

A0502/78

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)  
DISTRIBUTION FOR INCOMING MATERIAL

50-296

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TN VALLEY AUTH

DOCDATE: 05/04/78  
DATE RCVD: 05/11/78

DOCTYPE: LETTER NOTARIZED: NO

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SUBJECT:

LTR 1 ENCL 1

FORWARDING LICENSEE EVENT REPT (RO 50-296/78-010) ON 04/09/78 CONCERNING RBM  
CHANNELS BECAME CONTINUOUSLY BYPASSED... ALL ROD MOVEMENT WAS  
TERMINATED... W/ATT.

PLANT NAME: BROWNS FERRY - UNIT 3

REVIEWER INITIAL: XJM  
DISTRIBUTOR INITIAL: DL

\*\*\*\*\* DISTRIBUTION OF THIS MATERIAL IS AS FOLLOWS \*\*\*\*\*

INCIDENT REPORTS  
(DISTRIBUTION CODE A002)

FOR ACTION: BR CHIEF LEAR\*\*W/4 ENCL

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REG FILE\*\*W/ENCL  
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NOVAK/CHECK\*\*W/ENCL  
KNIGHT\*\*W/ENCL  
HANAUER\*\*W/ENCL  
EISENHUT\*\*W/ENCL  
SHAO\*\*W/ENCL  
KREGER/J. COLLINS\*\*W/ENCL  
K SEYFRIT/IE\*\*W/ENCL

NRC PDR\*\*W/ENCL  
MIPC\*\*W/3 ENCL  
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TEDESCO\*\*W/ENCL  
BAER\*\*W/ENCL  
VOLLMER/BUNCH\*\*W/ENCL  
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EXTERNAL:

LPDR'S  
ATHENS, AL\*\*W/ENCL  
TIC\*\*W/ENCL  
NSIC\*\*W/ENCL  
ACRS CAT B\*\*W/16 ENCL

COPIES NOT SUBMITTED PER  
REGULATORY GUIDE 10.1

DISTRIBUTION: LTR 45 ENCL 45  
SIZE: 1P+1P+1P

CONTROL NBR: 781320020

\*\*\*\*\*

THE END

\*\*\*\*\*

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TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

MAY 1 1978

REGULATORY DOCKET FILE COPY

Mr. James P. O'Reilly, Director  
U.S. Nuclear Regulatory Commission  
Office of Inspection and Enforcement  
Region II  
230 Peachtree Street, NW., Suite 1217  
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 3 -  
DOCKET NO. 50-296 - FACILITY OPERATING LICENSE DPR-68 - REPORTABLE  
OCCURRENCE REPORT BFRO-50-296/7810

The enclosed report provides details concerning both RBM channels which became continuously bypassed during power ascension. This report is submitted in accordance with Browns Ferry unit 3 Technical Specification 6.7.2.a.(2).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

H. S. Fox  
Director of Power Production

Enclosure (3)  
cc (Enclosure):  
Director (3)  
Office of Management Information and Program Control  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Director (40)  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

US NRC  
DIST. INJECTION SERVICES  
BRANCH

1978 MAY 11 PM 2 33

DISTRIBUTION  
SERVICES UNIT



A002  
5/11

THE UNIVERSITY OF CHICAGO

11-15-50

23-11172

10

**LICENSEE EVENT REPORT**

**EXHIBIT A**

CONTROL BLOCK: 1										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)																									
01		A L B R F 13				2 0 0 - 0 0 0 0 0 - 0 0				3 4 1 1 1 1				4		5																			
CONT		L 6 0 5 0 0 0 2 9 6				7 0 4 0 9 7 8				8 0 5 0 2 7 8				9																					
REPORT SOURCE		DOCKET NUMBER				EVENT DATE				REPORT DATE																									
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10																																			
02		During power ascension, both RBM channels became continuously bypassed.																																	
03		The RBM was not operable as specified in technical specification 3.2.C.1.																																	
04		Upon discovery all rod movement was terminated. There have been no previous																																	
05		events of this type. Prior to the discovery of the malfunction, all rod																																	
06		movements were properly prescribed by nuclear engineers; core thermal																																	
07		limits monitored and significant margin to all thermal limits were																																	
08		maintained. There was no potential for hazard to public safety.																																	
09		SYSTEM CODE 11				CAUSE CODE 12		CAUSE SUBCODE 13		COMPONENT CODE 14				COMP. SUBCODE 15		VALVE SUBCODE 16																			
17		LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.																							
18		X		7 8		0 1 0		0 1		T		0																							
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		APPRO-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER																			
A 18		X 19		Z 20		Z 21		0 0 0 0		Y 22		N 24		N 26		C 3 4 5 28																			
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27																																			
10		Contact 5-6 of rod select relay KXB for CRD 38-03 (C.P. Clare MR4MC-1023)																																	
11		stuck closed and maintained 28 volts on the edge rod bus. This condition																																	
12		improperly bypassed the RBM. Following replacement of the defective relay,																																	
13		the RBM was verified functional.																																	
14																																			
15		FACILITY STATUS 28				% POWER 29				OTHER STATUS 30				METHOD OF DISCOVERY 31				DISCOVERY DESCRIPTION 32																	
16		E 28				0 7 7 29				N/A 30				A 31				Operator observation. 32																	
17		ACTIVITY CONTENT RELEASED OF RELEASE 33				AMOUNT OF ACTIVITY 35				LOCATION OF RELEASE 36																									
18		Z 33				Z 35				N/A 36																									
19		PERSONNEL EXPOSURES NUMBER 37				TYPE 38				DESCRIPTION 39																									
20		0 0 0 37				Z 38				N/A 39																									
21		PERSONNEL INJURIES NUMBER 40				DESCRIPTION 41																													
22		0 0 0 40				N/A 41																													
23		LOSS OF OR DAMAGE TO FACILITY TYPE 42				DESCRIPTION 43																													
24		Z 42				N/A 43																													
25		PUBLICITY ISSUED DESCRIPTION 44																																	
26		N 44				N/A 45																													
NAME OF PREPARER																		PHONE																	

**\*Revision**



## REPORTABLE OCCURRENCE REPORT

Report Number : BFRO-50-296/7810  
Report Date : May 2, 1978  
Occurrence Date: April 9, 1978  
Facility : Browns Ferry Nuclear Plant Unit 3

### Identification of Occurrence

Operator observation of RBM recorders downscale and RBM bypass lights on.

### Conditions Prior to Occurrence

Normal operation at 77-percent power, during ascension to full load.

### Description of Occurrence

Both RBM channels became continuously bypassed. Review of potential reportable occurrence report revealed report should have been a prompt report as required by Technical Specification 6.7.2.a.(2).

### Designation of Apparent Cause of Occurrence

Maintained voltage on edge rod selected bus. Misinterpretation of the technical specifications.

### Analysis of Occurrence

Contact 5-6 of rod select relay KXB for CRD 38-03 stuck closed.

### Corrective Action

Replacement of defective relay. Discussed meaning of technical specification with plant staff.

### Failure Data

No previous failures.

