

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Browns Ferry Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 5 9	PAGE (3) 1 OF 0 2
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TITLE (4)
Accidental Bump of Radiation Monitor Output Cable Initiates Control Room Emergency Ventilation

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)																				
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)																		
0	2	2	1	8	7	8	7	8	7	0	0	4	0	0	0	3	2	0	8	7	Browns Ferry Unit 2	0	5	0	0	0	2	6	0
												Browns Ferry Unit 3	0	5	0	0	0	2	9	6									

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)									
POWER LEVEL (10) 01010	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)							
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)							

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME Stephen B. Jones, Engineer, PORS		AREA CODE 2 0 5	7 2 9 1 3 7 8 8

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)		<input checked="" type="checkbox"/> NO			

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

On February 21, 1987, at 1025, the control room emergency ventilation (CREV) system unexpectedly started. An assistant shift engineer (ASE) working in the area of a control bay air inlet radiation monitor accidentally moved the signal output cable. This, caused a momentary spike in the monitor's output and the logic initiated both CREV units, and isolated the normal control bay ventilation. CREV was secured and returned to standby readiness by 1035.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Browns Ferry Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 5 9 8 7	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
			0 0 4	0 0	0 2	OF	0 2

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

Units 1, 2, and 3 were in refueling outages. The control bay ventilation for all three units was affected by this event.

On February 21, 1987, at 1025, an ASE was removing debris from a congested area between the control room air inlet radiation monitor (RM) (45) 90-259 B and a wall. The ASE accidentally moved the connector of the RM signal output cable causing a momentary spike in the RM output which initiated the CREV (VI) trains A and B. The ASE promptly notified the shift engineer of his error. CREV was secured and returned to standby readiness by 1035.

The licensed operator who caused the occurrence was counseled for not paying close attention while performing his activities. No equipment damage occurred, and further corrective action is not required.

The event had no affect on the safe operation of the plant. The only equipment affected was the control bay ventilation which is designed to enhance control room habitability in the event of a fuel handling or loss of coolant accident. The system responded as designed. If this event had occurred during power operation the equipment would have responded in the same manner. No adverse effects on plant operation would have occurred since the equipment response places the control bay in a more conservative operating configuration.

Previous Events - BFRO 50-259/86034
 BFRO 50-259/86005

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

March 20, 1987

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

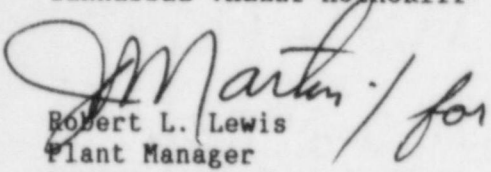
Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 1 - DOCKET
NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT
BFRO-50-259/87004

The enclosed report provides details concerning the accidental bump of the
radiation monitor output cable that initiated control room emergency
ventilation. This report is submitted in accordance to 10 CFR 50.73 (a)(2)(iv).

Very truly yours,

TENNESSEE VALLEY AUTHORITY


Robert L. Lewis
Plant Manager
Browns Ferry Nuclear Plant

Enclosures

cc (Enclosures):

Regional Administration
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