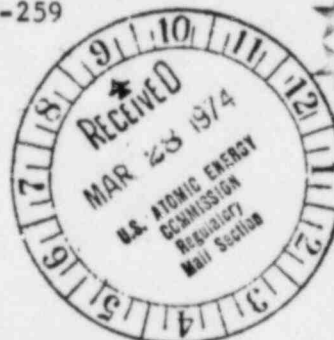


TENNESSEE VALLEY AUTHORITY  
CHATTANOOGA, TENNESSEE  
37401



March 25, 1974

50-259



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 1 -  
DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - ABNORMAL  
OCCURRENCE REPORT BFAO-7417W

The enclosed report is to provide details concerning failure of  
suppression chamber to drywell vacuum breaker valve FCV 64-28M  
to fully close as indicated by a check light which occurred on  
Browns Ferry Nuclear Plant unit 1 on March 15, 1974, and is  
submitted in accordance with Appendix A to Regulatory Guide 1.16,  
Revision 1, October 1973.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

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

*Handwritten:* 50-259

2619

8305060125 740426  
PDR ADOCK 05000259  
S PDR

COPY SENT REGION II

## ABNORMAL OCCURRENCE REPORT

Report No.: BFAO-7417W  
Report Date: March 25, 1974  
Occurrence Date: March 15, 1974  
Facility: Browns Ferry Nuclear Plant unit 1

### Identification of Occurrence

Failure of suppression chamber to drywell vacuum breaker valve FCV 64-28M to fully close as indicated by a check light.

### Conditions Prior to Occurrence

The reactor was shut down and in hot standby at 880 psig.

### Description of Occurrence

At 8:30 p.m., following the completion of special test 29, it was discovered that the green check light for suppression chamber to drywell vacuum breaker valve FCV 64-28M failed to come back on when the valve operated. The other indicating lights for FCV 64-28M operated properly.

### Designation of Apparent Cause of Occurrence

The exact cause of the failure cannot be determined until the vacuum breaker valve inside the suppression chamber can be investigated.

### Analysis of Occurrence

The vacuum breaker is equipped with switches indicating disc opening to approximately 80 degrees open and 3 degrees open and a check switch which indicates fully closed. The vacuum breaker valve is considered inoperable for full closure only because the valve position indicating lights confirmed opening and closure to within 3 degrees of fully closed. This is an allowable condition for reactor operation in accordance with technical specification 3.7.A.4.b.

### Corrective Action

Our investigation indicates that the check light circuit is open. Therefore, either the valve is not fully closed or the limit switch is out of adjustment or defective. A previous failure of an identical limit switch in this same location occurred February 21, 1974, and was reported in BFAO-7411W. During an outage following that occurrence, the switch actuating plunger was found to be sticking. The switch was replaced with a new switch and the vacuum breaker valve operated several times satisfactorily. The valve and circuitry will be inspected and repairs made at the earliest opportunity when suppression chamber entry can be made.

### Failure Data

Failure data will be reported when the cause of the failure has been determined.