

TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE
37401



June 21, 1974



Mr. John F. O'Leary, Director
Directorate of Licensing
Office of Regulation
U.S. Atomic Energy Commission
Washington, DC 20545

Dear Mr. O'Leary:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 1 -
DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - ABNORMAL
OCCURRENCE REPORT BFAO-7440W

The enclosed report is to provide details concerning the radwaste building vent monitoring channel which was out of service for more than 1 hour without providing a temporary monitor in violation of technical specification 3.8.B.8. and is submitted in accordance with Appendix A to Regulatory Guide 1.16, Revision 1, October 1973. This event occurred on Browns Ferry Nuclear Plant unit 1 on June 14, 1974.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

E. F. Thomas
E. F. Thomas
Director of Power Production

Enclosure

CC (Enclosure):

Mr. Norman C. Moseley, Director
Region II Regulatory Operations Office, USAEC
230 Peachtree Street, NW., Suite 818
Atlanta, Georgia 30303

Handwritten signature and date 5-25-79

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ABNORMAL OCCURRENCE REPORT

Report No.: BFAO-7440W
Report Date: June 24, 1974
Occurrence Date: June 14, 1974
Facility: Browns Ferry Nuclear Plant unit 1

Identification of Occurrence

The radwaste building vent monitoring channel was out of service for more than 1 hour without providing a temporary monitor in violation of technical specification 3.8.B.8.

Conditions Prior to Occurrence

Reactor was operating at approximately 80 percent in the startup test program.

Designation of Apparent Cause of Occurrence

During the routine daily background check at approximately 3:50 a.m., the high voltage on the vent monitoring channel constant air monitor (CAM) was turned off to remove the filters and again to replace them. After the unit was reassembled, the high voltage was inadvertently left off causing all three detectors to be inoperable.

At approximately 5:30 a.m., it was noticed that the channel was not responding. The high voltage was then turned on and the CAM returned to service.

Analysis of Occurrence

During the period that the high voltage was turned off, the sample pump was operational. Therefore, a particulate and a halogen sample were being collected on the respective filters which would have indicated a higher reading than that before the background check had a release of radioactive particulate or halogens occurred. Since no higher reading was indicated, the local air particulate monitors and area radiation monitors in the radwaste building showed no changes, and no operations that would lead to a release of airborne radioactivity took place during the period of inoperability, there is reasonable assurance that no unmonitored release of radioactivity occurred.

Corrective Action

The immediate corrective action was to turn the high voltage on which restored the detectors to service. Subsequently, the procedure for obtaining background readings was modified to specifically require the high voltage be turned back on if applicable and to verify proper operation of instrument. Employees involved in the background check procedure will be reminded of the critical nature of effluent monitors and to exercise caution in assuring proper operation after performing checks.

Failure Data

No equipment failure was involved in this occurrence.