TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401

May 30, 1975

Mr. Benard C. Rusche
Director of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Dear Mr. Rusche:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 2 - DOCKET NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - ABNORMAL OCCURRENCE REPORT BFAO-50-260/757W

The enclosed report is to provide details concerning the manual valve in the drive water supply on control rod drive module 50-15 which was found in the open position instead of shut as required by the temporary technical specifications. This report 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.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

SUH 3

J.A. Coppey for
E. F. Thomas
Director of Power Production

Enclosure
CC (Enclosure):
Mr. Norman C. Moseley, Director
U.S. Nuclear Regulatory Commission
Regional Office
230 Peachtree Street, NW., Suite 818
Atlanta, Georgia 30303

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ABNORMAL OCCURRENCE REPORT

Report No.: BFAO-50-260/757W
Report Date: May 30, 1975
Occurrence Date: May 20, 1975
Facility: Browns Ferry Nuclear Plant unit 2

Identification of Occurrence

The manual valve in the drive water supply on control rod drive module 50-15 was found in the open position instead of shut as required by the temporary technical specifications.

Conditions Prior to Occurrence

The unit was in cold shutdown condition with the mode switch locked in the shutdown position. All control rods were fully inserted and their directional control valves disarmed electrically.

Description of Occurrence

During review of surveillance instruction data, the drive water supply valve to control rod drive module 50-15 was noted as having been found in the open position during performance of the surveillance inspection.

Apparent Cause of Occurrence

The reason for the valve being open is unknown. The valve had last been verified shut during a surveillance inspection on May 16, 1975. Movement from the shut position had not been authorized. No work had been performed in this area except general cleaning.

Analysis of Occurrence

All control rods remained inserted continuously with their directional control valves disarmed electrically. There were no adverse effects to the public health and safety as a result of this occurrence.

Corrective Action

The valve was repositioned to its required closed position. A surveillance inspection was performed immediately thereafter to ensure that all control rod drive module manual drive water supply valves on both units were in the closed position.

Failure Data

None