

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1 DOCKET NUMBER (2) 0 5 0 0 0 3 2 7 1 OF 0 2
TITLE (4)

Auxiliary Building Ventilation Isolations

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)
03	22	84	84	021	00	04	20	84			0 5 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)

OPERATING MODE (8)	20.402(b)	20.406(c)	50.73(a)(2)(iv)	73.71(b)
6	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POWER LEVEL (10)	20.406(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
01010	20.406(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	<input type="checkbox"/>
	20.406(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)
	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)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Glenn Duggin, Compliance Section Engineer TELEPHONE NUMBER 615 870-6146
AREA CODE 615

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)

YES (If yes, complete EXPECTED SUBMISSION DATE) ☒ NO ☐ EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

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

A high radiation alarm was actuated which caused an auxiliary building isolation (ABI) to occur. Investigation revealed that the spent fuel pit radiation monitor had alarmed due to the movement of contaminated C-zone clothing and trash by the monitor.

This monitor has a setpoint of 15 mrem/hr, and normal background is 10 to 12 mrem/hr. Unit 1 has been in a refueling outage, and a dressout area for contaminated area entry was nearby. Removal of these clothes and trash by the monitor was enough to set off the alarm since background was already near setpoint.

8404260002 840420
PDR ADDCK 05000327
S PDR

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			
Sequoyah, Unit 1	0 5 0 0 0 3 2 7 8 4	—	0 2 1	—	0 0	0 2	OF 0 2

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

This LER involves five separate incidents. The first auxiliary building isolation (ABI) occurred at 0225C on 03/22/84 while unit 1 was in mode 6 (0% power, 0 psig, 88 degrees F) and the ventilation system was returned to service at 0250C on 03/22/84. The second ABI occurred at 0219C on 03/30/84 while unit 1 was in mode 5 (0% power, 0 psig, 112 degrees F) and the ventilation system was returned to service at 0230C on 03/30/84. The third ABI occurred at 0215C on 03/31/84 while unit 1 was in mode 5 (0% power, 15 psig, 112 degrees F) and the ventilation system was returned to service at 0235C on 03/31/84. The fourth ABI occurred at 0624C on 04/01/84 while unit 1 was in mode 5 (0% power, 0 psig, 112 degrees F) and the ventilation system was returned to service at 0650C on 04/01/84. The fifth ABI occurred at 0731C on 04/03/84 while unit 1 was in mode 5 (0% power, 175 psig, 113 degrees F) and the ventilation system was returned to service at 0750C on 04/03/84. All associated equipment and personnel responded and performed as expected during the ABI. The operator responded to the alarm (RM-90-102) and determined that the alarm was in fact inadvertently actuated and that the alarm was not caused by a high radiation condition in the auxiliary building or around the spent fuel pit. The alarm was cleared, and the monitor was returned to service.

The radiation monitor is set to alarm at 15 mrem/hr (the accuracy of the monitor has been verified by Health Physics). The background radiation level has increased to a level near the setpoint of the radiation monitor due to the amount of spent fuel now stored in the spent fuel pit. A nearby source of 2 to 5 millirems would be enough to raise the monitor reading above setpoint. The movement of contaminated used clothing and trash is sometimes radioactive enough and carried close enough to the monitor to cause it to go above the setpoint level. Presently, the setpoint is set by the technical specifications. A request will be forthcoming requesting a technical specification change to raise the setpoint of the radiation monitor from 15 to 50 mrem/hr to allow for the increase in background radiation due to future spent fuel storage. This change would also allow movement of low level waste to the disposal area without causing a false indication of radiation levels in the auxiliary building. Until this change can be made, contaminated clothing and trash will be checked to determine if it might set off the alarm. If so, the material will be kept further away when passed by the monitor, or the monitor will be blocked to prevent an isolation from occurring until the material is removed. This increased coordination and communication between personnel will decrease the number of isolations caused by inadvertent actions of personnel.

There was no effect upon public health or safety, and no plant safety margins were exceeded. Radiation levels in the auxiliary building were not above normal during this time.

Previous occurrences - SQRO-50-327/84010, SQRO-50-327/84002, SQRO-50-327/84008, SQRO-50-327/84016, SQRO-50-327/84015.

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant
Post Office Box 2000
Soddy Daisy, Tennessee 37379

April 20, 1984

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

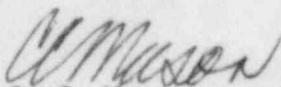
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/84021

The enclosed licensee event report provides details concerning the auxiliary building ventilation isolations (ABI) caused by moving of contaminated C-zone clothing and trash by the radiation monitor. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.iv.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



C. C. Mason
Power Plant Superintendent

Enclosure
cc (Enclosure):

James P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Suite 2900
101 Marietta Street, NW
Atlanta, Georgia 30303

Records Center
Institute of Nuclear Power Operations
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

NRC Inspector, NUC PR, Sequoyah

IF22
1/1