

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Browns Ferry - Unit 1	0 5 0 0 0 2 5 9	1 OF 0 2

TITLE (4)
Containment Isolation Initiation

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	6	0	4	8	5	8	5	0	2	1	0	0	0	7	0	2	8	5	Browns Ferry - Unit 2	0 5 0 0 0 2 6 0
0	6	0	4	8	5	8	5	0	2	1	0	0	0	7	0	2	8	5	Browns Ferry - Unit 3	0 5 0 0 0 2 9 6
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																	
N			20.402(b)			20.405(c)			<input checked="" type="checkbox"/> 50.73(a)(2)(iv)			73.71(b)								
POWER LEVEL (10)			20.406(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)			73.71(c)								
0 0 0			20.406(a)(1)(ii)			50.36(c)(2)			50.73(a)(2)(vii)			OTHER (Specify in Abstract below and in Text, NRC Form 366A)								
			20.406(a)(1)(iii)			50.73(a)(2)(i)			50.73(a)(2)(viii)(A)											
			20.406(a)(1)(iv)			50.73(a)(2)(ii)			50.73(a)(2)(viii)(B)											
			20.406(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(ix)											

LICENSEE CONTACT FOR THIS LER (12)											
NAME										TELEPHONE NUMBER	
R. C. Steele										AREA CODE	
										2 0 5 7 2 9 1 - 3 5 8 1 3	

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	
AT	J M	F U	M 1 7 5	Yes							
AU	J M	R L Y	P 2 9 7	Yes							

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)

Two independent events resulted in secondary containment isolations.

1. On June 4, 1985, a primary containment isolation occurred when one primary containment isolation system trip channel was being removed from service for relay changeout. An undetected blown fuse in the redundant channel caused the isolation. The blown fuse was replaced, and the isolation signal reset.
2. On June 5, 1985, while performing a surveillance instruction a radiation monitor mode switch was taken out of operate mode resulting in a containment isolation. A defective relay was responsible for the isolation. The relay failure is considered random and no further corrective action is planned.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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 2 1	-	0 0	0 2 OF 0 2

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

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

The following events occurred independently.

1. On June 4, 1985, when one primary containment isolation (JM) system channel was removed from service for a relay (RLY) changeout, an isolation of unit 2 reactor zone, refueling zone, initiation of standby gas treatment, and control room emergency ventilation occurred. The relay was being changed to comply with NRC IE Bulletin 84-02. Investigation revealed that the redundant channel had a blown fuse. The fuse failure in the redundant channel is considered random. The blown fuse was replaced and the isolation signal was reset. As recurrence control, the fuses in redundant channels will be checked to be functional before removing any circuits from service for relay changeout under IE Bulletin 84-02.
2. On June 5, 1985, while performing surveillance instruction 4.2.A.10 to determine the cause of a "refueling zone exhaust downscale" annunciation, the radiation monitor mode switch was taken out of operate mode resulting in isolation of unit 2 reactor zone, refueling zone, initiation of standby gas treatment, and control room emergency ventilation.

The annunciator is shared between two radiation monitors, RM-90-140 and RM-90-141. When the mode switch on RM-90-141 was taken out of operate, it generated a downscale trip. That signal in conjunction with the existing downscale trip signal (generating "refueling zone exhaust downscale") resulted in the isolation. This confirmed that the defect was in RM-90-140; and further investigation revealed that relay K-1 (Potter and Brumfield model KH 4690) contacts failed, generating the alarm. The defective relay was replaced, and the surveillance instruction was completed satisfactorily. The relay failure is considered random, and there are no planned recurrence controls.

In each of the above events, the safety systems functioned as designed with no adverse effects noted.

Responsible Plant Section - EM

Previous Events - BFRO 50-259/85011

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

July 2, 1985

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

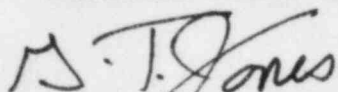
Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT (BFN) UNIT 1 -
DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE
OCCURRENCE REPORT BFRO-50-259/85021

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
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INPO Records Center
Suite 1500
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NRC Resident Inspector, BFN

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