

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

May 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

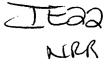
Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT (BFN) - UNIT 1 - DOCKET 50-259 - FACILITY OPERATING LICENSE DPR - 33 - LICENSEE EVENT REPORT (LER) 50-259/2009-002-00

The enclosed report provides details of unexpected logic lockout of the Loop II Residual Heat Removal system pumps. TVA is reporting this in accordance with 10 CFR 50.73(a)(2)(v)(D), as any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident.

There are no commitments in this letter.

R. G. West Site Vice President, BFN cc: See page 2



U.S. Nuclear Regulatory Commission Page 2 May 20, 2009

Enclosure cc (Enclosure):

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Mr. Eugene F. Guthrie, 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

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Browns Ferry Nuclear Plant Unit 1	05000259	2009	002	00	2 of 4							

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NARRATIVE

I. PLANT CONDITION(S)

Prior to the event, Units 1, 2, and 3 were in operating in Mode 1 at 100 percent thermal power (approximately 3458 megawatts thermal). Unit 1 continued to operate at full power thought the event and Units 2 and 3 were unaffected by the event.

II. DESCRIPTION OF EVENT

A. Event:

On March 20, 2009, at 2055 hours Central Daylight Time (CDT), BFN operations prepared to perform scheduled surveillance 1-SR-3.3.5.1.6(BI), Functional Test of Residual Heat Removal (RHR) [BO] Loop I Pump And Minimum Flow Valve Logic. Operations declared RHR pumps 1A and 1C inoperable, entering Technical Specification Limiting Condition for Operation (LCO) 3.5.1. Condition A and Required Action A.1: With one low pressure Emergency Core Cooling System (ECCS) injection/spray subsystem inoperable, within 7 days, restore low the pressure ECCS injection/spray subsystem to Operable status. On March 21, 2009 at approximately 0406 hours CDT, while placing a jumper in accordance with the surveillance, Unit 1 received RHR Pump Initiate Lockout signal for Loop II RHR Pumps 1B and 1D. With the lockout signal in place, the automatic start function of RHR Pumps 1B and 1D is inhibited. Operations immediately recognized the placement of the jumper per the instruction as an incorrect action. At approximately 0406 hour CDT, Unit 1 entered TS LCO 3.5.1. Condition H, Action H.1, with two or more low pressure ECCS injection/spray subsystems inoperable for reasons other than Condition A, immediately enter TS LCO 3.0.3. After approximately one minute, Operations restored the automatic start function of RHR Pumps 1B and 1D, and exited TS LCO 3.5.1 Condition H and TS LCO 3.0.3.

TVA is submitting this report in accordance with 10 CFR 50.73(a)(2)(v)(D), as any event or condition that could have prevented the fulfillment of the safety function needed to mitigate the consequences of an accident.

B. <u>Inoperable Structures, Components, or Systems that Contributed to the Event:</u>

None.

C. Dates and Approximate Times of Major Occurrences:

March 21, 2009 at 1050 hours CDT

TVA made an eight hour report to the NRC in accordance with 10 CFR 50.72(b)(3)(v)(D) as any event or condition that at the time of discovery could have prevented the fulfillment of the safety function of structures of systems that are needed to mitigate the consequences of an accident.

D. Other Systems or Secondary Functions Affected

None.

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

Operations received main control room indication that the automatic start function of RHR Pumps 1B and 1D was inhibited.

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Browns Ferry Nuclear Plant Unit 1	05000259	2009	002	00	3 of 4

F. Operator Actions

Operations personnel suspended performance of surveillance 1-SR-3.3.5.1.6(BI). They entered the appropriate TS LCO and took immediate actions to restore the automatic start function of RHR Pumps 1B and 1D.

G. <u>Safety System Responses</u>

None.

III. CAUSE OF THE EVENT

A. Immediate Cause

The immediate cause for the event was an inadequate procedure step.

B. Root Cause

The functional test, 1-SR-3.3.5.1.6(BI) contained an error previously identified and not corrected. A pre-performance walkdown of the surveillance recognized that the jumper was being installed in panel 1-9-33 and removed from panel 1-9-32. However, when the revision was made to rectify the panel location, the wrong surveillance step was revised. Instead of revising the surveillance to install the jumper in the correct panel, 1-9-32, the revision removed the jumper from the wrong panel, 1-9-33. Consequently, the action to place and remove a jumper took place in the incorrect panel.

C. <u>Contributing Factors</u>

The surveillance contained errors not corrected during the initial performance as part of Unit 1 restart in September of 2006. The March 20, 2009, performance of this surveillance was the second performance since restart of Unit 1. The initial performance on September 10, 2006, during Unit 1 restart activities did not note any discrepancies in the effected section.

IV. ANALYSIS OF THE EVENT

At the time the event occurred on March 21, 2009, Operations installed a jumper that simulated an accident signal from the Unit 2 RHR Channel A logic system. As soon as the jumper installation was completed, the amber lights indicating that 1B and 1D RHR pumps auto start function was inhibited illuminated. Operations immediately realized the 1B and 1D auto start function was inhibited they took actions to restore the auto-start function. The auto-start function remained inhibited for approximately one minute.

V. ASSESSMENT OF SAFETY CONSEQUENCES

The safety consequences of this event were not significant. During the timeframe, the RHR auto start function was inhibited for RHR Pumps 1B and 1D, other ECCS, the Core Spray [BM] and the High Pressure Coolant Injection [BJ] systems were available for ECCS injection. Additionally, the RHR pumps impacted during this event were available for manual operation. Operations readily recognized the condition and the required entry into TS LCO 3.0.3 lasted for only approximately one minute. Therefore, TVA concludes that the event did not affect the health and safety of the public.

 VI. CORRECTIVE ACTIONS A. Immediate Corrective Actions Unit 1 operations suspended the performance of surveillance 1-SR-3.3.5.1.6(BI). Operations revised the affected step in 1-SR-3.3.5.1.6(BI), and then successfully completed the surveillance. B. Corrective Actions to Prevent Recurrence⁽¹⁾ Procedures which have not been satisfactorily performed (24 Month ECCS logic surveillances) have been placed on administrative hold until a technical review is completed and any needed revisions are made. Operations Procedures Group procedure writers will be re-indoctrinated on adequate independent qualified review techniques. VII. ADDITIONAL INFORMATION A. Failed Components None. B. Previous LERs on Similar Events None. Corrective action document PER 166487. D. Safety System Functional Failure Consideration: This event is a safety system functional failure in accordance with NEI 99-02. E. Loss of Normal Heat Removal Consideration: This event was not a complicated scram according to NEI 99-02. 			LICENSE				<u>_</u>	
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