TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE
37401

TVA 40TH ANNIVERSARY OF PEOPLE IN PARTNERSHIP

August 30, 1974

50-260

Mr. John F. O'Leary, Director
Directorate of Licensing
Office of Regulation
U.S. Atomic Energy Commission
Washington, DC 20545

Dear Mr. O'Leary:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 2 - DOCKET NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - ABNORMAL OCCURRENCE REPORT BFAO-50-260/749W

The enclosed report is to provide details concerning failure of torus-to-drywell vacuum breaker position indicating light circuits and is submitted in accordance with Appendix A to Regulatory Guide 1.16, Revision 1, October 1973. This event occurred on Browns Ferry Nuclear Plant unit 2 on August 20, 1974.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

For E. F. Thomas
Director of Power Production

Enclosure
CC (Enclosure):
Mr. Norman C. Moseley, Director
Region II Regulatory Operations Office, USAEC
230 Peachtree Street, NW., Suite 818
Atlanta, Georgia 30303

50-260 inquiry

9099

COPY SENT REGION II

ABNORMAL OCCURRENCE REPORT

Report No.: BFAO-50-260/749W
Report Date: August 30, 1974
Occurrence Date: August 20, 1974
Facility: Browns Ferry Nuclear Plant unit 2

Identification of Occurrence

Failure of torus-to-drywell vacuum breaker position indicating light circuits of valves FCV 64-28G and FCV 64-28L.

Conditions Prior to Occurrence

The unit was in a cold shutdown condition.

Description of Occurrence

On August 20, 1974, during routine surveillance testing, it was observed that the valves FCV 64-28G and FCV 64-28L position indicating light did not operate as required.

The FCV 64-28G green check light, which indicates the valve fully closed, did not go out. The FCV 64-28L red light, which indicates the valve within 3° of full closure, would not go off. The green check light of FCV 64-28L was also reported inoperable but operated properly when investigated.

Designation of Apparent Cause of Occurrence

The cause of failure of the green check light on valve FCV 64-28C was minor corrosive or scale buildup on the operating plunger of the limit switch mounted on the valve. The cause of failure of the red light was an improperly adjusted limit switch on FCV 64-28L valve.

Analysis of Occurrence

All valves were operable and would have performed their intended function had they been called upon to do so.

Corrective Action

All limit switch operating plungers on all torus-to-drywell vacuum breakers have been cleaned, lubricated with a light coat of silicone grease, and tested several times. The red light limit switch on FCV 64-28L was properly adjusted. All valves were satisfactorily retested.

Failure Data

The failure of the unit 2 check light limit switch on FCV 64-28G is similar to a failure experienced in unit 1 and reported in Abnormal Occurrence Report number BFAO-7411W.

Failure Data (Continued)

Check light limit switch: Licon part No. 65-430095

The adjustment failure of the red light on FCV 64-28L is a first-time incident; therefore, no failure data is available.