JUN 24 1985

ENCLOSURE 1

NOTICE OF VIOLATION

Tennessee Valley Authority
Browns Ferry 1, 2, and 3

Docket Nos. 50-269, 260, and 296
License Nos. DPR-33, 52, and 68

The following violations were identified during an inspection conducted on April 26 - May 25, 1985. The Severity Levels were assigned in accordance with the NRC Enforcement Policy (10 CFR Part 2, Appendix C).

1. Technical Specification 3.11.A.1.a. requires that the high pressure fire protection system shall have two high pressure fire pumps, operable, and aligned to the high pressure fire header.

   Contrary to the above, the requirement was not met in that from 1530 on May 21, 1985, to 2130 on May 23, 1985, only one high pressure fire pump was aligned to the high pressure fire header and no compensatory fire watches were posted as allowed by Technical Specification 3.11.A.2. when only one high pressure fire pump is available.

   This is a Severity Level IV violation (Supplement I), and is applicable to all three units.

2. 10 CFR 50, Appendix B, Criterion V requires that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings and shall be accomplished in accordance with these instructions, procedures, or drawings.

   a. Contrary to the above, this requirement was not met for the following two examples:

      (1) Units 1, 2, and 3 diesel generator battery racks were not seismically mounted as required by TVA drawing 48N897 series.

      (2) 3EB shutdown board battery was not seismically mounted as per C and D installation instructions Section 12-600-1.

   b. Contrary to the above, the licensee failed to adhere to Standard Practice 8.3., Plant Modifications, in that Workplan No. 0049-84 did not list S.I. 4.11.A.5., High Pressure Fire Protection System Valve Alignment, as one of the instructions requiring review and updating as a result of a field change request. Section 8.3.1. of Standard Practice 8.3. requires that plant personnel list any plant instructions requiring revision in Section XII of the workplan control form. Since the workplan was implementing a field change to the fire protection system drawings, S.1.4.11.A.5. should have been listed among those instructions requiring review and updating.

This is a Severity Level IV violation (Supplement I), and is applicable to all three units.

3. 10 CFR 50, Appendix B, Criterion XVI requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment and nonconformances are promptly identified and corrected and that the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

   Contrary to the above, the licensee failed to promptly identify and correct the cause of repeated failures of a 480/120 VAC transformer which supplies power to the Unit 1 Standby Liquid Control (SLC) system piping trace heaters. The cause of the transformer failure was not identified until February 27, 1985, even though an excessive failure history of six transformers dating back to January 1979 existed for this normally reliable component. The transformers were found to be overloaded by 39%, a condition which has reportedly existed since original installation.

   This is a Severity Level IV violation (Supplement I), and is applicable to Unit 1 only.

4. 10 CFR 50.73(a)(2) requires that the licensee shall submit a Licensee Event Report (LER) within 30 days after discovery of any event or condition that alone could have prevented the fulfillment of the safety function of systems that are needed to mitigate the consequences of an accident or that resulted in manual or automatic actuation of an Engineered Safety Feature (ESF), including the Reactor Protection System (RPS).

   a. Contrary to the above, the licensee failed to submit an LER within 30 days after the discovery of a condition in the Unit 1 Standby Liquid Control (SLC) system that alone could have rendered the SLC System inoperable. The SLC System is needed to bring the reactor from full power to cold shutdown in the event that withdrawn control rods cannot be inserted. On February 27, 1985, the licensee determined that the SLC pump suction piping heat trace (both normal and alternate) was oversized by about 39% resulting in an overload condition on the 480/120 volt AC power supply transformers (the transformers had failed due to the overload at least six times in that last six years). Failure of the power supply transformers renders the SLC inoperable by allowing the suction piping temperature to cool to below the Technical Specification required limit.

   b. Contrary to the above, the licensee failed to submit an LER within 30 days of an event which occurred on January 16, 1985, in which the Unit 1 automatically actuated to scram the reactor on a low reactor water level trip signal. The High Pressure Coolant Injection System (HPCI) and Reactor Core Isolation Cooling System (RCIC) were also automatically actuated during the event.

This is a Severity Level IV violation (Supplement I), and is applicable to Unit 1 only.

5. Technical Specification 6.3.A requires that detailed written procedures covering the items listed below shall be prepared, approved, and adhered to:

- Normal startup, operation, and shutdown of all systems involving nuclear safety of the facility.

- Surveillance and testing requirements.

a. Contrary to the above, the licensee failed to prepare adequate procedures for fire protection system surveillance requirements in the following examples:

(1) Technical Specification (TS) 4.11.C.5 requires that smoke detector's sensitivity be checked in accordance with manufacturer's instructions. Surveillance Instruction (SI) 4.11.C.1 and C.5, Fire Protection Testing of Smoke and Heat Detectors, was inadequate in that it failed to comply with the manufacturer's instructions contained in Walter Kidde and Company Bulletin 841 "Fire Alert CPD-1212 Installation and Technical Data". SI 4.11.C.1 and C.5 was additionally inadequate in that it describes a method for testing a Fire Alert Model FT-200 smoke detector which could not be located in the manufacturer's instructions.

(2) TS 4.11.A.5 requires principal header and component isolation valves of the high pressure fire protection system be checked open quarterly. SI 4.11.A.5, High Pressure Fire Protection System Valve Alignment, was inadequate in that it did not contain the following major header and component isolation valves: 0-26-1400 and 0-26-1401 (header isolations south side from emergency diesel driven fire pump) 1-26-1397, 1-26-1363, 1-26-1364, 3-26-1398, 3-26-1367, 3-26-1368 (Units 1, 2, and 3 cable spreading room preaction sprinkler system isolation valves).

b. Contrary to the above, the licensee failed to prepare adequate procedures for the Reactor Core Isolation Cooling System (RCIC) in that the valve checklist contained in Operating Instruction No. 71 Reactor Core Isolation Cooling System, did not include valves 71-221 and 71-222. These are root isolation valves for the RCIC steam flow instrument PDIS 71-1B which initiates a RCIC isolation signal in the event of a RCIC Steam line rupture.

This is a Severity Level V violation (Supplement I), and is applicable to all three units.

6. Technical Specification 6.2.B.4.e requires that the Plant Operations Review Committee (PORC) review reportable events, unusually events, operating anomalies, and abnormal performance of plant equipment.

Contrary to the above, as of May 14, 1985, the Plant Operations Review Committee failed to review two events which occurred in January 1985, that were classified as Notification of Unusual Events (which indicated abnormal performance of plant equipment) in accordance with the licensee's Radiological Emergency Plan. These two events occurred on Unit 1 and involved the inoperability of the containment cooling mode of the Residual Heat Removal System on January 9, 1985, and the inoperability of the Standby Liquid Control System on January 11, 1985.

This is a Severity Level V violation (Supplement I), and is applicable to Unit 1 only.

7. 10 CFR 50, Appendix B, Criterion II requires that the quality assurance program be carried out in accordance with written policies, procedures, or instructions.

Contrary to the above, the licensee failed to carry out the quality assurance program in accordance with written policies, procedures, or instructions in that no evaluation for reportability under 10 CFR 21 was performed in accordance with Browns Ferry Standard Practice 15.23, (10 CFR 21 Evaluation and Reporting Requirement). The licensee was informed by the manufacturer of a generic problem with the main steam relief valve acoustic flow monitor (TEC 914 Module) that the circuit malfunction experienced by the licensee during a scram on January 16, 1985, was attributed to overdriving of the bar graph driver chip.

This is a Severity Level V violation (Supplement I), and is applicable to all three units.

Pursuant to 10 CFR 2.201, you are required to submit to this office within 30 days of the date of this Notice, a written statement or explanation in reply, including: (1) admission or denial of the alleged violations; (2) the reasons for the violations if admitted; (3) the corrective steps which have been taken and the results achieved; (4) corrective steps which will be taken to avoid further violations; and (5) the date when full compliance will be achieved.

Security or safeguards information should be submitted as an enclosure to facilitate withholding it from public disclosure as required by 10 CFR 2.790(d) or 10 CFR 73.21.

Date: JUN 24 1985