

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 2 8	PAGE (3)
		1 OF 2

TITLE (4)

Containment Ventilation Isolation

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	6	8	4	0	0	6	0	0	0	5	0	0	0
0	4	0	6	8	4	0	0	6	0	0	0	5	0	0	0

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
	20.402(b)	20.405(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	73.71(b)						
POWER LEVEL (10) 1 0 0	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 366A)						
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)(x)								

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 6

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

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> 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) which was spurious in one incident and caused by a personnel error in another incident. Radiation levels were not above normal during this time.

The spurious radiation alarms were reset, and the monitor was returned to service. A time delay is being added to the actuation signal to prevent short spikes on the radiation monitor from causing future CVIs.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1) Sequoyah, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 2 8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	— 0 0 6	— 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 0110C on 04/06/84 while unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 0125C on 04/06/84. The second CVI occurred at 0439C on 04/08/84 while unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 0510C on 04/08/84. All associated equipment and personnel responded and performed as expected during the CVI. The operator responded to the alarm (RM-90-106) 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.

In the first incident, an EMI spike of very short duration caused the actuation of the high radiation alarm and a CVI. An operator advancing the filter paper caused the spike. No failure was found associated with the monitor, and it was reset. Instrumentation is adding a time delay to the actuation signal to allow time for the spike to decay.

In the second incident, maintenance was performing a modification under a workplan when a cable with a metal jacket slipped from the hands of the employee and shorted across a terminal block. This short caused the loss of a breaker on vital instrument board 2-III which cut power to radiation monitor 106 and caused a CVI. Personnel have been re cautioned to be extremely careful when handling metallic objects around energized equipment.

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 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-50-328/84001, SQRO-50-328/84002, SQRO-50-328/84003.

TENNESSEE VALLEY AUTHORITY

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

May 1, 1984

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

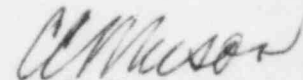
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET NO.
50-328 - FACILITY OPERATING LICENSE DPR-79 - REPORTABLE OCCURRENCE REPORT
SQRO-50-328/84006

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

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