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NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION (5-92) LICENSEE EVENT REPORT TEXT CONTINUATION			APPROVED ED BURDEN PER RESI IGN REQUEST: 50.1 ESTIMATE TO THE (MNBB 7714), U. FON, DC 20555-001 (3150-0104), C FON, DC 20503	BY OMB NO. 3150 KPIRES 5/31/95 PONSE TO COMPLY O HRS. FORWAR INFORMATION AN .S. NUCLEAR RE 01, AND TO THE DFFICE OF MAN/	D-0104 WITH THIS INFORMATION D COMMENTS REGARDING D RECORDS MANAGEMENT GULATORY COMMISSION, PAPERWORK REDUCTION AGEMENT AND BUDGET,
FACILITY NAME (1)	DOCKET NUMBER (2)		LED NUMBER (6)	PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Browns Ferry Unit 3	05000296	95	003	. 00	2 of 5

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

I. PLANT CONDITIONS

Unit 3 and Unit 1 were shutdown and defueled. Unit 2 was operating at 3291 megawatts thermal (approximately 100 percent power).

II. DESCRIPTION OF EVENT

A. Event

At 1834 hours on September 1, 1995, all four Unit 3 diesel generators (DGs) [EK] inadvertently auto started during the performance of Common Accident Signal (CAS) logic surveillance instruction (SI) 1/2-SI-4.9.A.3.a. At 1835 hours, Emergency Equipment Cooling Water (EECW) [BI] pump A3 started as expected to provide cooling water to the Unit 3 DGs.

At the time of the event, electricians [utility, nonlicensed] were conducting tests on the Division I CAS logic and were placing a boot on a Unit 3 pre-accident signal relay [RLY]. The boot was being placed on the contacts of relay 14A-K35A (General Electric {GE} type HGA located in Panel 3-9-32 in the Auxiliary Instrument Room) to inhibit a pre-accident signal to the Unit 3 DGs.

When the Unit 3 DGs auto started, the Shift Operations Supervisor (SOS) [utility, licensed] notified the personnel in the Auxiliary Instrument Room to stop activities associated with the surveillance on the CAS logic. At 1901 hours, the DGs were stopped and at 1907 hours EECW pump A3 was stopped. The DGs were returned to standby readiness at 1914 hours.

This event is reportable in accordance with 10 CFR 50.73 (a)(2)(iv) as an event or condition that resulted in an automatic actuation of an Engineered Safety Feature (ESF).

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

None.

C. Dates and Approximate Times of Major Occurrences:

September 1, 1995

at 0813 hours

CAS SI began



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(5-92)	LICENSI TEXT	SE EVENT R CONTINUAT	EPORT TION	ESTIMATE COLLECTI BURDEN BRANCH WASHINGT PROJECT WASHINGT	ED BURDEN PER RESF ON REQUEST: 50.0 ESTIMATE TO THE (MNBB 7714), U. ON, DC 20555-000 (3150-0104), O ON, DC 20503	PIRES 5/31/95 PONSE TO COMPLY DHRS. FORWAR INFORMATION AN S. NUCLEAR RE DI, AND TO THE FFICE OF MANA	WITH THIS INFORMATION D COMMENTS REGARDING D RECORDS MANAGEMENT GULATORY COMMISSION, PAPERWORK REDUCTION NGEMENT AND BUDGET,
FACIL	ITY NAME	(1)	DOCKET NUMBER (2)		LED NUMBER (6)	PAGE (3)
Browns Fer	ry Unit	± 3	05000296	YEAR 95	SEQUENTIAL NUMBER 003	REVISION NUMBER OO	3 of 5
TEXT (If more	space is	required, use	additional copies of	NRC Form 3	66A) (17)		f + + + + = + = + = + =
		at 18 at 18 at 19	334 hours 335 hours 901 hours	Uni EEC Uni	it 3 DGs auto CW pump A3 st it 3 DGs stop	o started carted oped	
		at 19 at 19	907 hours 914 hours	Uni rea	it 3 DGs retu adiness	irned to sta	andby
		at 20	035 hours	TV2 50. Ope	A provided a .72(b)(2)(ii) erations Cent	10 CFR notificat: er	ion to NRC
	D.	Other Sys	tems or Seconda	ry Funct	ions Affecte	<u>:d</u> :	
		None.					
	E.	<u>Method of</u>	Discovery:				
		This cond [utility, Superviso alarms (A and 3D) h	lition was disco licensed] and r [utility, lic LM] and indicat ad auto started	vered wh the Assi ensed] i ions tha	en the Unit stant Shift n the contro t the Unit 3	Operator Operations I room rece DGs (3A, 3	eived BB, 3C,
	F.	Operator	Actions:				
n,		The opera immediate to stop a	tors observed t by notified per ctivities assoc	he alarn sonnel i iated wi	ns in the cor n the Auxili th the CAS 1	atrol room. ary Instrum. ogic survei	The SOS ment Room Lllance.
	G.	<u>Safety Sy</u>	stem_Responses:				
		The safet	y systems respo	nded as	designed for	this type	of event.
111.	CAUSE	OF THE EV	VENT		*		
	A.	Immediate	Cause:				•
		The immed relay 14A Unit 3 DG	liate cause of t A-K35A contacts	his ever which re	nt was an ina esulted in th	ndvertent cl ne auto stan	losure of rt of the

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NRC FORM 366A U.S. NUCL (5-92) LICENSEE EVE TEXT CONTI	EAR REGULATORY COMMISSION NT REPORT NUATION	APPROVED BY OWB NO. 3150-0104 EXPIRES 5/31/95 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503					
FACILITY NAME (1)	DOCKET NUMBER (2)	1	LED NUMBER (6)	PAGE (3)		
đ		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Browns Ferry Unit 3	05000296	95	003	00	4 of 5		

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

B. Root Cause:

The root cause of this event was personnel error. While performing the task of placing a boot on relay 14A-K35A contacts 2 and 8, the electricians inadvertently made up the contacts resulting in the auto start of the Unit 3 DGs.

C. <u>Contributing Factors</u>:

The process of placing boots on GE HGA relays is inherently difficult. The work requires two individuals: one to hold both fingers of the relay, and a second to push the finger to be booted toward the normally open contact and slip the boot over the finger. Compounding this difficulty was the location of the relay (in the bottom corner of the panel approximately 12 inches off the floor) which requires both individuals to be kneeling to perform the task.

IV. ANALYSIS OF THE EVENT

The DGs are designed to auto start when an accident signal is received. In this event, the auto start of the DGs was a successful completion of the designed function. Operations personnel immediately identified the cause of the ESF actuation and took appropriate corrective actions to restore the DGs to standby readiness. Therefore, this event did not affect the health and safety of plant personnel or the public.

V. CORRECTIVE ACTIONS

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

The surveillance was stopped and the DGs were stopped.

B. <u>Corrective Actions to Prevent Recurrence</u>:

The electricians were counselled to further emphasize the need to be more cautious when working on energized equipment, to apply the 'STAR' (i.e., Stop, Think, Act, and Review) procedure, and to question work that is difficult and has a high potential for causing an adverse system response.



NRC FORM 366A U.S. N (5-92) LICENSEE E TEXT CON	UCLEAR REGULATORY COMMISSION EVENT REPORT TINUATION	ESTIMATE COLLECTI BURDEN BRANCH WASHINGI PROJECT WASHINGI	APPROVED ED BURDEN PER RESI ION REQUEST: 50. ESTIMATE TO THE (MNBB 7714), U. ION, DC 20555-00 (3150-0104), C ION, DC 20503	BY ONE NO. 315 XPIRES 5/31/95 PONSE TO COMPLY O HRS. FORWA INFORMATION A S. NUCLEAR R 01, AND TO TH DFFICE OF MAN	O-0104 WITH THIS INFORMATION RD COMMENTS REGARDING ND RECORDS HANAGEMENT EGULATORY COMMISSION, E PAPERWORK REDUCTION MAGEMENT AND BUDGET,
FACILITY NAME (1)	DOCKET NUMBER (2)	-	LED NUMBER (6)	PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Browns Ferry Unit 3	05000296	95	003	00	5 of 5
TEXT (If more space is requi	ired, use additional copies o	f NRC Form	366A) (17)		

TVA has revised the SI to eliminate the need to boot the HGA relay contacts. TVA is also reviewing the present methodology of placing a boot on energized relay contacts for GE HGA relays to determine if other methods can be used during testing.¹

VI. ADDITIONAL INFORMATION

A. <u>Failed Components</u>:

None.

B. <u>Previous LERs on Similar Events</u>:

There have been several LERs written to document unplanned DG autostarts. Five of these LERs (i.e., 296/87004, 259/89014, 259/91004, 296/94001, and 296/95002) occurred as a result of miscellaneous personnel errors, but none of them involved booting relay contacts. Accordingly, the corrective actions for these LERs would not have precluded this event (LER 296/95003). In one LER (296/91003), the individual did not properly install an inhibiting boot during the performance of an SI. Corrective actions included training maintenance personnel on the proper installation of boots. LER 296/91003 is similar to this LER 296/95003; however, the corrective actions in LER 296/91003 would not have precluded LER 296/95003 since the boot was properly installed on the relay contacts in LER 296/95003.

VII. COMMITMENTS

None.

1

Energy Industry Identification System (EIIS) system and component codes are identified in the text with brackets (e.g., [XX].

This action is not a regulatory commitment.

