

TENNESSEE VALLEY AUTHORITY  
CHATTANOOGA, TENNESSEE  
37401



September 30, 1974

Mr. Edson G. Case  
Acting Director of Licensing  
Office of Regulation  
U.S. Atomic Energy Commission  
Washington, DC 20545

Dear Mr. Case:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 2 -  
DOCKET NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - ABNORMAL  
OCCURRENCE REPORT BFAO-50-260/7414W

The enclosed report is to provide details concerning failure of the  
drywell equipment drain primary containment isolation valve FCV 77-15B  
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 September 20, 1974.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

*E. F. Thomas*  
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

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# ABNORMAL OCCURRENCE REPORT

Report No.: BFAO-50-260/7414W  
Report Date: September 30, 1974  
Occurrence Date: September 20, 1974  
Facility: Browns Ferry Nuclear Plant unit 2

## Identification of Occurrence

Failure of the drywell equipment drain primary containment isolation valve FCV 77-15B.

## Conditions Prior to Occurrence

The reactor was at approximately 2-percent power.

## Description of Occurrence

While attempting to close the drywell equipment drain sump pump primary containment isolation valves from the control room, FCV 77-15B failed to close.

## Designation of Apparent Cause of Occurrence

The solenoid-operated valve, FSV 77-15B, supplying air to the air-operated valve, FCV 77-15B, was sticking.

## Analysis of Occurrence

At the time of failure of FCV 77-15B, the other valve, FCV 77-15A, closed. This satisfied technical specification requirements calling for at least one of the valves to be in the mode corresponding to the isolated condition when there is an inoperable isolation valve in that line. This failure caused no damage to any systems, components, or structures. There were no adverse effects on the health or safety of the public as a result of this failure.

## Corrective Action

The solenoid valve was changed out. The valve was then cycled several times, operating satisfactorily each time. The solenoid was disassembled to determine the cause of sticking. Particles of foreign material were found in the armature housing probably causing the armature to stick.

## Failure Data

The solenoid valve is manufactured by Versa Products Company with the following nameplate:

Valve, solenoid product No. USG-3521, suffix detail U-14-15-21-31.

A previous failure of this type of solenoid valve on unit 1 was reported in BFAO-7351W.