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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OM8 NO. 3150-0104 EXPIRES 8/31/85

ACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)	
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Unit 1 was at 100 percent power, unit 2 was at 61 percent power, and unit 3 was in a refueling outage. Only units 1 and 2 were affected by this event.

At 2115 on May 5, 1984, it was determined that: (1) Cabling (CBL) for the main steam relief valves (RV) assigned to the automatic depressurization system was not adequately separated from cabling for nonautomatic depressurization system main steam relief valves. (2) Cabling for the high pressure coolant injection (BJ) system was not adequately separated from automatic depressurization system cabling. This is contrary to the design basis of Final Safety Analysis Report, Sections 10.11 and 8.9, and the Browns Ferry Fire Recovery Plan (Part X, Section A, paragraph 3.1.2). These errors were discovered during TVA's design review for 10 CFR 50, Appendix R evaluation and recorded by a noncomformance report to the site.

Immediate corrective action was to establish a fire watch at 2300 on May 8, 1984 at the areas of inadequate separation. An evaluation had previously determined that four relief valves are adequate to achieve safe shutdown in the event of a fire. Administrative controls were initiated to identify the particular valves which would be available and to revise operating instructions accordingly; these actions were completed May 10, 1984.

It was subsequently determined that four relief valves on unit 1 were adequately separated and could be operated from either the control room or the backup control center in the event of a fire. Modifications on unit 2 were completed May 24, 1984 to achieve adequate separation in accordance with the fire recovery plan and to provide a minimum of four operable relief valves in the event of a fire. Fire watches were removed, but were later reestablished after discussions with NRC Region II. Evaluation of this problem continues.

This situation was caused by design error during recovery from the 1975 Browns Ferry fire and further complicated by later modification.

This error was found by TVA's Engineering Design group as part of the Appendix R review which is ongoing. A followup report will be submitted in about 90 days.

This event is deemed Part 21 reportable. TVA, Office of Engineering, is the designer of the cabling for main steam relief valves, automatic depressurization valves, and the high pressure coolant injection system.

Safety Analysis

A similar design error was identified in three other boiling water reactors as noted in Inspection and Enforcement Notice 79-32. As identified for those plants plants there is no significant decrease in the health and safety of the public.

Responsible Plant Section - ED

Previous Similar Events - None

RC Form 366A

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA. TENNESSEE 37401 Browns Ferry Nuclear Plant P. O. Box 2000 Decatur, Alabama 35602

August 8, 1984

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

Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 1 - DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT BFR0-50-259/84021 R1

The enclosed updated report provides information concerning Part 21 reportability. Subsequent review of this event reveals that it should be noted as Part 21 reportable. This report was initially submitted in accordance with 10 CFR 50.73 (a)(2)(ii).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

Abundill

G. T. Jones Plant Manager Browns Ferry Nuclear Plant

Enclosure

cc (Enclosure): Regional Administrator U. S. Nuclear Regulatory Commission Office of Inspection and Enforcement Region II 101 Marietta Street, Suite 2900 Atlanta, GA 30303

INPO Records Center Suite 1500 1100 Circle 75 Parkway Atlanta, GA 30339

NRC Resident Inspector, BFN

IE22 11,