NRC Form (9-83)	344					LIC	ENSE	E EVEI	NT REI	PORT (LER)			AP	POVE	D OMB NO 8/31/85		
FACILITY	Y NAME (1)										D	OCKET N	UMBER	(2)		PAC	GE 130
Br	owns	s F	err	y -	Unit	1							151	0 10	0 12	1519	1 OF	0 12
TITLE 14		120										-					h	
	Uni	lde	nti	fied	Leak	tage In	Dry	well										
EVE	ENT DATE	(6)		-	LER NUMBER	(6)	ASI	PORT DATE	(7)			-	ACILITIE	S INVOL	VED 18	1		-
MONTH	DAY	YEAR	A YE	YEAR SEQUENTIAL REVE			MONTH DAY YEAR			FACILITY NAMES				DOCKET NUMBER(S)				
1															0 5	1010	101	1.1.
0 1	2 1	8	5 8	5	0 0 1	-00	0 2	1 5	8 5						0 5	1010	101	()
-	RATING		THI	REPOR	T 18 BUBMITT	TED PURSUANT T	O THE R	EQUIREME	NTS OF 10	CFR 8: /C	heck one	or more of	f the follo	wingi (11	-			
MODE (9) N				20.402(b) 20.408(a)(1)(i) 20.408(a)(1)(ii) 20.408(a)(1)(iv) X 30.408(a)(1)(v)			60.36(e)(1) 60.36(e)(2) 60.73(a)(2)(i) 60.73(a)(2)(ii)		50.73(a)(2)(v) 50.73(a)(2)(vii)(A) 50.73(a)(2)(viii)(B) 50.73(a)(2)(x)			73.71(b) 73.71(c) OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
NAME							ICENSEE	CONTACT	FOR THIS	LER (12)						HONE NUM		
Jimmy B. Walker													CODE		7 12 1 91 - 12 1 51 31		316	
					COMPLET	E ONE LINE FOR	EACH CO	MPONENT	FAILURE	DESCRIBE	O IN THE	REPORT	and the same of the	1-1	, 1-	1,1	1-1-	Tale
CAUSE	AUSE SYSTEM COMPO		PONEN	MANUELO L		REPORTABLE TO NPROS				SYSTEM	COMPONENT		MANUFAC TURER			ORTABLE NPRDS	A Part	
		1	1										1	11				
		1	1		111				127									
	-	-			BUPPLEN	MENTAL REPORT	EXPECTE	ID (14)	1						_	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)						-	X NO					SUBMISSION DATE (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.

8502280275 850215 PDR ADOCK 05000259 PDR

NF	TC.	For	m	36	6A	
	83					

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/86

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

Upon drywell entry, the leakage was identified to be caused by a temporary hose (TBG) which was used to test Core Spray 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 applicable Surveillance and Maintenance Instructions have been revised to provide continuity of the instructions and to prevent further occurrences.

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 - None

TENNESSEE VALLEY AUTHORITY

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

February 15, 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 BFR0-50-259/85001

The enclosed report provides 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

G. T. Jones Plant Manager

Browns Ferry Nuclear Plant

Enclosures

cc (Enclosures):

Regional Administrator
U. S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region II
101 Marietta Street, Suite 2900
Atlanta, Georgia 30303

NRC Resident Inspector, BFN

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

