

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1): RIVER BEND STATION

DOCKET NUMBER (2): 0 5 0 0 0 4 E 1 8 1 OF Q 3

PAGE (3): 1 OF Q 3

TITLE (4): Fuel Building Charcoal Filtration System Initiation Due to Lifting Wrong Lead

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 NAMES			
08	27	88	88	019		00	09	26	88	U 5 0 0 0		
0 5 0 0 0												

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

OPERATING MODE (9): 3	20.402(a)	20.408(a)	<input checked="" type="checkbox"/>	60.73(a)(2)(iv)	73.71(a)
POWER LEVEL (10): 0 p 10	20.408(a)(1)(i)	60.36(a)(1)	<input type="checkbox"/>	60.73(a)(2)(iv)	73.71(a)
	20.408(a)(1)(ii)	60.36(a)(2)	<input type="checkbox"/>	60.73(a)(2)(v)	OTHER (Specify in Abstract below and in Text NRC Form 306A)
	20.408(a)(1)(iii)	60.73(a)(2)(i)	<input type="checkbox"/>	60.73(a)(2)(vii)(A)	
	20.408(a)(1)(iv)	60.73(a)(2)(ii)	<input type="checkbox"/>	60.73(a)(2)(vii)(B)	
	20.408(a)(1)(v)	60.73(a)(2)(iii)	<input type="checkbox"/>	60.73(a)(2)(iii)	

LICENSEE CONTACT FOR THIS LER (12):

NAME: L.A. England - Director-Nuclear Licensing

TELEPHONE NUMBER: 5 10 14 3 B 1 1 - 1 4 1 1 4 5

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

CAUSE	SYSTEM	COMPONENT	MANUFAC TURE	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFAC TURE	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14):

YES (if yes, complete EXPECTED SUBMISSION DATE):  NO

EXPECTED SUBMISSION DATE (15):

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 words - i.e. approximately fifteen single space typewritten lines) (16):

At 0251 on 8/27/88 with the unit in hot shutdown (Operational Condition 3), an Engineered Safety Feature actuation occurred of the fuel building ventilation charcoal filtration system while performing a maintenance task on radiation monitor 1RMS\*RE5B. This radiation monitor provides the automatic initiation signal. After verifying that no actual high radiation condition existed, the fuel building filtration system was returned to its normal standby configuration.

Investigation into the cause of this actuation determined that the technicians were required to lift leads in the radiation monitor's adjacent junction box as stated in the work procedure, but instead lifted leads in the systems RM-80 control cabinet. The technicians incorrectly assumed that the adjacent junction box was in the RM-80 control cabinet. This action caused the radiation monitor to de-energize, generating the fail-safe actuation signal.

As corrective action, the technicians involved have been retrained and the proper leads to be lifted for this task will be uniquely identified and noted in the work procedure.

The safety function of the system performed as designed upon loss of the radiation monitor. In addition, there was no irradiated fuel being handled in the fuel building and hence, there was no possibility of producing airborne radioactivity which would have required the initiation of this system. Therefore, there was no adverse impact on the health and safety of the public as a result of this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 8	- 0 1 1 9	- 0 0 0	2	0	0

TEXT (if more space is required, use additional NRC Form 365A's) (17)

Reported Condition

At 0251 on 8/27/88 with the unit in hot shutdown (Operational Condition 3), an Engineered Safety Feature (ESF) actuation occurred of the fuel building (\*ND\*) ventilation charcoal filtration system (\*BH\*). The actuation was caused by technicians lifting the wrong leads while performing maintenance on radiation monitor (\*RE\*) IRMS\*RE5B which provides the automatic initiation signal for this system. After verifying that no actual high radiation condition existed, the fuel building filtration system was returned to its normal standby configuration.

Investigation

Investigation into the cause of this actuation determined that the technicians lifted the wrong leads as part of the maintenance task. Leads were required to be lifted to prevent an unnecessary actuation of the ventilation system prior to de-energizing radiation monitor IRMS\*RE5B to replace its sample filter paper (\*FLT\*). Personnel involved in this incident were required to lift leads in the monitors adjacent junction box (\*JBX\*) as stated in the work procedure, but instead lifted leads in the systems RM-80 control cabinet (\*CAB\*). The technicians incorrectly assumed that the adjacent junction box was in the RM-80 control cabinet. This action caused the radiation monitor to de-energize generating the fail-safe actuation signal.

A review of previous LERs submitted by River Bend Station revealed that LERs 85-018, 85-028, 85-056, and 86-058 reported ESF actuations as a result of station personnel incorrectly identifying equipment. Corrective action for LER 85-018 included actions to make the correct relay more easily identifiable by adding test jacks. Corrective action for each of these events included counseling for the individuals involved.

Corrective Action

The technicians involved and their foreman have been counseled on the need to increase their attention to detail. In addition, both technicians involved have been retrained on the correct method for performing this type of maintenance. All I&C technicians will also be retrained on how to safely perform this type of maintenance by 10/31/88. Additionally, to prevent similar occurrence in the future, the proper cabinet and the leads that are required to be lifted for performance of this task will be uniquely identified for this and all other radiation monitors which can provide an ESF actuation. This unique identification will be noted in the work procedure that performs this maintenance to avoid a similar confusion in the future. This action will also be completed by 10/31/88.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	

TEXT (if more space is required, use additional NRC Form 388A's) (17)

Safety Assessment

The safety function of the system performed as designed upon loss of power to the radiation monitor which initiates the fail-safe high radiation signal. Therefore, the system performed its conservative function by filtering the air released from the fuel building prior to releasing it to the environment. Additionally, there was no irradiated fuel being handled in the fuel building at the time of this event. Therefore, there was no possibility of producing airborne radioactivity which would have required the initiation of this system. As a result, there was no adverse impact on the health and safety of the public as a result of this event.

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



**GULF STATES UTILITIES COMPANY**

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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. 88-019 for River Bend Station - Unit 1. This report is being submitted pursuant to 10CFR50.73.

Sincerely,

*J. E. Booker* by *RJK*

J. E. Booker  
Manager-River Bend Oversight  
River Bend Nuclear Group

JEB/TFP/PDG/DAS/ch

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