

## NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER  
INCIDENT REPORT

TO: Mr. Norman C. Moseley	FROM: Tennessee Valley Authority Chattanooga, Tennessee H. S. Fox	DATE OF DOCUMENT: 4/14/77
<input type="checkbox"/> LETTER <input type="checkbox"/> ORIGINAL <input type="checkbox"/> COPY	<input type="checkbox"/> NOTORIZED <input type="checkbox"/> UNCLASSIFIED	DATE RECEIVED 4/19/77
PROP	INPUT FORM	NUMBER OF COPIES RECEIVED ONE

## DESCRIPTION

Ltr. trans the following:

**DO NOT REMOVE**

## PLANT NAME:

Browns Ferry Unit No. 2

(1-P)

RJL

**ACKNOWLEDGED**

## ENCLOSURE

Licensee Event Report (RO 50-260/778) on  
3/16/77 concerning neither isolation valve  
in one TIP tube could have been closed if  
required....

(1-P)

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED  
SEND DIRECTLY TO KREGER/J. COLLINS

## FOR ACTION/INFORMATION

BRANCH CHIEF:	Schwanner
W/3 CYS FOR ACTION	
LIC. ASST.:	Sheppard
W/1 CYS	
ACRS 16 CYS HOLDING/SENT	As CATB

## INTERNAL DISTRIBUTION

REG FILE			
NRC-PDR			
I & E (2)			
MIPC			
SCHROEDER/IPPOLITO			
HOUSTON			
NOVAK/CHECK			
GRIMES			
CASE			
BUTLER			
HANAUER			
TEDESCO/MACCARY			
EISENHUT			
BAER			
SHAO			
VOLLMER/BUNCH			
KREGER/J. COLLINS			

## EXTERNAL DISTRIBUTION

LPDR: Athens, AL			
TIC:			
NSIC:			

## CONTROL NUMBER

77110125





# TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

April 14, 1977 **REGULATORY DOCKET FILE COPY**

Mr. Norman C. Moseley, Director  
U.S. Nuclear Regulatory Commission  
Office of Inspection and Enforcement  
Region II  
230 Peachtree Street, NW., Suite 1217  
Atlanta, Georgia 30303



Dear Mr. Moseley:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 2 -  
DOCKET NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - REPORTABLE  
OCCURRENCE REPORT BYRO-50-260/778

The enclosed report is to provide details concerning a random failure of two isolation valves in one traversing incore probe (TIP) tube that could not have been closed if required between 2045 hours on March 16, 1977, and 0100 hours on March 17, 1977. This report is submitted in accordance with Browns Ferry Technical Specifications Section 6. This event occurred on Browns Ferry unit 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, D.C. 20555

Director (40)

Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

100-443887-100

SECRETARY OF DEFENSE

[illegible][illegible]

*[Faint handwritten notes at the bottom of the page]*

1. 在“  ”处填上适当的词语。  
 2. 在“  ”处填上适当的词语。  
 3. 在“  ”处填上适当的词语。  
 4. 在“  ”处填上适当的词语。  
 5. 在“  ”处填上适当的词语。  
 6. 在“  ”处填上适当的词语。  
 7. 在“  ”处填上适当的词语。  
 8. 在“  ”处填上适当的词语。  
 9. 在“  ”处填上适当的词语。  
 10. 在“  ”处填上适当的词语。

...the ...

$\frac{1}{2} \times \frac{1}{2}$

[illegible]

*[Faint handwritten notes at the bottom of the page]*

# LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME														LICENSE NUMBER												LICENSE TYPE					EVENT TYPE	
01	A	L	B	R	F	2	0	0	-	0	0	0	0	0	0	-	0	0	4	1	1	1	1	0	3							
7	8	9				14	15											25	26				30	31	32							
01 CONT		CATEGORY		REPORT TYPE	REPORT SOURCE	DOCKET NUMBER				EVENT DATE				REPORT DATE																		
01	CONT			L	L	0	5	0	-	0	2	6	0	0	3	1	6	7	7													
7	8			57	58	59	60			61				68	69					74	75				80							

## EVENT DESCRIPTION

02	Between 2045 hours, 3/16/77, and 0100 hours, 3/17/77, neither isolation valve in one																								80
03	TIP tube could have been closed if required. This is a random failure. An inspec-																								80
04	tion of all tubing in the ball valve rooms is underway to prevent recurrence.																								80
05	(BFRO-50-260/778)																								80
06																									80

SYSTEM CODE		CAUSE CODE		COMPONENT CODE				PRIME COMPONENT SUPPLIER		COMPONENT MANUFACTURER				VIOLATION	
07	S	H	B	V	A	J	V	E	X	N	C	5	6	0	N
7	8	9	10	11	12				17	43	44			47	48

## CAUSE DESCRIPTION

08	(See reverse side.)																								80
09																									80
10																									80

FACILITY STATUS		% POWER		OTHER STATUS				METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
11	E	0	7	5	NA	A	Alarm received in control room						
7	8	9	10	12	13	44	45	46				80	
FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY				LOCATION OF RELEASE					
12	2	2	NA	NA	NA	NA	NA						
7	8	9	10	11		44	45					80	

## PERSONNEL EXPOSURES

NUMBER		TYPE		DESCRIPTION								
13	0	0	0	2	NA							
7	8	9	11	12	13							80

## PERSONNEL INJURIES

NUMBER		DESCRIPTION										
14	0	0	0	NA								
7	8	9	11	12								80

## OFFSITE CONSEQUENCES

15	NA																								80
----	----	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	----

## LOSS OR DAMAGE TO FACILITY

TYPE		DESCRIPTION										
16	2	NA										
7	8	9	10									80

## PUBLICITY

17	NA																								80
----	----	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	----

## ADDITIONAL FACTORS

18	NA																								80
----	----	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	----

19																									80
----	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	----

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### CAUSE DESCRIPTION

The tubing flare connector between the shield chamber and shear valve opened allowing the detector and cable to run out of the tube. The detector could not be withdrawn to the shield and consequently the ball valve could not be closed. However, the ball valve could have been closed during this period by removing the power from it. The loose detector cable loosened the shear valve connector making the shear valve inoperable. The connector was tightened making the shear valve operable. The ball valve was placed in the closed position by deenergizing the solenoids. The system was returned to service following the repair of the tubing and the replacement of the cable and detector.

#### CAUSE DESCRIPTION

The tubing flare connector between the shield chamber and shear valve opened allowing the detector and cable to run out of the tube. The detector could not be withdrawn to the shield and consequently the ball valve could not be closed. However, the ball valve could have been closed during this period by removing the power from it. The loose detector cable loosened the shear valve connector making the shear valve inoperable. The connector was tightened making the shear valve operable. The ball valve was placed in the closed position by deenergizing the solenoids. The system was returned to service following the repair of the tubing and the replacement of the cable and detector.

