						LIC	ENSE	E EVE	NT R	EPORT	(LER)	U.S. NO	APPROVED OMB		
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During routine activities on February 10, 1986, the licensed reactor operator received a high radiation alarm from RM-90-259A in the control room which initiated actuation of the control room emergency ventilation system A and B trains. Plant personnel were dispatched to the detector to determine the cause of the high radiation alarm. Due to an internal source motor mounting bracket failure, the radiation detector's internal calibration source had fallen into close proximity of its detector giving a high radiation reading. The detector's calibration source was readjusted and Surveillance Instruction 4.2.G-1 was successfully performed. The control room emergency ventilation system A and B trains were secured to standby readiness.

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YES I'I yes complete EXPECTED SUBMISSION DATE!

ABSTRACT (Limit to 1400 spaces, i.e., approximately tifteen single-space typewritten

NRC Form 366A 9-831	LICENSEE EVENT R	UATION	IJS NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0164 EXPIRES 8/31/88			
FACILITY NAME (1)		DGCKET NUMBER (2)	LER NUM	Ø1R (6)	PAGE (3)	
			YEAR SEGUI	HER NUMBER		
Browns Ferry	- Unit 1	0 15 10 10 10 12 15 1	9 816 - 010	0 5 - 0 0	012 0 012	

Units 1 and 2 were in refueling outages, and unit 3 was in an extended maintenance outage.

At 1352 on February 10, 1980, the licensed reactor operator received a high radiation alarm (RA) from RM-90-259A (IL) in the control room; and this initiated the control room emergency ventilation systems A and B trains (VI). Plant personnel were sent to the detector (DET) for analysis of the high alarm.

After an auxiliary unit operator determined the area where the detector was located was not in a high radiation condition, the detector was investigated. It was found that the internal calibration source motor mounting bracket was cracked which allowed the source to fall too close to the detector giving the high radiation alarm. This type failure is extremely rare with the cause of fracture unknown. The mounting bracket was repaired, the applicable Surveillance Instruction 4.2.G-1 successfully performed, and the control room emergency ventilation system A and B trains returned to standby readiness.

Since the detector performed its safety function of initiating the high radiation alarm and initiating actuation of the control room emergency ventilation system, no adverse safety situation existed during this event. No further corrective action is planned since this was a random event.

Responsible Plant Section - N/A

Previous Events - BFRO-50-260/85012

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

March 11, 1986

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

Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 1 - DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT BFR0-50-259/86005

The enclosed report provides details concerning control room emergency ventilation system actuation. This report is submitted in accordance to 10 CFR 50.73 (a)(2)(iv).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

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

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

NRC Resident Inspector, Browns Ferry Nuclear Plant

RIMS, MR 4N 72A-C (w/10CFR21, Form BF-19, and Form BF-90)

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