NRC FORM 366 (7-77)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

01 | ALBRF2 (2) | 00-000-00 (3) | 4 1 1 1 1 (4) | (5)

LICENSEE CODE (7–14) LICENSE NUMBER (15–25) LICENSE TYPE (26–30) CAT (57–58)

CON'T 01 | REPORT SOURCE L (6) | 05000261 (7) | 110580 (8) | 112480 (9)

DOCKET NUMBER (60–68) EVENT DATE (69–74) REPORT DATE (75–80)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During the performance of SI 4.7.D.1-d (TS 3.7.D.1), it was found that the

03 internals for the excess flow check valve in instrument line to PDIS-75-28,-56;

04 PDT-85-17,-18, PI-85-19, and PDT-68-52 was missing. There was no effect on the

05 public health or safety. There are no redundant systems. Previous events: None.

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07

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09 SYSTEM CODE IB (11) | CAUSE CODE A (12) | CAUSE SUBCODE E (13) | COMPONENT CODE VALVEX (14) | COMP. SUBCODE C (15) | VALVE SUBCODE G (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR 80 | — | SEQUENTIAL REPORT NO. 046 | / | OCCURRENCE CODE 01 | REPORT TYPE T | — | REVISION NO. 0

ACTION TAKEN C (18) | FUTURE ACTION G (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS 0000 (22) | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER N (25) | COMPONENT MANUFACTURER M090

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause was construction installation error. The ½ inch flow check valve

11 model 280619 was replaced and SI 4.7.D.1-d was successfully completed. A

12 mechanical maintenance instruction will be written with a QC sign off for

13 proper installation of valve parts.

14

15 FACILITY STATUS H (28) | % POWER 000 (29) | OTHER STATUS (30) NA | METHOD OF DISCOVERY B (31) | DISCOVERY DESCRIPTION (32) Surveillance testing.

16 ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) NA | LOCATION OF RELEASE (36) NA

17 PERSONNEL EXPOSURES NUMBER 000 (37) | TYPE Z (38) | DESCRIPTION (39) NA

18 PERSONNEL INJURIES NUMBER 000 (40) | DESCRIPTION (41) NA

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) | DESCRIPTION NA

20 PUBLICITY ISSUED N (44) | DESCRIPTION (45) NA | NRC USE ONLY

NAME OF PREPARER _____ PHONE: _____

8011250442

Tennessee Valley Authority
Browns Ferry Nuclear Plant

Form BF-17
BF 15.2
1/10/79

LER SUPPLEMENTAL INFORMATION

BFRO-50- 260 / 8046 Technical Specification Involved 3.7.D.1

Reported Under Technical Specification 6.7.2.A.3

Date of Occurrence 11/05/80 Time of Occurrence 0900 Unit 2

Identification and Description of Occurrence:

During refueling while performing SI 4.7.D.1-d, it was found that the internals for the excess flow check valve in instrument line to PDIS-75-28,-56; PDT-85-17,-18; PI-85-19; and PDT-68-52 were missing.

Conditions Prior to Occurrence:

Unit 1 @ 97%

Unit 2 @ refueling

Unit 3 @ 92%

Action specified in the Technical Specification Surveillance Requirements met due to inoperable equipment. Describe.

None.

Apparent Cause of Occurrence:

Construction installation error.

Analysis of Occurrence:

There was no damage to plant equipment. There was no activity release, no personnel exposure or injury and no danger to the health or safety of the public.

Corrective Action:

Valve was replaced. Mechanical maintenance instruction will be written.

Failure Data:

None

*Retention: Period - Lifetime; Responsibility - Administrative Supervisor

*Revision: