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

YES (If yes, complete EXPECTED SUBMISSION DATE)

During performance of instrument check surveillance instruction, RI-90-142 was taken to the "zero" position to check recorder reading resulting in an inadvertent initiation of group 6 containment isolation logic. A caution note was added to the applicable plant surveillance instruction to prevent similar occurrences in the future. The containment isolation signal was reset and equipment returned to normal after verifying the affected safety systems availability.

SUPPLEMENTAL REPORT EXPECTED (14)

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U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

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

Unit 1 was in cold shutdown, unit 2 was in refueling outage, and unit 3 was in cold shutdown.

On April 29, 1985, during performance of an instrument check surveillance instruction on unit 3, radiation indicator (RI-90-142) was taken to the "zero" position to verify the reading. For this particular instrument, this action will cause a trip of group 6 initiation logic. When the mode switch was placed in the "zero" position an upscale trip was accordingly generated. The surveillance instruction did not caution the operator about the possibility of generating a containment isolation signal.

The upscale trip is designed to initiate isolation of the reactor building ventilation (VA), isolation of drywell control air system (VB), isolation of the control room ventilation (VI), and starting of the standby gas treatment system (BH). The equipment functioned as designed. Initiation of containment isolation was inadvertent in that there were no precautionary notes in the instrumentation check surveillance instruction. The containment isolation signal was reset and equipment returned to normal after verifying the affected safety system availability.

To prevent similar events from occurring in the future, the instrumentation check surveillance instruction was revised to include a caution statement and a reference to reactor building ventilation radiation monitors surveillance instruction.

Responsible Plant Section - N/A

Previous Events - None

TENNESSEE VALLEY AUTHORITY

P. O. Box 2000 Decatur, Alabama 35602

May 24, 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-50-259/85014

The enclosed report provides details concerning containment isolation initiation. This report is submitted in accordance with 10 CFR 50.73 (a)(2)(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