As a result, there was no impact on the health and safety of the public.

(Energy Industry Identification System Codes are identified as *XX*).