

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) RIVER BEND STATION DOCKET NUMBER (2) 050004581 OF 03

TITLE (4) STP Not Performed At High Point Vents

Table with columns: EVENT DATE (1), LER NUMBER (6), REPORT DATE (7), OTHER FACILITIES INVOLVED (8). Includes sub-columns for month, day, year and facility names.

Table for regulatory requirements: OPERATING MODE (1), POWER LEVEL (10), and checkboxes for 10 CFR 50.72(a) through (j).

LICENSEE CONTACT FOR THIS LER (12) NAME: E.R. Grant - Director-Nuclear Licensing TELEPHONE NUMBER: 510461351-1619195

Table for component failures: COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13). Columns include CAUSE, SYSTEM, COMPONENT, MANUFACTURER, REPORTABLE TO NRC.

SUPPLEMENTAL REPORT EXPECTED (14) YES (if yes, complete EXPECTED SUBMISSION DATE) NO EXPECTED SUBMISSION DATE (15) 013 115 817

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16) At 1630 on 10/2/86 with reactor power at 100 percent it was discovered that venting of the A and B Low Pressure Coolant Injection (LPCI) lines to verify that the piping from the pump discharge valve to the injection valve is filled with water was not being performed at the vents in the highest point in the piping as required by the Technical Specifications. Technical Specification Section 4.5.1.a.1 requires that the piping for the LPCI systems be verified to be filled with water at the high point vents at least once per 31 days. The surveillance was being performed using vents which were not at the piping high point on LPCI Loops A and B. The correct high point vent valves were installed in August, 1985 prior to initial plant startup but after issuance of the applicable Surveillance Test Procedures (STP). The correct vents were not incorporated into the STPs until the day after the error was discovered on 10/2/86. When the error was discovered, the loops were vented using the correct high point vents. No air was discovered in the lines. The health and safety of the public was not affected since no system damage occurred and all related systems have functioned as designed.

Handwritten signature/initials: IE22

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	OF	
		8 6	- 0 5 9	- 0 1		
RIVER BEND STATION	0 5 0 0 0 4 5 8				0 2	0 3

TEXT IS MORE READABLE IF REPORTED, AND ADDITIONAL NRC Form 288a (1/17)

REPORTED CONDITION

At 1630 on 10/2/86 with the reactor at 100 percent power, an engineer was performing the restoration steps in a Surveillance Test Procedure (STP) which required venting the Low Pressure Coolant Injection (LPCI) Loop A injection piping. It was discovered that although Loops A and B injection piping had been verified to be full of water on a monthly basis as required by Technical Specification 4.5.1.a.2, the vents used were not located at the highest point in the piping.

INVESTIGATION

On 6/8/85, prior to initial plant startup, the high point vents of the LPCI System Loops A and B were discovered to be located on the vertical run of pipe a few feet below where the piping turned horizontally toward the LPCI injection valves. Because of the long run of horizontal pipe beyond this point (approximately 30 feet of piping on the A loop and 38 feet on the B loop upstream of the injection valves) it could not be verified to be full of water using the installed high point vents. A design change was incorporated during construction to add new high point vents in the horizontal runs of pipe. The modifications were completed in August, 1985.

The original issue of the STP's written to verify that system piping from the pump discharge valve to the system injection valve is filled with water were issued in December, 1984 and revised in June and July of 1985. Therefore, the STP's used the valves which were originally intended to be the high point vents. After the modifications to add the new vents were completed, the STP's remained as originally written. The investigation into how and why the STP's were not revised to reflect the revised design discovered that during the final stages of construction, a number of construction design changes (E&DCR's) were closed without verification that they had been implemented into plant procedures. This occurred during June, July and August of 1985 just prior to fuel load. The controlling procedure for E&DCR's required the verifications to be completed prior to closure of the E&DCR. During this period of time, the control of design changes was being gradually transferred from the construction organizations to the operating organizations. Since completion of the design transfer, the above condition has not occurred.

A review of the E&DCR's which did not receive a complete review for changes to plant procedures was performed. A few cases were found where plant procedures were not updated to reflect a E&DCR. Other than the case which initiated this LER, none were found that could have affected the operability of plant systems or components.

An analysis is currently in progress to determine the effects had the piping between the incorrect high point vents and the injection valves been full of air. The results of this analysis will be provided in a revised report expected to be submitted by 3/15/87.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0 5 0 0 0 4 5 8	8 6 - 0 5 9	- 0 1	0 2	OF	0 3

RIVER BEND STATION

TEXT IF MORE SPACE IS REQUIRED, USE ADDITIONAL NRC Form 2854 (1/17)

The piping is now being vented through the correct high point vents and no air has been discovered. The system injection valves are exercised open during cold shutdown for the ISI pump and valve testing program. This provided an additional system vent for any air that may have accumulated in the horizontal run of pipe to the reactor vessel.

CORRECTIVE ACTION

The piping was immediately vented from the correct vents and no air was discovered in the lines. The applicable STP's were revised to use the correct high point vents. Since all E&DCR's completed during the transition phase have been reviewed for incorporation into plant procedures and all appropriate procedure changes have been completed, no further corrective action is necessary.

SAFETY ASSESSMENT

There were no adverse affects on the health and safety of the public as a result of this event since no system damage occurred and all related systems have functioned as designed.



GULF STATES UTILITIES COMPANY

RIVER BEND STATION POST OFFICE BOX 220 ST FRANCISVILLE, LOUISIANA 70775

AREA CODE 504 635-6094 346-8651

January 9, 1987
RBG-25209
File Nos. G9.5, G9.25.1.3

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

Dear Sir:

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

Please find enclosed Licensee Event Report No. 86-059 Revision 1 for River Bend Station - Unit 1. This revision is being submitted pursuant to 10CFR50.73 to provide the results of additional investigation.

Sincerely,

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

ug
JEB/TFP/PDG/DAS/je

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

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

NRC Resident Inspector

IE22
11