

Tennessee Valley Authority, Post Office Box 2000, Decatur, Alabama 35609-2000

April 20, 2009

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Mail Stop: OWFN, P1-35 Washington, D. C. 20555-0001 10 CFR 50.73

Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT (BFN) - UNIT 1 -DOCKET 50-259 - FACILITY OPERATING LICENSE DPR - 33 - LICENSEE EVENT REPORT (LER) 50-259/2009-001-00

The enclosed report provides details of a turbine trip and reactor scram from a power load unbalance signal on the main generator. TVA is reporting this in accordance with 10 CFR 50.73(a)(2)(iv)(A), as an event that resulted in a manual or automatic actuation of the systems listed in paragraph 10 CFR 50.73(a)(2)(iv)(B). There are no commitments in this letter.

Sincerely,

Kandich R. G. West

Site Vice President, BFN cc: See page 2

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Enclosure

cc (Enclosure):

Ms. Eva A. Brown, Project Manager U.S. Nuclear Regulatory Commission (MS 08G9) One White Flint, North 11555 Rockville Pike Rockville, Maryland 20852-2739

Ms. Heather J. Gepford, Acting Branch Chief U.S. Nuclear Regulatory Commission Region II Sam Nunn Atlanta Federal Center 61 Forsyth Street, SW, Suite 23T85 Atlanta, Georgia 30303-8931

NRC Resident Inspector Browns Ferry Nuclear Plant 10833 Shaw Road Athens, Alabama 35611-6970

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION																
(9-2007)		66	L	.S. NUCLE	EAR REGUL	ATORY	COMMIS	SION /								
(0-2007)	LICENSEE EVENT REPORT (LER)								Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.							
	1. FACILITY NAME Browns Ferry Unit 1							2. DOCKET NUMBER 3. PAGE 05000259 1 of 5					5			
4. TITLE: Turbine Trip and Reactor Scram Due To Power Load Unbalance Signal On Main Generator																
5.	EVENT	DATE	6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIE				ES INVOLVED			
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	which resulted in the automatic actuation of the reactor protection system. Water that had settled in the idle bus															
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	(HVAC) system design. The design process does not consider full range of operation of HVAC systems using raw cooling water as a cooling medium during the winter months. BFN inspected the Unit 1 isophase bus for															
	damage. No damage was identified. BFN installed a drain with a site glass on each Unit 1 bus duct cooling fan															
	housing. General Operating Instruction, Operations Round Logs, was revised requiring verification that there is															

housing. General Operating Instruction, Operations Round Logs, was revised requiring verification that there is no water in the idle fan and to drain any water that may have accumulated prior to placing it into service. BFN will modify the design change technical considerations checklist to provide design process guidance for consideration of seasonal variations in operating conditions for HVAC design.

NRC FORM 366A (9-2007)	ULATORY COMMISSION				
LICENS	SEE EVENT F	REPORT	(LER)		
FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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Browns Ferry Nuclear Plant Unit 1	05000259	2009	001	00	2 of 5

NARRATIVE

I. PLANT CONDITION(S)

Prior to the event, Units 1 and 3 were in operating in Mode 1 at 100 percent thermal power (approximately 3458 megawatts thermal). Unit 2 was shutdown after manually scramming on February 16, 2009, due to a loss of the main generator stator cooling water [TJ]. LER 260/2009-001 discusses the manual scram event. Units 2 and 3 were unaffected by the event.

II. DESCRIPTION OF EVENT

A. Event:

February 18, 2009, at 0351 hours Central Standard Time (CST), following a scheduled preventative maintenance activity, Unit 1 reactor automatically scrammed from a turbine [TA] trip due to a power load unbalance signal on the main generator [TB]. Specifically, at 0349 hours CST, Operations swapped the Unit 1 Main Generator Isophase Bus Duct System cooling fan from the running to the alternate fan. When the alternate fan started, water entrapped in the fan housing was expelled into the bus provided a path to ground inside the bus duct. This resulted in actuation of the generator protective relays and a turbine trip and automatic reactor scram, which resulted in the automatic actuation of the reactor protection system [JC].

All automatic functions resulting from the turbine trip and automatic reactor scram occurred as expected. All control rods [AA] inserted. The level 3 scram setpoint was reached during the post scram water level shrink. Thus, the primary containment isolation system (PCIS) [JE] isolations: Group 2 (residual heat removal (RHR) system [BO] shutdown cooling), Group 3 (reactor water cleanup (RWCU)) [CE], System Group 6 (ventilation), and Group 8 (traversing incore probe (TIP)) [IG] were received along with the auto start of the control room emergency ventilation (CREV) [VI] system and the three standby gas treatment (SGT) [BH] system trains. The reactor scram resulted in the reactor water level briefly attaining minus 43-inches, and reactor pressure 1140 psig, hence; Operations briefly entered Emergency Operating Instruction, (EOI-001) Reactor Pressure Vessel Control.

Following verification that the 2-AOI-100-1, Reactor Scram, actions were completed the reactor mode switch was placed in shutdown. Operations reset the reactor scram by 0420 hours CST. Also, by approximately 0420 hours CST, operations reset the PCIS actuations and secured the SGT and CREV systems.

TVA is submitting this report in accordance with 10 CFR 50.73(a)(2)(iv)(A), as an event that resulted in a manual or automatic actuation of the systems listed in paragraph 10 CFR 50.73(a)(2)(iv)(B) (i.e., reactor protection system including reactor scram or trip, and general containment isolation signals affecting containment isolation valves in more than one system).

B. Inoperable Structures, Components, or Systems that Contributed to the Event:

None.

C. Dates and Approximate Times of Major Occurrences:

February 18, 2009 at 0351 hours CST	Unit 1 received automatic turbine trip and reactor scram.
February 18, 2009 at 0415 hours CST	Unit 1 operation reset Scram

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	February 18, 2009 at 0703 hours CST 10 CFR 50.72(b)(2)(iv)(B) and an eight hour non-emergency report per 10 CFR 50.72(b)(3)(iv)(A).							
D.	Other Systems or Secondary Fu	Inctions Affect	ted					
	None.							
Ε.	Method of Discovery					1.		
	The turbine trip and reactor scram through numerous alarms and indi		ately appa	arent to the co	ontrol room	staff		
F.	Operator Actions							
	Operations personnel responded to	o the event ac	cording to	o applicable p	lant proced	dures.		
G	Safety System Responses							
	The RPS logic responded to the reactor scram. All control rods inserted. The PCIS isolation Group 2 (RHR system shutdown cooling), Group 3 (RWCU system), Group 6 (ventilation), and Group 8 (TIP) isolation were received as expected, due to the lowering of the reactor water level, along with the auto start of the CREV system and the three SGT system trains. Emergency core cooling system actuation was not required.					ntilation), reactor		
III. CA	AUSE OF THE EVENT							
Α.	Immediate Cause							
-	Water that had settled in the idle bus duct cooling fan housing was expelled into the main generator isophase bus duct upon fan startup providing a conductive path to ground.							
В.	Root Cause							
	The root cause of this event was less than adequate design process guidance for consideration of seasonal variations in the operating conditions for heating ventilation and air conditioning (HVAC) design.							
C.	Contributing Factors							
	None.							
IV. AN	ALYSIS OF THE EVENT							
ac co is i va ins	The original design of the BFN isophase bus cooling system included a single fan that pulled air across a cooling coil set and forced this air through the ductwork surrounding the electrical bus controlling the isophase bus temperature. The cooling medium for the isophase bus cooling system is raw service water, drawn from the Tennessee River. The temperature of the raw service water varies widely during the summer and winter months. Previous history review found sporadic instances of water in the isophase bus cooling system area during winter operation. However, the amount of water previously found did not previously pose any problems with plant operation.							
	Studies performed as part of the Extended Power Uprate (EPU) project found a design change was necessary to manage the heat load generated by the isophase bus at EPU conditions. Hence, BFN							

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issued design for a high capacity isophase bus cooling system. The design, based on the worst-case summer operating conditions, did not address wintertime operating conditions. BFN installed the high capacity Unit 1 isophase bus cooling system in 2006 as part of the Unit 1 recovery effort. The new installation contained two fan units.

On February 17, 2009, at approximately midnight, it began to rain at BFN. During the high humidity period, moisture carry over from the isophase bus cooling coil pooled within the idle fan housing. When operations started the idle fan, water that was in the idle fan housing was expelled into the bus duct grounded the isophase bus to the duct.

V. ASSESSMENT OF SAFETY CONSEQUENCES

The safety consequences of this event were not significant. BFN Unit 1 transient analysis includes a turbine trip and automatic reactor scram from 100 percent power. During and following the automatic scram, all safety systems operated as required. The operator actions taken in response to the scram were appropriate. These actions included the verification that the reactor had shutdown, the expected system isolations and indications had occurred, and subsequent restoration of these systems to normal pre-scram alignment.

PCIS groups 2, 3, 6, and 8 isolations were as expected. Although the Emergency Core Cooling Systems were available, none was required. No main steam relief valves [SB] actuated. The turbine bypass valves [JI] maintained reactor pressure. The main condenser remained available for heat rejection. Reactor water level was recovered and maintained by the reactor feed water [SJ] and condensate [SG] systems. Therefore, TVA concludes that the event did not affect the health and safety of the public.

VI. CORRECTIVE ACTIONS

A. <u>Immediate Corrective Actions</u>

BFN inspected the Unit 1 isophase bus for damage. No damage was identified.

BFN installed a drain with a site glass on each Unit 1 bus duct cooling fan housing. General Operating Instruction, Operations Round Logs, was revised requiring verification that there is no water in the idle fan and to drain any water that may have accumulated prior to placing it into service.

B. <u>Corrective Actions to Prevent Recurrence</u>⁽¹⁾

BFN will modify the design change Technical Considerations Checklist to provide design process guidance for consideration of seasonal variations in operating conditions for HVAC design.

VII. ADDITIONAL INFORMATION

A. Failed Components

None.

¹ TVA does not consider the corrective action a regulatory requirement. TVA will track the completion of the actions in the Corrective Action Program.

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NARRA	TIVE							
	в.	Previous LERs on Similar Eve	ents					
		None.						
	C.	Additional Information						
		Corrective action document PE	R 163815.					
	D.	Safety System Functional Fail	lure Consider	ation:				
		This event is not a safety system	n functional fa	ilure in ac	cordance with	NEI 99-02.		
	Ε.	Loss of Normal Heat Removal	Consideratio	<u>on:</u>				
		This event was not a complicate	ed scram accoi	rding to NI	El 99-02.			
VIII.	CON	MITMENTS						
	Non	е.						
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