

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 2 1 7 1 OF 0 2										PAGE (3) 1 OF 0 2	
TITLE (4) Auxiliary Building 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	1 8	8 4	8 4	0 2	8	0 0	0 5	1 7	8 4						0 5 0 0 0						
OPERATING MODE (9) 3			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)																		
POWER LEVEL (10) 0 1 9 0			20.402(b)			20.406(c)			XX 50.73(a)(2)(iv)			73.71(b)									
			20.406(a)(1)(i)			50.36(e)(1)			50.73(a)(2)(v)			73.71(c)									
			20.406(a)(1)(ii)			50.36(e)(2)			50.73(a)(2)(vi)			OTHER (Specify in Abstract below and in Text, NRC Form 365A)									
			20.406(a)(1)(iii)			50.73(a)(2)(ii)			50.73(a)(2)(viii)(A)												
			20.406(a)(1)(iv)			50.73(a)(2)(iii)			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 6 1 5 8 7 0 - 1 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)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR							
YES (If yes, complete EXPECTED SUBMISSION DATE)										XX NO											

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 personnel were placing boric acid evaporator 'B' in service and draining the vent header at the same time that the volume control tank was being burped (vented). This simultaneous action increased the vent header pressure and caused excessive gas to be vented causing the auxiliary building ventilation system to isolate.

8405220276 840517
PDR ADOCK 05000327
S PDR

IE22
1/1

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 8	0 0	0 2	OF	0 2

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

This auxiliary building ventilation isolation (ABI) occurred at 2358C on 04/17/84 while unit 1 was in mode 3 (0% power, 2235 psig, 541 degrees F) and the ventilation system was returned to normal at 0100C on 04/18/84. All associated equipment and personnel responded and performed as expected during the ABI. The operator responded to the alarm (RM-90-101), investigated the ABI, and evacuated the auxiliary building. No personnel or equipment were contaminated. The ventilation system removed the airborne radiation and the building was returned to normal.

The auxiliary building (AB) assistant unit operator (AUO) was placing boric acid evaporator 'B' in service. The instruction required the AUO to vent (drain) the vent header. At the same time the AUO was venting, the operator burped (vented) the volume control tank (VCT) which increased the vent header pressure and caused excessive gas to be vented. This vented gas was distributed by the auxiliary building ventilation system and was picked up by the radiation monitor which caused an ABI. Upon receiving the isolation signal, which isolated the building, the AB was evacuated until the air had been cleaned up. Auxiliary building ventilation was reestablished and returned to normal at 0100C, and the building was ready for access at 0405C on 04/18/84. This situation has been discussed with Operations personnel, and they have been informed of the consequences when burping the VCT while venting the waste gas header. Better coordination and information exchange between personnel should prevent this error from occurring in the future.

There was no effect on public health or safety, and no plant safety margins were exceeded.

Previous occurrences - SQRO-50-327/84008.

TENNESSEE VALLEY AUTHORITY

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

May 17, 1984

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

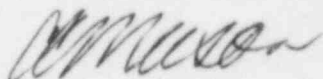
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/84028

The enclosed licensee event report provides details concerning the auxiliary building ventilation isolation (ABI) caused by burping of the volume control tank (VCT) and venting the waste gas header at the same time. 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

JE22
11