### TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

1750 Chestnut Street Tower II

BINERIAS. 10

December 14, 1981

Mr. James P. O'Reilly, Director U.S. Nuclear Regulatory Commission Office of Inspection and Enforcement Region II 101 Marietta Street, Suite 3100 Atlanta, Georgia 30303

Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 3 - DOCKET NO. 50-296 - FACILITY OPERATING LICENSE DPR-68 - REPORTABLE OCCURRENCE REPORT BFRO-50-296/81068

The enclosed report provides details concerning 3 EN reactor motor-operated valve board motor-generator set which was removed from service to investigate rising vibration problems. This report is submitted in accordance with Browns Ferry unit 3 Technical Specification 6.7.2.b(2).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

H. J. Green

Director of Nuclear Power

Enclosure (3) cc (Enclosure):

Director (3)

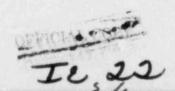
Office of Management Information and Program Control U.S. Nuclear Regulatory Commission Washington, DC 20555

Director (40)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Records Center Institute of Nuclear Power Operations 1820 Water Place Atlanta, Georgia 30339

Mr. R. F. Sullivan, NRC Inspector, Browns Ferry

8112240135 811214 PDR ADDCK 05000296 PDR



V. S. NUCLEAR REGULATORY COMMISSION  (7-77)  LICENSEE EVENT REPORT
CONTROL BLOCK:
0 1 A L B R F 3 2 0 0 - 0 0 0 0 - 0 0 3 4 1 1 1 1 1 4 5 5 7 8 9 LICENSE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58
CON'T    REPORT   L   6   0   5   0   0   0   2   9   6   7   1   1   1   5   8   1   8   1   2   1   4   8   1   9     SOURCE   60   61   DOCKET NUMBER   68   69   EVENT DATE   74   75   REPORT DATE   80   9     EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
During refueling outage, 3 EN RMOV board MG set was removed from service to investi-
[0]3   gate rising vibration problems. (T.S. 3.9.C.4) There was no danger to the health
0 4 or safety of the public. Redundant systems were available and operable. There
0 5 were no previous similar events.
06
0 7
7 8 9
CODE   CAUSE   CAUSE   COMPONENT CODE   COMPONENT CODE   SUBCODE   SUBCODE
SEQUENTIAL OCCURRENCE REPORT REVISION  LER/RO EVENT YEAR REPORT NO.  ODE TYPE NO.  17) REPORT   8   1
NUMBER 21 22 23 24 26 27 28 29 30 31 32  ACTION FUTURE EFFECT SHUTDOWN HOURS 22 ATTACHMENT FORM SUB. PRIME COMP. COMPONENT MANUFACTURER  A 18 X 19 Z 20 Z 21 0 0 0 0 0 Y 23 N 24 Z 25 Z 9 9 9 9 26  CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27
1 0 Investigation of rising vibration problems. Flywheel bearing on motor side had become
noisy and was replaced as a preventive maintenance action and MG set was realigned.
[1]2   Since no failure occurred, no recurrence control is required other than the established
periodic monitoring of the MG sets.
1 4 1 8 9
FACILITY STATUS NA OTHER STATUS 0 METHOD OF DISCOVERY DESCRIPTION 02  1 5 H 28 0 0 0 0 0 0 0 0 0 0 NA A 0 0 0 0 0 0 0
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35  NA  1 6 Z 33 Z 34 NA  NA  NA  PERSONNEL EXPOSURES  AMOUNT OF ACTIVITY 35  NA  44 45
NUMBER   TYPE   DESCRIPTION (39)   NA   NA   NA   NA   NA   NA   NA   N
7 8 9 11 12 13 PERSONNEL INJURIES NUMBER DESCRIPTION 41
1 A 9 11 12 NA 80
LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION NA  NA
PUBLICITY POR ADDCK 05000296  8112240142 811214  NRC USE ONLY  S NAC USE ONLY  S NAC USE ONLY
PDR 68 69 80 5
NAME OF PREPARED Gene Holder PHONE (205) 729-6134

#### LER SUPPLEMENTAL INFORMATION

BFRO-50- 296 / 81068	Technical Spec	eification In	volved 3.9.C.4
Reported Under Technica	al Specification	6.7.2.b(2)	* Date Due NRC 12/15/81
Date of Occurrence 11/1	.5/81 Time of	Occurrence	2040 Unit 3
Identification and Descrip	ption of Occurre	ence:	
3 EN RMOV board MG set w	ras removed from	service to	investigate rising vibration.
Conditions Prior to Occu	rrence:		

Unit 1 at 64%.
Unit 2 at 91%.

Unit 3 in refueling outage.

Action specified in the Technical Specification Surveillance Requirements met due to inoperable equipment. Describe.

None

# Apparent Cause of Occurrence:

Rising vibration

# Analysis of Occurrence:

There was no danger to the health or safety of the public, no release of activity, no damage to the plant or equipment, and no resulting significant chain of even+s.

## Corrective Action:

Flywheel bearing on motor side of MG set was replaced as a preventive maintenance action and MG set was realigned. Since no failure occurred, no recurrence control is required other than the established periodic monitoring of the MG sets.

Failure Data: None

Retention: Period - Lif time; Responsibility - Document Control Supervisor

\*Revision: Ahraneu