

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8710010242 DOC. DATE: 87/09/25 NOTARIZED: NO DOCKET #  
FACIL: 50-260 Browns Ferry Nuclear Power Station, Unit 2, Tennessee 05000260  
AUTH. NAME AUTHOR AFFILIATION  
JONES, S. B. Tennessee Valley Authority  
WALKER, J. G. Tennessee Valley Authority  
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-008-00: on 870826, unplanned actuation of standby gas treatment, control room emergency ventilation & refuel zone isolation occurred. Caused by personnel error. Personnel involved counseled & restart personnel trained. W/870925 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4  
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: Zwolinski 3 cy. 1cy ea to: Axelrad, Ebnetter, S. Richardson, 05000260  
Liaw, G. Zech, OI, OIA.

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	JAMERSON, C	1 1	PD	1 1
	GEARS, G	1 1	STANG, J	1 1
INTERNAL:	ACRS MICHELSON	1 1	ACRS MOELLER	2 2
	AEOD/DOA	1 1	AEOD/DSP/NAS	1 1
	AEOD/DSP/ROAB	2 2	AEOD/DSP/TPAB	1 1
	DEDRO	1 1	NRR/DEST/ADS	1 0
	NRR/DEST/CEB	1 1	NRR/DEST/ELB	1 1
	NRR/DEST/ICSB	1 1	NRR/DEST/MEB	1 1
	NRR/DEST/MTB	1 1	NRR/DEST/PSB	1 1
	NRR/DEST/RSB	1 1	NRR/DEST/SGB	1 1
	NRR/DLPQ/HFB	1 1	NRR/DLPQ/QAB	1 1
	NRR/DOEA/EAB	1 1	NRR/DREP/RAB	1 1
	NRR/DREP/RPB	2 2	NRR/DRIS/SIB	1 1
	NRR/PMAS/ILRB	1 1	REG FILE 02	1 1
	RES DEPY GI	1 1	RES TELFORD, J	1 1
	RES/DE/EIB	1 1	RGN2 FILE 01	1 1
EXTERNAL:	EG&G GROH, M	5 5	H ST LOBBY WARD	1 1
	LPDR	1 1	NRC PDR	1 1
	NSIC HARRIS, J	1 1	NSIC MAYS, G	1 1
NOTES:		12 12		

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Browns Ferry Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 2 6 0				PAGE (3) 1 OF 2						
TITLE (4) Personnel Error Causes Engineered Safety Feature Actuation																				
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)										
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES				DOCKET NUMBER(S)							
0	8	2	6	8	7	8	7	0	0	8	0	0	0	9	2	5	8	7	Browns Ferry Unit 1	0 5 0 0 0 2 5 9
0	8	2	6	8	7	8	7	0	0	8	0	0	0	9	2	5	8	7	Browns Ferry Unit 3	0 5 0 0 0 2 9 6
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																		
N		20.402(b)				20.405(c)				X 50.73(a)(2)(iv)				73.71(b)						
POWER LEVEL (10)		0 0 0				20.405(a)(1)(i)				50.73(a)(2)(v)				73.71(c)						
		20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
		20.405(a)(1)(iii)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(A)										
		20.405(a)(1)(iv)				50.73(a)(2)(iii)				50.73(a)(2)(viii)(B)										
		20.405(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(x)										
LICENSEE CONTACT FOR THIS LER (12)																				
NAME										TELEPHONE NUMBER										
Stephen B. Jones, Engineer, Plant Operations Review Staff										2 0 5 7 2 9 - 3 7 8 8										
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																				
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS										
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR				
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO								

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

On August 26, 1987, at 0945, with all three units defueled, an unplanned actuation of standby gas treatment, control room emergency ventilation and refuel zone isolation occurred during the performance of a restart test procedure. Personnel error during installation of jumpers caused a relay to deenergize and initiate the engineered safety features. The personnel involved were counseled and all restart test personnel received training on the event.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)  Browns Ferry Unit 2	DOCKET NUMBER (2)  0 5 0 0 0 2 6 0 8 7 - 0 0 8 - 0 0 0 2 OF 0 3	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Description of Event

Units 1, 2, and 3 were all in extended refueling outages at the time of the event. This event effected ventilation on all three units.

On August 26, 1987, a restart test was being performed on the control air/drywell control air (EIIS identifier LE). In order to prevent engineering safety feature actuations during the test, contacts on a primary containment isolation system (EIIS identifier JM) relay were being jumpered. At 0945, during the installation of the jumpers, the relay coil was inadvertently shorted causing the relay to deenergize. The following engineered safety feature actuations resulted.

1. Refuel zone ventilation isolation (EIIS identifier VG)
2. Standby gas treatment trains A and C initiation (EIIS identifier BH)
3. Control room emergency ventilation train A initiation (EIIS identifier VI)

The assistant shift engineer verified the actuations were the results of the restart test and notified the unit 1 and unit 2 operators that the affected systems could be returned to normal operating or standby readiness configurations. The isolations and initiations were reset by 0955.

Cause of Event

The electrical technician installing the jumpers inadvertently contacted the terminal immediately adjacent to the intended terminal. This shorted the relay coil and deenergized it causing the ESF actuations. The extreme closeness and limited access to the relay contacts involved contributed to the personnel error.

Corrective Action

The personnel involved were counseled on using more caution when performing similar work in the future. Restart test personnel received training to emphasize the identification of potential system actuations in procedures and in the pretest briefing.

Analysis of Event

This event did not affect the safe operation of the plant as it placed affected systems in conservative operating configurations. Similar type events could occur during performance of surveillance instructions or routine maintenance while the reactor is at power. The results would be the same, affected systems placed in conservative operating configurations. Plant safety would not be affected.

# LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER				
Browns Ferry Unit 2	0 5 0 0 0 2 5 9	8 7	— 0 0 8	— 0 0	0 3	OF	0	3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Previous Similiar Events - BFRO-50-259/87022, BFRO-50-259/87002,  
BFRO-50-260/86005, BFRO-50-260/86004,  
BFRO-50-296/86003, BFRO-50-296/85019

Commitments - None

TENNESSEE VALLEY AUTHORITY

Browns Ferry Nuclear Plant  
Post Office Box 2000  
Decatur, Alabama 35602

September 25, 1987

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

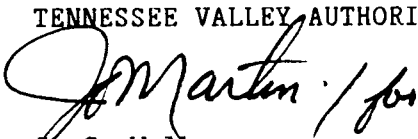
Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 2 - DOCKET  
NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - REPORTABLE OCCURRENCE REPORT  
BFRO-50-260/87008

The enclosed report provides details concerning the unplanned actuation of  
engineered safety features. This report is submitted in accordance with  
10 CFR 50.73 (a)(2)(iv).

Very truly yours,

TENNESSEE VALLEY AUTHORITY



J. G. Walker  
Plant Manager  
Browns Ferry Nuclear Plant

Enclosures

cc (Enclosures):

Regional Administration  
U.S. Nuclear Regulatory Commission  
Office of Inspection and Enforcement  
Region II  
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Atlanta, Georgia 30303

INPO Records Center  
Suite 1500  
1100 Circle 75 Parkway  
Atlanta, Georgia 30339

NRC Resident Inspector, Browns Ferry Nuclear Plant

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