

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) RIVER BEND STATION	DOCKET NUMBER (2) 0 2 1 0 0 0 4 5 8	PAGE # 1 OF 0 3
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TITLE (4) **Alternate Rod Insertion/Anticipated Transient Without Scram (ARI/ATWS) System Initiation causing Reactor Scram due to Misleading Surveillance Test Procedure Wording**

EVENT DATE (8)			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 (8)
0 1	1 0	8 8	8 8	0 0 2	0 0 0	2 0	9 8	8 8				0 5 0 0 0
												0 5 0 0 0

OPERATING MODE (5) **1**

POWER LEVEL (10) **0 9 5**

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

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(a)	<input checked="" type="checkbox"/> 20.736(c)(1)(v)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.406(a)(1)(B)	<input type="checkbox"/> 20.396(a)(1)	<input type="checkbox"/> 20.736(c)(1)(v)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.406(a)(1)(B)	<input type="checkbox"/> 20.396(a)(2)	<input type="checkbox"/> 20.736(c)(1)(v)	OTHER (Specify in Abstract below and in Text, NRC Form 308A)
<input type="checkbox"/> 20.406(a)(1)(B)	<input type="checkbox"/> 20.736(a)(2)(i)	<input type="checkbox"/> 20.736(c)(1)(v)(A)	
<input type="checkbox"/> 20.406(a)(1)(D)	<input type="checkbox"/> 20.736(a)(2)(ii)	<input type="checkbox"/> 20.736(c)(1)(v)(B)	
<input type="checkbox"/> 20.406(a)(1)(H)	<input type="checkbox"/> 20.736(a)(2)(iii)	<input type="checkbox"/> 20.736(c)(1)(v)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Rick King - Supervisor-Nuclear Licensing	TELEPHONE NUMBER
	AREA CODE 51014 NUMBER 31811-1411417

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

On 1/10/88 at approximately 0933 hours, with the unit in power operation at approximately 95 percent power, instrument and controls (I&C) technicians inadvertently initiated a full scram via the alternate rod insertion (ARI) trip system, while performing Surveillance Test Procedure (STP)-051-4269, "ATWS Recirc Pump Trip Reactor Vessel Pressure High Monthly Channel Functional, 18 Month Channel Cal, 18 Month LSFT." Investigation revealed that the technicians lifted leads from the wrong terminal block, which caused two ARI trip units to lose their signal and caused an ARI/Anticipated Transient Without Scram (ATWS) system initiation. The STP was misleading in the location of the terminal block and improperly led the technicians to terminal block TB6 instead of the correct terminal block, TB0006.

The STP was revised, and the procedure was rerun with no problem. I&C technicians were trained on this incident through shop training. ATWS STPs were reviewed, evaluated, and reworded to clearly define the corrected terminal board location.

The initiation of ARI caused all control rods to be inserted shutting down the reactor. All plant responses occurred as designed. There was no impact on the safe operation of the plant or to the health and safety of the public as a result of this event.

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		88	002	00	02	OF 03

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

REPORTED CONDITION

On 1/10/88 at approximately 0933, with the unit in power operation (mode 1) at approximately 95 percent power, instrument and controls (I&C) technicians inadvertently initiated a full reactor scram, via the alternate rod insertion (ARI) trip system, and an Anticipated Transient Without Scram (ATWS) recirculation pump trip. While performing Surveillance Test Procedure (STP)-051-4269, "ATWS Recirc Pump Trip Reactor Vessel Pressure High Monthly Channel Functional, 18 Month Channel Cal, 18 Month LSPT," for monthly function testing requirements, the technicians lifted wiring from terminal block TB6, terminals 4 and 5. Removal of the wiring from terminal 4 resulted in breaking the common ground from trip units 1B21-N699A and 1B21-N699F initiating an ARI/ATWS trip and reactor scram. The correct leads to be lifted were on terminal block TB0006, terminals 4 and 5, located in the same panel.

INVESTIGATION AND CORRECTIVE ACTION

Investigation revealed the procedure was misleading in the location of the terminal block, describing it as "behind the trip unit" and led the technician to TB6 on the back of the trip unit rack.

Corrective action to prevent recurrence included shop training for I&C technicians on the incident. ATWS STPs were reviewed, evaluated, and reworded to clearly define the correct terminal board location. ATWS control room panels were marked with caution signs which note the common power supply and signal common wiring configuration and indicate the potential for causing a reactor scram.

A review of previously submitted LERs from River Bend Station revealed some similar instances of performing procedures as written containing errors which led to the inadvertent actuation of engineered safety features (ESF). LER 87-032 reported a procedural error causing the isolation of the backup water supply for the control rod drive hydraulic pumps which later necessitated a manual reactor scram to comply with Technical Specifications. LERs 85-055 and 85-062 identified incorrect terminal locations for the placement of jumpers which led to an inadvertent reactor protection system (RPS) actuation and reactor water cleanup (RWCU) isolation, respectively. LER 87-022 identified improperly sequenced steps in a procedure which led to a loss of shutdown cooling due to a residual heat removal (RHR) system isolation. Corrective actions for these events could not have detected the procedural error which led to the event reported here.

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

SAFETY IMPACT

The initiation of ARI/ATWS caused all control rods to be inserted safely shutting down the reactor and tripping both recirculation pumps. All other plant responses were as designed; therefore, there was no impact on the safe operation of the plant or to the health and safety of the public as a result of the event.

NOTE: Energy Industry Identification Codes are identified in the text as (*X)*.



GULF STATES UTILITIES COMPANY

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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. 88-002 for River Bend Station - Unit 1. This report is being submitted pursuant to 10CFR50.73.

Sincerely,

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

JEB
JEB/TFP/AOF/RRS/ch

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