NAC Form 244 (\$-33)								CENSEE EVENT REPORT (LER)					U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3180-0104 EXPIRES 8/31-88						
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ABSTRACT (Limit to 1400 special i.e. approximately fifteen single space type writts fill all (18)

YES IT YES COMPLETE EXPECTED SUBMISSION DATE!

SUPPLEMENTAL REPORT EXPECTED IN

At 0500 hours on 8/15/88, with the unit at 100 percent power, an automatic isolation of the reactor water cleanup system (RWCU) occurred during the performance of a surveillance test procedure (STP). Also, division II main steam line drain valves isolated as well as the division II isolation valve to the reactor sample panel.

The actuations occurred due to technicians not following steps in the proper sequence as required by the STP.

The personnel involved were counseled on this event. All instrument and controls (I&C) technicians received training on the requirement of following steps in sequence as prescribed in procedures.

The system performed as designed when it was inadvertently actuated. No other challenges to ESF systems occurred, and the system was returned to its normal configuration after the event.

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MONTH DAY

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NAC Form 386A	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION							U.S. NUCLEAR REGULATORY COMM. 4810N APPROVE" OMB NO 3150-0104 EXPIRES 8-31-98									
ACILITY NAME (1)		DOCKET NUMBER (2)		LE	-	NUMBER (6)				PAGE (3)							
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Reported Condition

At 0500 hours on 8/15/88, with the unit at 100 percent power, an automatic isolation of the reactor water cleanup system (RWCU) (*CE*) occurred during the performance of a surveillance test procedure (STP). Also, division II main steam line drain (*DRN*) valves (*V*) isolated as well as the division II isolation valve (*ISV*) to the reactor sample panel. This condition is being reported as an inadvertent Engineered Safety Feature (ESF) actuation pursuant to 10CFR50.73(a)(2)(iv).

Investigation

This actuation occurred due to instrumentation and controls (I&C) technicians incorrectly following the sequence of steps prescribed in STP-058-4501, "Containment and Drywell Manual Isolation Actuation Monthly Channel Functional Test". During the surveillance, the technicians were nearing completion of the test section for the "B" channel of the manual nuclear steam supply shutoff system (NSSSS) isolation pushbutton. Before completing this section, the technicians proceeded to make initial preparations to test the "C" logic channel. These preparations consisted of unscrewing covers to relay (*RLY*) boxes used to maintain electrical separation between redundant channels.

Contrary to the requirements of the procedure, the technicians did not stop at this point and instead continued with the testing of the "C" logic channel. Neglecting steps not yet completed for the "B" channel, the technicians requested the at-the-controls operator to arm and depress the manual NSSSS isolation pushbutton to the "C" logic channel. The system performed as designed with the subsequent system isolation occurring.

A review of previously reported LERs from River Bend Station revealed instances of ESF actuations due to a failure to follow procedures. LERs 85-031, 85-045, 85-051, and 86-051 reported RWCU isolations during surveillance testing when personnel failed to place the RWCU isolation bypass switch in the bypass position causing the system isolation.

In LER 85-045 a technician omitted a procedural step in an STP causing and Emergency Core Cooling System (ECCS) injection, and in LER 87-012 electrical intenance personnel caused a loss of electrical power to feedwate: "ulating valves via a power interruption due to not followin. "eir job plan and maintenance procedure for troubleshooting a batter; nverter. In each of those events, the involved personnel were counseled or procedures revised to improve clarit; and enhance procedure performance.

Corrective Action

The technicians involved have been counseled on this event. In addition, training was conducted to caution all technicians on the requirements for following steps in the sequence prescribed in procedures. All I&C foreman have been counseled on the need to more actively monitor technicians performing sensitive testing.

Safety Assessment

The system performed as designed when it was inadvertently actuated. No other challenges to plant ESF systems occurred as a result of this event. The systems were returned to their normal standby configurations shortly after the occurrence.

Note: Energy Industry Identification System Codes are identified in the test as (*XX*).

GULF STATES UTILITIES COMPA KEVER BEND 11-DON: A. 10FFICE BOX 220 BY FRANCISVILLE LOUISIANA 20725

AREA CODE SC4 835 6094 346 8661 .

September 12, 1988 RBG-28782 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. 88-016 for River Bend Station - Unit 1. This report is being submitted pursuant to 10CFR50.73.

Sincerely,

Att J. E. Booker

Manager-River Bend Oversight River Bend Nuclear Group

cc: U.S. Nuclear Regulatory Commission 611 Ryan Plaza Drive, Suite 1000 Arlington, TX 76011

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

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