NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Browns Ferry - Unit 1	0 5 0 0 0 2 5 9	1 OF 0 2

TITLE (4)
Unidentified Leakage In Drywell

EVENT DATE (5)			LER NUMBER (6)					REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR		SEQUENTIAL NUMBER		REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
												0 5 0 0 0
0 1	2 1	8 5	8 5	-	0 0 1	-	0 1	0 3	2 9	8 5		0 5 0 0 0

OPERATING MODE (9): N

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	X 50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Jimmy B. Walker	2 0 5 7 2 9 - 2 5 3 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

During normal startup of unit 1, an unidentified drywell leakage rate in excess of that allowed by Technical Specifications was noted. An orderly shutdown was initiated in accordance with Technical Specification requirements.

The leak was identified to be caused by a temporary hose which was used to test a check valve located inside the drywell.

In addition to the hose leak, a small weld crack inside the drywell was identified and repaired.

No safety limits were exceeded. Procedure inadequacy was the root cause for the first event. The pertinent procedures have been revised to prevent further occurrences.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Browns Ferry - Unit 1	0 5 0 0 0 2 5 9	8 5	— 0 0 1	— 0 1	0 2 OF 0 2

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Unit 1 was in startup, unit 2 was in a refueling outage, and unit 3 was at 100 percent power. This event affected unit 1 only.

During startup of unit 1 on January 21, 1985, after a short outage, at 1710 it was noted that drywell (BD) leakage had exceeded the technical specification limit of 5 gallons per minute (gpm). The measured leakage rate was approximately 32 gpm as detected by drywell sump flow. An orderly shutdown was initiated in accordance with Technical Specification 3.6.C.3 which required cold shutdown within 24 hours. Unit shutdown was started at 1820 on January 21, 1985, and the unit was in cold shutdown at 1030 on January 22, 1985.

Upon drywell entry, the leakage was identified to be caused by a temporary hose (TBG) which was used to test core spray (BM) testable check valve (FCV-75-26) (FCV) located in the drywell between the inboard and outboard isolation valves. The hose was positioned across the check valve for testing purposes but was not removed prior to unit startup. A pressure of approximately 800 psig was achieved during startup and with the associated drain valves left open, the temporary rubber hose slipped off its Chicago fitting. This resulted in leakage into the drywell.

Inadequate procedures were cited as the root cause of this incident. The surveillance instruction did not reference the applicable maintenance instruction, and the maintenance instruction did not have a second part verification that all temporary equipment had been removed and drain valves returned to normal. The net result was that workers failed to remove the hose upon completion of testing. The applicable surveillance and maintenance instructions have been revised to provide continuity of the instructions and to prevent further occurrences.

The misplaced hose partially compromised the isolation function of FCV 75-26, core spray inboard check valve, in that a small bypass route was created. Had this event occurred at full pressure, we expect that it would have been detected by very similar symptoms to those described above.

During a drywell inspection on January 22, 1985, a .50 inch long crack in a socket weld was discovered on "A" recirculation (AD) discharge bonnet vent valve 68-509 on principal recirculation valve FCV-68-3 (FCV). The bonnet vent valves and associated pipe were removed. The socket opening was plugged and seal welded. The cause for the weld to crack was fatigue failure due to vibration.

Both of these events are isolated cases, and no further actions are required.

Responsible Plant Section - MM

Previous Events - BFRO-50-259/82-020 (for cracked welds)

TENNESSEE VALLEY AUTHORITY
Browns Ferry Nuclear Plant
P. O. Box 2000
Decatur, Alabama 35602

March 29, 1985

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

Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT (BFN) UNIT 1 - DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT BFRO-50-259/85001 R1

The enclosed report provides additional details concerning unidentified leakage in the drywell. This report is submitted in accordance with 10 CFR 50.73 (a)(2)(ii) and (iv).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

S T Jones

G. T. Jones
Plant Manager
Browns Ferry Nuclear Plant

Enclosures
cc (Enclosures):
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NRC Resident Inspector, BFN

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