UPDATE REPORT PREVIOUS REPORT DATE 4/28/83

NRC FORM 366 (12-81) 10 CFR 50

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

APPROVED BY OMB 3150-0011

CONTROL BLOCK: [| | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | A L B R F 2 (2) | 0 0 - 0 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 (4) | | (5)

LICENSEE CODE · LICENSE NUMBER · LICENSE TYPE · CAT

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0 1 REPORT SOURCE L (6) | 0 5 0 0 0 2 6 0 (7) | 0 3 3 0 8 3 (8) | 0 6 1 6 8 3 (9)

DOCKET NUMBER · EVENT DATE · REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During a maintenance outage on unit 2 to repair main steam relief valve (MSRV)

0 3 numbered PCV-1-180 the air operator was found to have been assembled incorrectly.

0 4 Maintenance procedures which check for proper operability of valve components

0 5 were not followed during installation of the MSRV (T.S. 6.7.2.b(3)). All other

0 6 MSRVs were operable. There was no effect on public health or safety.

0 7

0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	C C (11)	A (12)	C (13)	V A L V O P (14)	D (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 1 4	/	0 3	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER (26)
X (18)	G (19)	A (20)	A (21)	0 0 7 7	Y (23)	N (24)	N (25)	T 0 2 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Target Rock Model No. 7567F-100 was inoperable due to not following procedure

1 1 in reassembly. Inspection didn't detect error due to procedural inadequacy.

1 2 Valve was repaired. Inspection procedure is being revised. Investigation of the

1 3 valve reassembly has been performed and additional details are provided on LER

1 4 Supplemental.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 0 0 (29)	NA	A (31)	During repair work

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

8306270327 830616
PDR ADOCK 05000260
S PDR

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	Y (44)	TVA toll free nuclear information line.	

NAME OF PREPARER E. T. Holder PHONE (205) 729-0885

TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401
1750 Chestnut Street Tower II

June 16, 1983

Mr. James P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Suite 2900
101 Marietta Street, NW
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 2 - DOCKET NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - REPORTABLE OCCURRENCE REPORT BFRO-50-260/83014 - REVISION 1

The enclosed report is a supplement to my letter dated April 28, 1983, concerning an incorrectly assembled main steam relief valve. This report is submitted in accordance with Browns Ferry unit 2 Technical Specification 6.7.2.b(3).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

Herbert A. Green

H. J. Green
Director of Nuclear Power

Enclosure
cc (Enclosure):
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Washington, D.C. 20555

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Atlanta, Georgia 30339

NRC Inspector, Browns Ferry

IE 22

1/1

Tennessee Valley Authority
Browns Ferry Nuclear Plant

Form BF 17
BF 15.2
2/19/82

LER SUPPLEMENTAL INFORMATION

BFRO-50- 260 / 83014R1 Technical Specification Involved 3.6.D

Reported Under Technical Specification 6.7.2.b(3) * Date Due NRC 6/15/83

Event Narrative:

Unit 1 was operating at 85 percent power, unit 2 was shut down for repair of a main steam relief valve and unit 3 was operating at 100 percent power. Only unit 2 was affected by this event. During repair of main steam relief valve numbered PCV-1-180 it was discovered that the air operator was incorrectly installed on the main steam relief valve. The apparent cause was personnel error because maintenance procedures were not followed in originally reassembling the valve. (Technical Specification 6.7.2.b(3)). There was no effect on public health or safety. All other relief valves were operable.

Due to procedural inadequacy, personnel erred by not completely performing the specified visual inspection of the relief valve air operator thus resulting in an inoperable relief valve. This inspection should have detected the original reassembly error. The solenoid was checked for proper operation but the air operator was not completely inspected through a viewing access port. A contributing factor was a change in personnel between original reassembly and reinstallation. The air operator wa removed, inspected and reinstalled. The personnel involved have been instructed to follow procedures. The procedural clarification will be made by June 15, 1983.

The investigation of the air operator installation on MSRV PCV-1-180 revealed that the air operator was not installed at the Wyle test site but was shipped independently to Browns Ferry and assembled on site. The air operator was improperly installed due to a procedure which lacked necessary detail to ensure that the collet and pilot stem were properly coupled and a verification step by a responsible individual.

The engineer that was responsible for valve reassembly erred by not controlling documentation as required by the maintenance procedure. The engineer is no longer employed by TVA. The maintenance procedure will be revised prior to any further air operator installation to include additional verifications during reassembly and traceability of the air operator to valve body.

* Previous Similar Events

None

Retention: Period - Lifetime; Responsibility - Document Control Supervisor

*Revision: JRB