

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)
Sequoyah, Unit 1DOCKET NUMBER (2)
0 5 0 0 0 3 2 7 1 OF 0 2TITLE (4)
Containment Ventilation IsolationEVENT DATE (5)
MONTH DAY YEAR
0 3 3 0 8 4 8 4
LER NUMBER (6)
YEAR SEQUENTIAL NUMBER REVISION NUMBER
0 2 2
REPORT DATE (7)
MONTH DAY YEAR
0 0 0 4 2 7 8 4
OTHER FACILITIES INVOLVED (8)
FACILITY NAMES DOCKET NUMBER(S)
0 5 0 0 0 0 0 0 0 0 0 0OPERATING MODE (9)
5
POWER LEVEL (10)
0 0 0
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)
20.402(b) 20.406(c) XX 50.73(a)(2)(iv) 73.71(b)
20.406(a)(1)(i) 50.38(c)(1) 50.73(a)(2)(v) 73.71(c)
20.406(a)(1)(ii) 50.38(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
Glenn Duggin, Compliance Section Engineer
TELEPHONE NUMBER
AREA CODE
6 1 5 8 7 0 - 6 1 4 6COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)
CAUSE SYSTEM COMPONENT MANUFACTURER REPORTABLE TO NRCDS
CAUSE SYSTEM COMPONENT MANUFACTURER REPORTABLE TO NRCDSSUPPLEMENTAL REPORT EXPECTED (14)
YES (If yes, complete EXPECTED SUBMISSION DATE) X 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 a containment ventilation isolation (CVI) to occur. Investigation revealed that a voltage spike occurred as a result of electromagnetic interference (EMI). Also, another incident was caused by a personnel error during a modification of the CVI circuit. Radiation levels were not above normal during this time.

The spurious high radiation alarm was reset and the monitor was returned to service. Time delay relays are being added to prevent a CVI from short duration radiation spikes.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 2 7	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	0 2 2	0 0	0 2	OF	0 2

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

This LER involves two separate incidents. The first containment ventilation isolation (CVI) occurred at 0730C on 03/30/84 while unit 1 was in mode 5 (0% power, 0 psig, 112 degrees F) and was returned to service at 0742C on 03/30/84. The second CVI occurred at 0740C on 04/09/84 while unit 1 was in mode 5 (0% power, 376 psig, 166 degrees F) and was returned to service at 0755C on 04/09/84. All associated equipment and personnel responded and performed as expected during the CVI. The operator responded to the alarm (RM-90-112) and determined that the alarm was in fact caused by a spurious spike and not by a high radiation level. Maintenance personnel were notified to check the monitor, reset the alarm in the control room, and repair or reset the monitor. No equipment or other failure was found; therefore, the alarm was cleared and the radiation monitor was reset.

In the first incident, an EMI spike possibly generated by welding in the area, caused the actuation of the high radiation alarm and a CVI. No failure was found associated with the monitor, and it was reset. Instrumentation is adding a time delay to the actuation signal to allow spike decay time.

In the second incident, a spurious CVI signal was generated during a modification to the CVI circuitry for the Technical Support Center. The input to the circuit was probably inadvertently grounded during the modification. The CVI signal was reset and the system returned to normal.

Recent corrective actions show a substantial reduction in CVIs due to spurious spikes. These reductions can be attributed to the monitor setpoint being raised, flow switches mounted on rubber mounts, revised instructions, better communications between personnel and other EMI protection. Long-term actions in process at this time include: (1) NCO will determine if a flow switch with sufficient deadband to reduce chattering at low flow is available and will initiate paperwork to change them out; (2) NCO will evaluate and specify a filter for the AC cables to the monitors; (3) Engineering Design will begin preliminary work on changing the flow alarm circuit from AC to DC power; and (4) NCO will evaluate the need to interlock CVI with purge air and vent dampers to inhibit CVI when dampers are closed. Some or all of these actions will be implemented as appropriate.

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

Previous occurrences - SQRO-50-327/84001, SQRO-50-327/84003, SQRO-50-327/84012, SQRO-50-327/84014, and SQRO-50-327/84020.

TENNESSEE VALLEY AUTHORITY

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

April 27, 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-50-327/84022

The enclosed licensee event report provides details concerning the inadvertent containment building ventilation isolations caused by spurious spikes. 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):

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NRC Inspector, NUC PR, Sequoyah

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