

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)										DOCKET NUMBER (2)				PAGE (3)	
Browns Ferry - Unit 2										0 5 0 0 0 2 6 0				1 OF 0 3	

Engineered Safety Feature Actuations From High Radiation Alarms

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)						
1	1	2008	5	8	5	0	1	7	0	0	1	22	0	8	5	0 5 0 0 0				
															0 5 0 0 0					

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)	X	50.73(a)(2)(iv)		73.71(b)			
POWER LEVEL (10)		20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)			
01010		20.405(a)(1)(ii)		50.38(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 365A)			
		20.405(a)(1)(iii)		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)(ix)					

LICENSEE CONTACT FOR THIS LER (12)	
NAME	TELEPHONE NUMBER
David L. Smith, Compliance Section Engineer	<div>AREA CODE</div> <div>205 71291-3865</div>

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

During handling of a spent local power range monitor (LPRM) in the fuel pool, the instrument tube was allowed to come too close to the water surface. This alarmed refuel floor area radiation monitors and also resulted in a secondary containment isolation since the refuel zone ventilation monitors were also tripped. The refuel bridge operator immediately lowered the tube, thus restoring radiation levels to normal background values. Personnel involved in the activity received a small dose due to the event.

LPRM replacement activities were halted for a critique of the occurrence. The causes were attributed to procedural deficiencies for handling of the spent LPRM tubes. Corrective action focused primarily on adding radiological caution statements to the procedure as well as adding formal prework briefing requirements and improvements in the instructions dealing with the physical manipulation of the tubes.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Browns Ferry - Unit 2	0 5 0 0 0 2 6 0	8 5	- 0 1 7	- 0 0 0	2	of	0 3

TEXT (If more space is required, use additional NRC Form 365A's) (17)

Units 1 and 2 were in refueling outages, and unit 3 was in an extended maintenance outage. This event affected unit 2 and common secondary containment isolation features.

At approximately 0900 hours, operations personnel were transporting a used local power range monitor (LPRM) (IG) from unit 2 reactor (RPV) to the spent fuel pool (DF). While being dragged across the edge of the vessel flange, the tip of the spring end of the LPRM was accidentally pulled off, although the tip and LPRM remained in the LPRM tool. This allowed the LPRM to slide through the LPRM safety hook and prevented normal handling of the tube. After the LPRM was placed in the spent fuel pool, the cold end of the LPRM was secured to the southeast corner of the spent fuel pool. Attempts were made to bow the LPRM to allow normal storage. The assistant unit operator (AUO) attempted to remove the LPRM tool, but the sliding effect of the LPRM through the tool hampered efforts to place the LPRM. During this movement of the LPRM tool, the LPRM was caught behind the source pin rack. The AUO unsuccessfully attempted to remove the LPRM from behind the source pin rack using the monorail hoist (HOI). The monorail hoist and LPRM tool were abandoned at this point, and manipulations continued using J-hooks and the LPRM safety hook. During this manipulation, the LPRM was inadvertently raised close to the pool surface. A health physics technician was monitoring the surface of the water during these activities. He noted an increased reading and that the LPRM hot end had risen to about 18-inches from the surface as he was turning to warn the operator. The area radiation monitor (ARM) (MON) on the refueling bridge and the ARM on the north wall of the refueling floor alarmed, and a high radiation alarm was received in the control room. The LPRM was immediately lowered.

The alarms received were: RA-90-1A (Fuel Pool (DF) Area Hi-Rad), RA-90-250A (Reactor (NH) and Turbine (NM) Building Vent Hi-Rad), RA-90-140A (Refuel Zone (NH) Hi-Rad), and RM-90-141 (Refuel Zone Radiation Monitor). Trip of the zone monitors initiated the following: refuel zone isolation, standby gas treatment (VA) system actuation, and control room emergency ventilation (VI) system initiation. After the condition was cleared by lowering the LPRM, the control room operator reset the isolation and realigned the named systems to normal status.

LPRM replacement activities were halted for a critique of the event by involved personnel from operations, health physics, and maintenance. The cause of the event was primarily attributed to an unanticipated and unplanned configuration with the damaged LPRM caught behind the source pin rack.

Corrective action focused on adding radiological caution statements to the procedure as well as adding formal prework briefing requirements and improvements in the instructions dealing with the physical manipulation of the tubes.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/88

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

Several of the personnel involved in the operation received small radiation doses. Maximum estimated dose was 22 millirem to the health physics technician nearest the LPRM hot end. All events concerning potential radiological exposure hazard to personnel are considered significant. The need for comprehensive prejob planning and recognition of potential radiation hazards during work activities was stressed in the described corrective actions.

Responsible Plant Section - IM

Previous Events - BFRO-50-259/85035, -260/85006

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

December 20, 1985

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

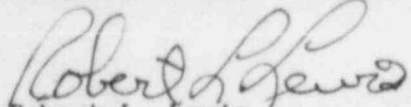
Dear Sir:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT (BFN) UNIT 2 -
DOCKET NO. 50-260 - FACILITY OPERATING LICENSE DPR-52 - REPORTABLE
OCCURRENCE REPORT BFRO-50-260/85017

The enclosed report provides details concerning engineered safety
feature actuations from high radiation alarms. This report is
submitted in accordance with 10 CFR 50.73 (a)(2)(iv).

Very truly yours,

TENNESSEE VALLEY AUTHORITY



Robert L. Lewis
Acting Plant Manager
Browns Ferry Nuclear Plant

Enclosures

cc (Enclosures):
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NRC Resident Inspector, BFN

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