

Tennessee Valley Authority, 1101 Market Street, Chattanooga, Tennessee, 37402

Joseph R. Bynum Vice President Nuclear Operations

## JAN 22 1991

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555

Dear Sir:

TVA - BROWNS FERRY NUCLEAR PLANT (BFN) UNIT 1 - DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT BFRO-50-259/90021

The enclosed report provides details concerning a violation of technical specifications that occurred when personnel performing roving fire watch duties could not enter an area. This report is submitted in accordance with 10 CFR 50.73(a)(2)(i)(B).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

Enclosure cc: see page 2

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## JAN 22 1991

cc (Enclosure):
INPO Records Center
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

NRC Resident Inspector, BFN

Regional Administration U.S. Nuclear Regulatory Commission Office of Inspection and Enforcement Region II 101 Marietta Street, Suite 2900 Atlanta, Georgia 30323

Mr. Thierry M. Ross U.S. Nuclear Regulatory Commission One White Flint, North 11555 Rockville Pike Rockville, Maryland 20852

| NRC  | Form | 366 |
|------|------|-----|
| (6-4 | 89)  |     |

### U.S. NUCLEAR REGULATORY COMMISSION

Approved OMB No. 3150-0104 Expires 4/30/92

#### LICENSEE EVENT REPORT (LER)

| FACILITY NAME (1)  |                |          |                    |                                | DOCKET NUMB |                                     |                    |                          |  |
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| [_[20,405(a)(1)(iv)  | 50.73(a)       |          |                    |                                | a)(2)(vili) | (B) Text,                           | NRC Form 36        | 6(A)                     |  |
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| Steve Austin, Compliance Engineer  |                |          |                    | 1                              | 2 0 5       | 7 2 9                               | - 2 0              | 4 9                      |  |
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On December 22, 1990, it was determined that on September 27, 1990, proper compensatory actions had not been taken for fire protection detection systems out of service when an hourly roving fire watch could not enter "A" 4160V shutdown board room to perform a visual inspection of the area, thus violating technical specifications.

TVA is presently conducting an investigation of this event. TVA will report the results in a supplement to this LER. The supplement will be submitted by February 14, 1991.

NRC Form 366A (6-89) .

## U.S. NUCLEAR REGULATORY COMMISSION

Approved OMB No. 3150-0104 Expires 4/30/92

# TEXT CONTINUATION

| FACILITY NAME (1)   | DOCKET NUMBER (  | 2)  |         | LER NUMBER (6) |        |          | ) |    |      |     | PAGE | (3) |
|---------------------|------------------|-----|---------|----------------|--------|----------|---|----|------|-----|------|-----|
|                     |                  |     |         | SEQUENTIAL     |        | REVISION |   |    | - 1  |     |      |     |
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

## DESCRIPTION OF EVENT

On December 22, 1990, it was determined that on September 27, 1990, proper compensatory actions had not been taken for fire protection detection systems [IC] out of service when an hourly fire watch could not enter "A" 4160V shutdown board room [NA] to perform a visual inspection of the area, thus violating technical specifications.

On September 27, 1990 at 1955 hours, the "A" 4160V shutdown board room was inspected by an hourly roving fire watch as required by compensatory measures for a fire protection equipment and barrier penetration removal from service permit (Attachment F).

At 2050 hours, the "A" 480V diesel auxiliary board [ED] was returned to its normal power supply during a planned evolution. Transfer of the "A" 480V diesel auxiliary board will cause a loss of the security card reading [IA] system, and for this planned evolution, security was required to manually lock vital area doors. Upon arriving at the locked door of "A" 4160V shutdown board room, the fire watch verified the temperature of the door surface was normal and, from the outward flow of air, there was no fire.

At 2130 hours, the fire watch returned to "A" 4160V shutdown board room, entered the room, and visually verified that no fire had occurred.

During this event, units 1, 2, and 3 were defueled. Failure to properly implement compensatory measures for the Attachment F resulted in a violation of technical specifications. This is reportable under 10 CFR 50.73(a)(2)(1)(B).

The event described in this LER is similar to the events that resulted in LERs 259/90018 and 259/90019. TVA is currently conducting an investigation of this event. TVA will report the results in a supplement.

### Commitment

TVA will issue a supplement to this LER on February 14, 1991.