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James J. Fisicaro
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February 15, 1996

U.S. Nuclear Regulatory Commission
Document Control Desk
Mail Stop P1-37
Washington, D.C. 20555

Subject: River Bend Station - Unit 1
Docket No. 50-458
License No. NPF-47
Licensee Event Report 50-458/96-005-00
File Nos. G9.5, G9.25.1.3

RBG-42380
RBF1-96-0027

Gentlemen:

In accordance with River Bend Station Operating License NPF-47, Section 2.E, enclosed is the subject report.

Sincerely,

James J. Fisicaro

JJF/WJF/kvm
enclosure

IE22
1/1

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

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

INPO Records Center
700 Galleria 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

NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
River Bend Station	05000-458	1 of 3

TITLE (4) **Noncompliance With License Condition By Inadequate Tagging of Hose and Cabling Due to Change Management**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
									N/A	05000
01	16	96	96	-- 005 --	00	02	15	96	FACILITY NAME: N/A	DOCKET NUMBER: 05000

OPERATING MODE (9)	5
POWER LEVEL (10)	000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	X OTHER
20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
D. N. Lorfing, Supervisor - Licensing	504-381-4157

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On January 16, 1996, with the plant in mode 5 for Refueling Outage 6, noncompliance with the requirements of Operating License Condition 2.C (17) to the River Bend Operating License was discovered during a QA surveillance. A fire hose and cabling for automated ultrasonic examinations was routed through the Fuel Building airlock without a tag at both ends identifying specific instructions to expedite removal. This did not meet the requirements of the license condition. Core alterations were in process at the time. This plant condition is reportable pursuant to the River Bend Station Operating License, NPF-47, Section 2.E.

Three root causes were associated with this event. They are: 1) change management in that change related documents were not fully developed, 2) work practices in that a procedure was not followed correctly and 3) written communication in that the procedure controlling obstruction tags and the obstruction tags themselves were unclear regarding the requirement to identify specific instructions to expedite removal. Corrective actions include Operator training, revising the controlling procedure, and review of the RBS training process for license amendments.

The noncompliance with Operational Condition 17 existed for approximately nine hours. This event was not safety significant. Two other recent RBS LERs (94-029 and 95-009) address the implementation of license changes.

REPORTED CONDITION

On January 16, 1996, with the plant in mode 5 for Refueling Outage 6 (RF6), it was discovered during a quality assurance (QA) surveillance that River Bend was not in compliance with Operating License Condition 2.C (17) as added by Amendment 85 of Operating License NPF-47, which requires that hoses and cables running through the airlock be tagged at both ends with specific instructions to expedite removal. Core alterations were in process at the time. This noncompliance existed for about nine hours on January 16, 1996, and is reportable pursuant to the River Bend Station (RBS) Operating License, NPF-47, Section 2.E.

INVESTIGATION

During a planned quality assurance surveillance of the implementation of Amendment 85 to NPF-47, a fire hose and cabling for automated ultrasonic test equipment was observed routed through the airlock from the Fuel Building to the Reactor Building. The hose and cabling did not have the required tags on both ends providing specific instructions to expedite removal.

The fire hose was installed to provide backup fire protection for the Reactor Building during maintenance and testing of fire protection water penetration and isolation valves. The hose was routed through the airlock per Operations request, but was not pressurized. During installation, a coupling was provided at the airlock and obstruction tags were installed. However, the obstruction tags did not contain specific instructions to expedite removal. The fire hose was listed in the obstruction log book.

The automated ultrasonic test cabling extended from the drywell through the airlock into the Fuel Building, but had not been connected and was coiled up outside the Fuel Building side of the airlock. The cabling had been pulled through the airlock approximately four hours before identification during the quality assurance surveillance. No obstruction tags were installed on the cabling and it was not listed in the obstruction log book.

Core alterations for RF6 had commenced on January 13, 1996, and continued on January 16th until this noncompliance was identified. Upon identification of the noncompliance with the operating license condition, the Operations Shift Superintendent immediately stopped core alterations. The ultrasonic cabling was removed, the labeling on the fire hose was corrected, tools to facilitate removal were staged at the fire hose coupling, an individual was stationed at the airlock to monitor use of obstructions during core alterations, and core alterations resumed after an interval of about 35 minutes.

ROOT CAUSE

Three root causes were associated with this event. They are: 1) change management in that change related documents were not fully developed, 2) work practices in that a procedure was not followed correctly and

3) written communication in that the procedure controlling obstruction tags and the obstruction tags themselves were unclear regarding the requirement to identify specific instructions to expedite removal.

Another contributing cause was identified concerning the training provided to Operations personnel on Amendment No. 85. The training was conducted using a copy of the original License Amendment Request submittal and did not include Operating License Condition 2.C (17). The training included the requirements which were contained within the license condition. However, the requirements were reflected as being included within a Technical Requirements Manual (TRM) change. The TRM change had not been issued.

A review of recent Licensee Event Reports (LERs) was performed for similar events. Two LERs (94-029 & 95-009), both associated with the implementation of Amendment #74 to the RBS License, were identified. LER 95-009 was issued on December 1, 1995. One of the corrective actions associated with LER 95-009 has direct impact on the causes of this LER and states that: "Specific implementation process improvements directed at the identification, review and revision requirements associated with all phases of the RBS license document change implementation process will be evaluated by a multi-discipline team to enhance the RBS process for implementing license document changes. Corrective actions will be assigned to the responsible departments to track completion of the process changes deemed necessary." This corrective action has not yet been completed.

CORRECTIVE ACTIONS TO PREVENT RECURRENCE

Follow-up training on this event and the controlling procedure was conducted during Operations shift briefings and Operating License Amendment No. 85 was routed as required reading for all Senior Reactor Operators.

The controlling procedure will be revised as necessary to clarify posting and labeling requirements. The obstruction tags will also be evaluated for clarification/improvement. Operators will receive training on the procedure revision and on the root causes associated with this event.

The process of evaluating improvements in the license document change process (per LER 95-009 above) will also include review of RBS training on license amendments.

SAFETY ASSESSMENT

Noncompliance with Operating License Condition 2.C (17) existed for about nine hours. Irradiated fuel was being moved; however, the need to re-establish primary containment did not occur during this time. Since the fire hose was not pressurized and contained a coupling at the airlock, it posed no special hazards and could have been removed within a few minutes. The ultrasonic cabling could also have been easily removed since it had not been connected and the unconnected end was coiled just outside the airlock on the Fuel Building side. As a result, this event was of little safety significance.