NRC FORM 365 , U.S. NUCLEAR REGULATORY COMMISSION 10 CFR 50 LICENSEE EVENT REPORT	APPROVED BY OME
CONTROL BLOCK:	YPE ALL REQUIRED INFORMATION)
0 1 A L B R F 1 2 0 0 - 0 0 0 0 0 - 0 0 3	4 1 1 1 1 1 1 3 4 57 CAT 38 5
CON T O 1 REPORT L 6 0 5 0 0 0 2 5 9 7 0 6 0 2 8	3 8 0 6 3 0 8 3 9
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) During normal operation of unit 3, both stack gas rad	
RM 90-148) became inoperable due to sample pump fails	ure. A grab sample program
0 4 for the stack effluent (SI 4.8.B.1.a.2) was initiated	d as required by
TS 3.8.B.8. There was no effect on public health and	i safety since the offgas
post-treatment monitors (3-RM-90-265/266) were operate	ble and grab sample analyses
o 7 indicated no significant increase in activity.	
08	
SYSTEM CAUSE CAUSE CODE CODE SUBCODE COMPONENT CODE	COMP. VALVE SUBCODE SUBCODE
	4 G 5 Z 6
SEQUENTIAL OCCURRENCE	REPORT REVISION
17 REPORT 8 3 - 0 2 8 0 3	L 0
ACTION FUTURE FRANCE SHIPTOWN	30 31 32 32 PRO-4 PRIME COMP. COMPONENT (C)
TAKEN ACTION ON PLANT METHOD HOURS (22) SUBMITTED FOR	M SUB. SUPPLIER MANUFACTURER 26
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	N (24) L (25) G 0 4 6
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The glass oil filter bowl on sample pump "A" was broken the control of the cont	ten. The broken filter
bowl was replaced. Sample pump "B" failed when the G	Wast Mfg. (Model 2065-V2)
rotary vacuum pump caused motor to trip out. A rebui	lt pump was installed. The
failure of pump "A" was a random occurrence. The fai	lure of pump "B" is being
investigated and a followup report will be issued.	
FACILITY METHOD OF	ao
1 5 H 28 0 0 0 0 29 NA A 30 Control R	oom Alarm (32)
ACTIVITY CONTENT RELEASE AMOUNT OF ACTIVITY (35) 1 6 Z (33) Z (34) NA NA	OCATION OF RELEASE (36)
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)	80
1 7 0 0 0 37 Z 38 NA	
PERSONNEL INJURIES NUMBER DESCRIPTION (41) 1 8 0 0 0 0 0 NA	**
LOSS OF OR DAMAGE TO FACILITY (43)	IEZZ "
1 9 Z 42 NA	1/1
SSUED DESCRIPTION (45) 8307120544 830630 PDR ADOCK 05000259 PDR PD	NRC USE ONLY
NAME OF PREPARER James W. Burton, III	HONE 205/729-0621

LER SUPPLEMENTAL INFORMATION

BFRO-50-259 / 83028 Technical Specification Involved 3.8.B.8

Reported Under Technical Specification 6.7.2.b. (2) * Date Due NRC 07/01/83

Event Narrative:

Unit 1 was in a refueling outage, unit 2 was in a maintenance outage, and unit 3 was operating at 95-percent power. All three units had the possibility of being affected by this event. At approximately 2200 hours on June 2, 1983, both stack gas radiation monitors (RM-90-147/148) became inoperable due to failure of stack gas radiation sample pump "A." The failure initiated a control room alarm. Plant operations personnel were immediately dispatched to place the redundant sample pump (pump "B") in service. A second control room alarm was received immediately after "B" sample pump was placed in service. Both "A" and "B" sample pumps were declared inoperable at this time.

The radiochemical laboratory was instructed to initiate a grab sample and analysis program for the stack effluent (SI 4.8.B.1.a.2) as required by Technical Specification 3.8.B.8. The sample pumps and their associated radiation monitors (RM-90-147/148) were declared operable at 0317 hours on June 3, 1983. Technical Specification 3.8.B.8 requires that a minimum of one stack gas radiation monitor be operable when any unit's steam jet air ejector, mechanical vacuum pump, or a standby gas treatment train is in service. This requirement was not met for approximately 5 hours and 17 minutes.

This event was caused by the failure of sample pumps "A" and "B." Sample pump "A" failed due to loss of oil (broken filter oil bowl) and sample pump "B" failed when the motor tripped out. It is believed that mechanical failure of pump "B" caused the motor to trip. The failure of pump "A" was a random occurrence. The failure of pump "B" is being investigated and a followup report will be issued upon completion of the investigation.

This event had no adverse effect on the health or safety of the public. No significant increase in activity levels was detected by analysis of the stack gas grab samples. Additionally, a review of SI 4.8.B.1.a.1 (Airborne Effluent Log) revealed no significant increase in activity during this time.

* Previous Similar Events:

None

Retention: Period - Lifetime; Responsibility - Document Control Supervisor

*Revision:

TENNESSEE VALLEY AUTHORITY

1750 Chestnut Street Tower II

June 30, 1983

ATLANTA, SEORGIA

83 JUNTAT A 9: 49

Mr. James P. O'Reilly, Director U.S. Nuclear Regulatory Commission Suite 2900 101 Marietta Street, NW Atlanta, Georgia 30303

Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 1 - DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT BFR0-50-259/83028

The enclosed report provides details concerning the failure of the stack gas radiation monitors because of pump problems. This report is submitted in accordance with Browns Ferry unit 1 Technical Specification 6.7.2.b(2).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

H. J. Green

Director of Nuclear Power

Enclosure cc (Enclosure):

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Institute of Nuclear Power Operations
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

NRC Inspector, Browns Ferry

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