

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Browns Ferry - Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 2 5 9 1										PAGE (3) 1 OF 0 2	
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TITLE (4)
Discontinuance of CAM Hourly Sampling Due to Personnel Error

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 4	0 3	8 5	8 5	0 1 0	0 0 0	5 0	3 8	5							0 5 0 0 0					
															0 5 0 0 0					

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) 0 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)															
	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)															
	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)															
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)																
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)																
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)																

LICENSEE CONTACT FOR THIS LER (12)										TELEPHONE NUMBER									
NAME David L. Smith										AREA CODE 2 1 0 5 7 1 2 9 1 - 3 8 6 1 5									

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

SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE) X NO														

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

During routine activities, the licensed reactor operator observed a CAM-1-90-250 upscale alarm and, after verification that the alarm was erroneous, declared the CAM inoperable at 1330. Hourly samples were taken until 2000 when the maintenance personnel relayed to the chemical analyst that the as found on the CAM had two of the three channels working properly. The chemical analyst, through personnel error, failed to continue hourly samples on the inoperable channel until the CAM was returned to service at 2358. The samples taken and the return-to-service readings all indicated no abnormal releases to the environment.

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PDR ADOCK 05000259
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

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

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

With units 1 and 3 in cold shutdown and unit 2 in a refueling outage, the licensed reactor operator on unit 1 noticed an upscale alarm (AA) for CAM-1-90-250 (MON). After verification checks, the CAM was declared inoperable at 1330, hourly sampling was adhered to per Surveillance Instruction 4.8.B.1.a requirements until 2000. However, the CAM was not returned to service until 2358. The calibration source had slipped down to the detector giving upscale readings.

The chemical analyst received information from the unit 1 operator that maintenance personnel had found two of the three channels operable. Through misinterpretation of approved plant procedures, the analyst incorrectly concluded that a four-hour sampling frequency was acceptable. This frequency error was found during the cognizant review of the sampling surveillance instruction.

CAM-1-90-250 monitors releases from the reactor building ventilation system (VA) associated with unit 1. Units 2 and 3 have independent CAMs and were operating normally during this event. The monitored readings from all operating CAMs and CAM-1-90-250's two operable channels (halogen and particulate) indicated that during this four-hour period no unusual releases occurred. Also, the readings for the inoperable channel (noble gas) returned to its approximate same previous readings when returned to service at 2358.

The personnel error was due to failure to strictly follow approved plant procedures. The person involved was disciplined. "Live-time" training was given to all chemical shift supervisors on this occurrence. No further corrective action is planned.

Responsible Plant Section - EN

Previous Events - None

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

May 3, 1985

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

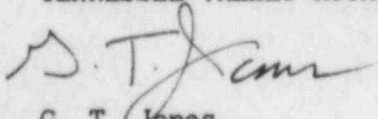
Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT (BFN) UNIT 1 -
DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE
OCCURRENCE REPORT BFRO-50-259/85010

The enclosed report provides details concerning the discontinuance of
CAM hourly sampling due to personnel error. This report is submitted
in accordance with 10 CFR 50.73 (a)(2)(i).

Very truly yours,

TENNESSEE VALLEY AUTHORITY



G. T. Jones
Plant Manager
Browns Ferry Nuclear Plant

Enclosures

cc (Enclosures):

Regional Administrator
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Office of Inspection and Enforcement
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INPO Records Center
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NRC Resident Inspector, BFN

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