Tennessee Valley Authority, Post Office Box 2000, Spring City, Tennessee 37381-2000

William R. Lagergren, Jr. Site Vice President, Watts Bar Nuclear Plant

## OCT 2 7 2003

10 CFR 50.73

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

Gentlemen:

In the Matter of ) Tennessee Valley Authority ) Docket No. 50-390

WATTS BAR NUCLEAR PLANT (WBN) - UNIT 1 - FACILITY OPERATING LICENSE NPF-90 - LICENSEE EVENT REPORT (LER) 50-390/2003-004

This submittal provides Licensee Event Report 390/2003-004. This LER addresses an event that occurred on August 28, 2003, which resulted in an a failure to meet Surveillance Request (SR) 3.5.2.3. This event is being reported under 10 CFR 50.73(a)(2)(i)(B).

The commitment documented in this letter is in Section VII of the Enclosure. If you have any questions about this change, please contact P. L. Pace at (423) 365-1824.

Sincerely,

V. R. Lagerg

Enclosure cc: See page 2



U.S. Nuclear Regulatory Commission Page 2

# OCT 2 7 2003

cc (Enclosure):

NRC Resident Inspector Watts Bar Nuclear Plant 1260 Nuclear Plant Road Spring City, Tennessee 37381

Ms. Margaret H. Chernoff, Project Manager U.S. Nuclear Regulatory Commission MS 08G9 One White Flint North 11555 Rockville Pike Rockville, Maryland 20852-2738

U.S. Nuclear Regulatory Commission Region II Sam Nunn Atlanta Federal Center 61 Forsyth St., SW, Suite 23T85 Atlanta, Georgia 30303

Institute of Nuclear Power Operations 700 Galleria Parkway, NW Atlanta, Georgia 30339-5957

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or pu of co as the sa 63 sy ali Or ve co St Pr	harging pumps (CCP) (EIIS CB). A r rder preparation. It was discovered d ump was drained to support maintena f the safety injection pump 1B-B may ontain instructions for draining and re ssure the "piggyback" supply piping t ne equipment to service. The operato afety injection pump 1B-B was perfor 3.01, "Safety Injection System." How ystem piping rather than the small po lignments outside the clearance bour on August 28, 2003, due to the suspic enting, a UT of the suction line to the ontrary to Technical Specification 3.5 urveillance Requirement (SR) 3.5.2.3 roblem Evaluation Report (PER) 03-0 ction Program	supply the suction of safe history review of that system luring that review, that on J ance activities. It appeared have been inadequate be filling, and because there we to the safety injection pump or log entry on January 15, rmed in accordance with the vever, the method in the pro- prtion that was actually drain dary and therefore, did no cion that gas may be in the pump was performed and 5.2, Emergency Core Cooli 3 which is to verify the ECC 014922-000 was initiated to	ety injection pump 1A-A ar m was being performed du lanuary 14-15, 2003, the s d that the draining and sul cause the associated wor was no evidence of specia p 1B-B was filled with wat 2003, indicated that fill an he System Operating Instr ocedure was for filling and ined. The procedure invol- ot adequately address the piping from the inadequa verified that gas was in the ing System, (ECCS) – Op CS piping is full of water.	nd both centrifugal uring the work afety injection bsequent refilling k orders did not al precautions to er when restoring id vent of the uction (SOI)- l venting the entire ved valve "piggy back" line. ate filling and he line. This is herating,

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There were no structures, components or systems inoperable at the start of the event that contributed to the event.

#### NRC FORM 366A (1-2001)

#### U.S. NUCLEAR REGULATORY COMMISSION

## LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET		6. LER NUMB	ER		3. PAG	E
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3	OF	7
Watts Bar Nuclear Plant, Unit 1	05000390	200	3 004	00			

17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

#### II. DESCRIPTION OF EVENT (continued)

#### C. Dates and Approximate Times of Major Occurrences

Time	Occurrences
January 14, 2003 2300 EDT	Entered Limiting Condition for Operation (LCO) 3.5.2 for safety injection pump 1B-B to remove pump from service for maintenance
January 15, 2003 1930 ED	Held pretest briefing for filling and venting of safety injection pump 1B-B using SOI-63.01.
January 15, 2003 2235 EDT	Exited LCO 3.5.2 for safety injection pump 1B-B due to all post modification testing being complete
August 28, 2003 1025 EDT	Entered LCO 3.5.2 Action A and LCO 3.6.6, Containment Spray System, Action B to allow UT inspection of the ECCS "piggyback" suction piping for the safety injection pump 1B-B due to suspicion that gas may be in the line.
August 28, 2003 1245 EDT	UT confirmed pockets of gas in the horizontal run of piping at Elevation 692 in the pipe chase were approximately 7/8 full.
August 28, 2003 1810 EDT	Plant Operations Review Committee approved a vent plan as this line was in the Auxiliary Building and was not in the procedure to verify the ECCS piping was full of water.
August 28, 2003 1850 EDT	Completed venting and achieved a solid stream of water for one minute. UT confirmed pipe was full of water.

#### D. Other Systems or Secondary Functions Affected

No other systems or secondary functions were affected by this event.

#### E. <u>Method of Discovery</u>

As discussed above, during preparation of Unit 1 Cycle 5 refueling outage, work orders were being prepared to perform UT on the ECCS safety injection system "piggy back" supply piping to the safety injection pump 1B-B. A history review of that system for the work order preparation discovered that on January 14-15, 2003, the safety injection pump was drained to support maintenance activities. It appeared that the draining and subsequent refilling of the safety injection pump 1B-B may have been inadequate because the associated work orders did not contain instructions for draining and refilling, and because there was no evidence of special precautions to assure the "piggyback" supply piping to the safety injection pump 1B-B was filled with water when restoring the equipment to service.

LICENSEE EVENT REPORT (LER)         I. FACILITY NAME       2. DOCKET       6. LER NUMBER         Variation of the second structure of	ORY COMMISSION	U.S. NUCLEAR REGULATO		19 <mark>-19, 000-1</mark> 9, 000-19	A	RM 366	NRC FO
I. FACILITY NAME         2. DOCKET         6. LER NUMBER           Watts Bar Nuclear Plant, Unit 1         05000390         2003 004 00         4           Watts Bar Nuclear Plant, Unit 1         05000390         2003 004 00         4           17. NARRATIVE (If more space is required, use additional cepies of NRC Form 366A) (17)         1         II. DESCRIPTION OF EVENT (continued)           F. Operator Actions         Upon discovery of the potential for gas to be in the piggyback supply piping to the safety injection p 18-B, LCO, Action A of Technical Specification 3.5.2 and LCO, Action B of Technical Specification were entered. The piggyback line was isolated by a tagout to ensure that the potential gas pocket u not be transported into any other section of ECCS piping if an ECCS pump started unexpectedly. Following venting and UT verification that the piping was full of water, the Technical Specifications Lt actions were exited.           G. Safety System Responses           There were no automatic or manual safety system responses and none were necessary.           III.         CAUSE OF EVENT           A. Immediate cause appeared to be inadequate procedural guidance for filling and venting of the safipecting pump 18-B suction line within the tagged out area of the work orders during the maintenan activities on January 14-15, 2003. In addition, that portion of the ECCS piping was not included in the procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water.           B. Root Cause         The root cause is still under development and will be provided in the supplement to this LER along		ER)	T REPORT (L	LICENSEE EVEN			(1-2001)
Watts Bar Nuclear Plant, Unit 1         Use additional copies of NRC Form 366A)         YEAR         SEQUENTAL         REWSION NUMBER         4           17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)         (17)         1         DESCRIPTION OF EVENT (continued)         7         0.04         -00         0.04         -00         10           18. DESCRIPTION OF EVENT (continued)         F.         Operator Actions         Upon discovery of the potential for gas to be in the piggyback supply piping to the safety injection p 18-B, LCO, Action A of Technical Specification 3.5.2 and LCO, Action B of Technical Specification were entered. The piggyback line was isolated by a tagout to ensure that the potential gas pocket o not be transported into any other section of ECCS piping if an ECCS pump started unexpectedly. Following venting and UT verification that the piping was full of water, the Technical Specifications Lt actions were exited.           G.         Safety System Responses           There were no automatic or manual safety system responses and none were necessary.           III.         CAUSE OF EVENT           A.         Immediate cause appeared to be inadequate procedural guidance for filling and venting of the safety injection pump 18-B suction line within the tagged out area of the work orders during the maintenan activities on January 14-15, 2003. In addition, that portion of the ECCS piping was not included in th procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water.           B.         Root Cause The root cause is still under deve	3. PAGE	6. LER NUMBER	2. DOCKET		1. FACILITY NAME	· · · · · · · · · · · · · · · · · · ·	
Watts Bar Nuclear Plant, Unit 1       05000390       2003 - 004 - 00         17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)       II.         II.       DESCRIPTION OF EVENT (continued)         F.       Operator Actions         Upon discovery of the potential for gas to be in the piggyback supply piping to the safety injection never entered. The piggyback line was isolated by a tagout to ensure that the potential gas pocket i not be transported into any other section of ECCS piping if an ECCS pump started unexpectedly. Following venting and UT verification that the piping was full of water, the Technical Specifications Li actions were exited.         G.       Safety System Responses         There were no automatic or manual safety system responses and none were necessary.         III.       CAUSE OF EVENT         A.       Immediate Cause         The immediate cause appeared to be inadequate procedural guidance for filling and venting of the safification stare of the work orders during the maintenan activities on January 14-15, 2003. In addition, that portion of the ECCS piping was not included in the procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water.         B.       Root Cause         The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies.         IV.       ANALYSIS OF EVENT         On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co vake, 1-FC	4 OF 7	YEAR SEQUENTIAL REVISION NUMBER NUMBER	· ·		······································		
<ul> <li>17. NARRATIVE (If more space is required, use additional copies of NRC Form 3664) (17)</li> <li>II. DESCRIPTION OF EVENT (continued)</li> <li>F. Operator Actions</li> <li>Upon discovery of the potential for gas to be in the piggyback supply piping to the safety injection p 18-B, LCO, Action A of Technical Specification 3.5.2 and LCO, Action B of Technical Specification were entered. The piggyback line was isolated by a tagout to ensure that the potential gas pocket i not be transported into any other section of ECCS piping if an ECCS pump started unexpectedly. Following venting and UT verification that the piping was full of water, the Technical Specifications Lt actions were exited.</li> <li>G. Safety System Responses</li> <li>There were no automatic or manual safety system responses and none were necessary.</li> <li>III. CAUSE OF EVENT</li> <li>A. Immediate Cause</li> <li>The immediate cause appeared to be inadequate procedural guidance for filling and venting of the safely existen recent procedure to implement Technical Specifications SR 3.5.2.3 to verify the ECCS piping is full of water.</li> <li>B. Root Cause</li> <li>The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies.</li> <li>IV. ANALYSIS OF EVENT</li> <li>On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co valve, 1-FCV-63-11. This valve is in a line in the ECCS piping on the discharge side of the RHR pump 18-1 normal position for 1-FCV-63-11 is closed and the valve is in a vertical configuration. The line connects the pump label and the centrificaal charding pump (CCF)</li> </ul>		2003 004 00	05000390		luclear Plant, Unit 1	Bar N	Watts
<ol> <li>DESCRIPTION OF EVENT (continued)</li> <li>Gerator Actions         Upon discovery of the potential for gas to be in the piggyback supply piping to the safety injection p 18-8, LCO, Action A of Technical Specification 3.5.2 and LCO, Action B of Technical Specification were entered. The piggyback line was isolated by a tagout to ensure that the potential gas pocket o not be transported into any other section of ECCS piping if an ECCS pump started unexpectedly. Following venting and UT verification that the piping was full of water, the Technical Specifications Lt actions were exited.     </li> <li>Safety System Responses         There were no automatic or manual safety system responses and none were necessary.     </li> <li>CAUSE OF EVENT         A. <u>Immediate Cause</u>         The immediate cause appeared to be inadequate procedural guidance for filling and venting of the satinjection part 12, 2003. In addition, that portion of the ECCS piping was not included in it procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water.     </li> <li>Root Cause         The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies.     </li> <li>ANALYSIS OF EVENT         On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co valve, 1-FCV-63-11. This valve is in a line in the ECCS piping on the discharge side of the RHR pump 18-normal position for 1-FCV-63-11 is closed and the valve is in a verticel configuration. The line connects the pump discharge to the suction of the setty line(cloud charging pump) floated in the vertice configuration. The line connects the pump discharge to the suction of the setty line(cloud charging pump) floated in the valve is in a vertice configuration. The line connects the pump discharge to the suction of the setery line(cloud charging pump) floated in the pump floated in</li></ol>		• <u>•</u> ••••••••••••••••••••••••••••••••••	Form 366A) (17)	additional copies of NRC I	(If more space is required, use a	RATIVE	17. NAR
<ul> <li>F. <u>Operator Actions</u> Upon discovery of the potential for gas to be in the piggyback supply piping to the safety injection p 1B-B, LCO, Action A of Technical Specification 3.5.2 and LCO, Action B of Technical Specification were entered. The piggyback line was isolated by a tagout to ensure that the potential gas pocket on to be transported into any other section of ECCS piping if an ECCS pump started unexpectedly. Following verting and UT verification that the piping was full of water, the Technical Specifications Lt actions were exited. </li> <li>G. <u>Safety System Responses</u> There were no automatic or manual safety system responses and none were necessary. </li> <li>III. CAUSE OF EVENT A. <u>Immediate Cause</u> The immediate cause appeared to be inadequate procedural guidance for filling and venting of the satinjection pump 1B-B suction line within the tagged out area of the work orders during the maintenan activities on January 14-15, 2003. In addition, that portion of the ECCS piping was not included in the procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water. B. <u>Root Cause</u> The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies. IV. ANALYSIS OF EVENT On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co valve, 1-FCV-63-11. This valve is in a line in the ECCS piping on the discharge side of the RHR pump 1B-normal position for 1-FCV-63-11 is closed and the valve is in a vertical configuration. The line connects the pump discharce to the suction of the safety injection pump 1B-B and the centifueal charging pumps (CCF)</li></ul>				tinued)	CRIPTION OF EVENT (cont	DES	IJ.
<ul> <li>Upon discovery of the potential for gas to be in the piggyback supply piping to the safety injection p 1B-B, LCO, Action A of Technical Specification 3.5.2 and LCO, Action B of Technical Specification were entered. The piggyback line was isolated by a tagout to ensure that the potential gas pocket i not be transported into any other section of ECCS pilping if an ECCS pump started unexpectedly. Following venting and UT verification that the piping was full of water, the Technical Specifications LI actions were exited.</li> <li>G. Safety System Responses There were no automatic or manual safety system responses and none were necessary.</li> <li>III. CAUSE OF EVENT</li> <li>A. Immediate Cause The immediate cause appeared to be inadequate procedural guidance for filling and venting of the safetying to a pump and 14-5, 2003. In addition, that portion of the ECCS piping was not included in the procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water.</li> <li>B. Root Cause The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies.</li> <li>IV. ANALYSIS OF EVENT On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co valve, 1-FCV-63-11. This valve is in a line in the ECCS piping on the discharge side of the RHR pump 18-normal position for 1-FCV-63-11 is closed and the valve is in a vertical configuration. The line connects the pump discharge to the suction of the safety injection pump 18-B and the centrifucal charging pump side and the centrifucal charging pump side and the centrifucal charging pump (CCF)</li> </ul>					Operator Actions	F.	
<ul> <li>G. <u>Safety System Responses</u> There were no automatic or manual safety system responses and none were necessary.</li> <li>III. CAUSE OF EVENT <ul> <li>A. <u>Immediate Cause</u></li> <li>The immediate cause appeared to be inadequate procedural guidance for filling and venting of the satisfication pump 1B-B suction line within the tagged out area of the work orders during the maintenan activities on January 14-15, 2003. In addition, that portion of the ECCS piping was not included in the procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water.</li> <li>B. <u>Root Cause</u></li> <li>The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies.</li> </ul> </li> <li>IV. ANALYSIS OF EVENT <ul> <li>On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co valve, 1-FCV-63-11. This valve is in a line in the ECCS piping on the discharge side of the RHR pump 18-1 normal position for 1-FCV-63-11 is closed and the valve is in a vertical configuration. The line connects the pump discharge to the suction of the safety injection pump 18-B and the centifucal charging pumps (CCF)</li> </ul> </li> </ul>	ion pump ation 3.6.6 cket could fly. ns LCO	oply piping to the safety injection action B of Technical Specificat sure that the potential gas pool CCS pump started unexpected ter, the Technical Specification	he piggyback su 3.5.2 and LCO, , by a tagout to er S piping if an E ing was full of wa	tential for gas to be in t echnical Specification back line was isolated by other section of ECC verification that the pip	Upon discovery of the pote 1B-B, LCO, Action A of Te were entered. The piggyb not be transported into any Following venting and UT v actions were exited.		
<ul> <li>There were no automatic or manual safety system responses and none were necessary.</li> <li>III. CAUSE OF EVENT <ul> <li>A. <u>Immediate Cause</u></li> <li>The immediate cause appeared to be inadequate procedural guidance for filling and venting of the safety injection pump 1B-B suction line within the tagged out area of the work orders during the maintenan activities on January 14-15, 2003. In addition, that portion of the ECCS piping was not included in the procedure to implement Technical Specification SR 3.5.2.3 to verify the ECCS piping is full of water.</li> <li>B. <u>Root Cause</u></li> <li>The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies.</li> </ul> </li> <li>IV. ANALYSIS OF EVENT <ul> <li>On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co valve, 1-FCV-63-11. This valve is in a line in the ECCS piping on the discharge side of the RHR pump 1B-normal position for 1-FCV-63-11 is closed and the valve is in a vertical configuration. The line connects the pump discharge to the suction of the safety injection pump 1B-B and the centrifugal charging pumps (CCF)</li> </ul> </li> </ul>				<u>s</u>	Safety System Responses	G.	1
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<ul> <li>The root cause is still under development and will be provided in the supplement to this LER along v human performance deficiencies.</li> <li>IV. ANALYSIS OF EVENT</li> <li>On August 28, 2003, a gas bubble with a volume of 5.5 cubic feet was discovered below the Unit 1 flow co valve, 1-FCV-63-11. This valve is in a line in the ECCS piping on the discharge side of the RHR pump 1B-I normal position for 1-FCV-63-11 is closed and the valve is in a vertical configuration. The line connects the pump discharge to the suction of the safety injection pump 1B-B and the centrifugal charging pumps (CCF)</li> </ul>					Root Cause	в.	
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Valve 1-FCV-63-11 is opened after the injection phase of an event when the ECCS pump suctions are trans from the refueling water storage tank to the containment sump at the start of long term recirculation.	ow control 1B-B. The ts the RHR (CCPs). transferred	liscovered below the Unit 1 flow charge side of the RHR pump onfiguration. The line connects e centrifugal charging pumps ( the ECCS pump suctions are f art of long term recirculation.	cubic feet was piping on the di is in a vertical of ump 1B-B and the of an event when nt sump at the s	ble with a volume of 5.5 s in a line in the ECCS is closed and the valve of the safety injection p ter the injection phase tank to the containme	August 28, 2003, a gas bubble, 1-FCV-63-11. This valve is hal position for 1-FCV-63-11 i p discharge to the suction of e 1-FCV-63-11 is opened after the refueling water storage for the set of the storage for the storage for the set of the set of the storage for the set of the set of the storage for the set of the set	On A valve norm pumj Valve from	
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#### U.S. NUCLEAR REGULATORY COMMISSION

## LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET		_6. LER NUMBI	ER		3. PAG	E
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	5	OF	7
Watts Bar Nuclear Plant, Unit 1	05000390	2003	3 004	00			

17. NARRATIVE If more space is required, use additional copies of NRC Form 366A)

#### IV. ANALYSIS OF EVENT (continued)

TVA's Nuclear Steam Supply System (NSSS) vendor for TVA's pressurized water reactors (PWR) has previously evaluated gas pockets for a TVA nuclear plant in similar locations to the pocket found at Watts Bar Nuclear Plant. The safety injection pumps and CCPs line sizes, pump flows, and general layout is essentially the same for both of TVA's PWR plants. Therefore, the NSSS vendor's evaluation is equally applicable to both plants. The amount of gas evaluated by the NSSS vendor was 6.0 cubic feet.

That evaluation considered piping length to the pumps, number of elbows and degree of the elbows, pump design and manufacturer, and the flow rates. That evaluation concluded that the gas in the piping would be moved through the piping and be mixed by the elbows. When compressed by RHR pumps, the initial 6.0 cubic feet of gas would be compressed to approximately 1.75 cubic feet, which would represent less than 5 percent void fraction as required to avoid damage to the CCPs. The evaluation concluded that catastrophic pump failure would be unlikely for a total gas accumulation of less than 6.0 cubic feet.

The piping containing the gas at Watts Bar is routed to both safety injection pumps and both CCPs. The previous evaluation addressed the CCPs. However, the evaluation included a statement that the gas in the lines could travel to the safety injection pumps but CCPs would be evaluated since the piping to the safety injection pumps is longer with more elbows than that for the CCPs. Consequently, it is assumed the acceptance criteria established for gas located in the piping applies to both the CCPs and the safety injection pumps.

Watts Bar compared the piping length to the pumps, number of elbows and degree of the elbows, pump design and manufacturer, and the flow rate to that in the previous NSSS vendor evaluation. Since the lines to the Watts Bar safety injection pumps have higher flows and a greater number of elbows, than that evaluated for TVA's other PWR plant, and since the overall volume fraction of gas was less than 5 percent, it is concluded that the previous evaluation bounds the condition for Watts Bar Nuclear Plant.

#### V. ASSESSMENT OF SAFETY CONSEQUENCES

Based on the discussion in Section IV above, the condition described in this event does not result in a loss of functional capability for the safety function provided by the ECCS. Therefore there was no safety significance to this event.

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		1. FACILITY NAME	2. DOCKET 6. LER NUMBER				3PAGE		
				YEAR	SEQUENTIAL NUMBER	NUMBER	6 OF		
Watts	Bar I	Nuclear Plant, Unit 1	05000390	200	3 004	00			
17. (/f m	ore spa	ace is required, use additional copies of NRC Form 366A)							
VI.	COF	RRECTIVE ACTIONS							
	A.	Immediate Corrective Actions							
		Initiated work order to perform UT on the pipe an LCO 3.5.2, Action A and LCO 3.6.6, Action B we present in the piggyback supply piping to the Sa the piping. The piping was subsequently vented Technical Specification LCOs was exited.	nd check for the ere entered to ch afety Injection pu and a follow up l	presenc neck for Imp 1B- UT verif	ce of gas. Te gas. The U B. A work o fied the piping	echnical Sp T verified th rder was in g was full o	ecification hat gas was itiated to ven f water. The		
	В.	<u>Corrective Actions to Prevent Recurrence</u> - (TVA does not consider these items to constitute re commitments. TVA's corrective action program tracks completion of these actions.)							
		<ol> <li>Valve 1-FCV-63-11-B was modified during the verification the ECCS line is full of water.</li> </ol>	e Unit 1, Cycle 5,	, Refuei	ing Outage to	o add a ver	nt to provide		
		The remainder of the correction actions is still un this LER.	nder developmen	it and w	ill be provide	d in the su	pplement to		
VII.	ADD	DITIONAL INFORMATION							
	Α.	Failed Components							
		There were no failed components involved in this	EER.						
	В.	Previous LERs on Similar Events							
		On June 26, 1996, SR 3.5.2.3 was implemented piping from the ECCS pumps to the reactor cool allowed for the venting requirements to be waived through administrative means that no periodic fill conjunction with leakage through a cold leg inject personnel initiated actions to perform 1-SI-63-10 had occurred during the month of May and that a the need to refill the CLA. A review of the packa refilling of the CLA had not been factored into this been waived. The cause for this event was dete system status issues such as the leakage throug	In Surveillance I lant system was d for the vent pai ling of the cold le ction line check v -A. During this a action had been uge for 1-SI-63-10 s performance of rmined to be tha gh the check value	Instructi full of w ths insice g accur valve. A activity i taken to D-A date f the SI the SI tho for ve. This	ion (SI) 1-SI- vater. Howey de containme mulator (CLA At 1545 hours it was noted to o back-seat a ed May 28, 19 and the vent mal process s event was	63-10-A, to ver, 1-SI-63 nt if it can I ) had occu s (EST), lice that refilling a check value 996, identif ing require exists to de documente	ensure the -10-A pe verified rred in ensed of a CLA ve to resolve ied that the ments had pocument id as LER		

(1-2001)		VENT REPORT (L	ER)							
				<u> </u>						
			YEAR SEQUENTIAL REVISION							
Watts	Bar Nuclear Plant Unit 1	05000390	2003 - 004 - 00							
17. NAR	RATIVE (If more space is required, use additional copies of	NRC Form 366A)		<u></u>						
VII.	ADDITIONAL INFORMATION (continued)									
	C. Additional Information:									
	None.									
	D. Safety System Functional Failure:									
	This event did not involve a safety system fun	ctional failure as defin	ned in NEI-99-02, Revision 0.							
	E. Loss of Normal Heat Removal Consideration									
	This event is not considered a scram with los	s of normal heat remo	oval.							
VIII.	COMMITMENTS									
	TVA will provide a supplement to LER 390/2003-0 December 19, 2003.	04 upon development	t of the root cause and correctiv	ve action						

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