

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

PAGE (3)

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	2	2	5	8	4	8	4	0	1	6	0	5	0	0	0
0	2	2	5	8	4	8	4	0	1	6	0	5	0	0	0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)									
POWER LEVEL (10)	01010	20.402(b)	20.405(e)	X	50.73(a)(2)(iv)	73.71(b)					
		20.405(a)(1)(i)	50.36(e)(1)		50.73(a)(2)(v)	73.71(c)					
		20.405(a)(1)(ii)	50.36(e)(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)(ix)						

LICENSEE CONTACT FOR THIS LER (12)

NAME

TELEPHONE NUMBER

Glenn Duggin, Compliance Section Engineer

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 NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs

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)

A high radiation alarm was actuated which caused an auxiliary building isolation (ABI) to occur. Investigation revealed that a vacuum cleaner had been pulled out of the fuel transfer canal, after cleanup of contamination in the canal. Health Physics was waiting at the top of the canal to survey the vacuum cleaner when it was brought up. Radiation level on contact was approximately 12 rem per hour. The vacuum cleaner was placed in a bag and removed to the radiation waste area. No airborne radiation was detected and no personnel were contaminated.

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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 8 4	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0	16	00	02	OF	02

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

This auxiliary building isolation (ABI) occurred at 1330C on 02/25/84 while unit 1 was in mode 5 (0% power, 25 psig, 105 degrees F) and was returned to service at 1354C on 02/25/84. All associated equipment and personnel responded and performed as expected during the ABI. The operator responded to the alarm (RM-90-103) and determined that the radiation level was high but was not caused by nuclear fuel, radiation leak, or an airborne condition. The radiation level was caused temporarily by a contaminated vacuum cleaner being removed from the fuel transfer canal to the radioactive waste area. The alarm was cleared and reset and the radiation monitor was reset. No personnel were contaminated, and no other unusual radiation was detected.

The radiation level of the vacuum cleaner on contact was 12 rem per hour. The vacuum cleaner was put in a bag to prevent any contamination from becoming airborne, and removed to the radioactive waste area. The vacuum cleaner had been used to help clean the fuel transfer canal prior to beginning refueling operations. Health Physics normally surveys highly contaminated parts and equipment before moving if the background radiation allows a meaningful survey and the equipment is accessible.

Better coordination between personnel will help prevent a similar incident from occurring again. To reduce the likelihood of this type of spurious alarm, an attempt will be made to revise the technical specification limit on the setpoint of the radiation monitor from 20 mr/hr to 50 mr/hr. Procedures will be revised to advise personnel of the likelihood of an ABI due to the moving of radioactive waste material.

There was no effect upon public health or safety, and no plant safety margins were exceeded. Radiation levels throughout the building were normal except for the area near the contaminated equipment.

Previous occurrences - none.

TENNESSEE VALLEY AUTHORITY

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

March 16, 1984

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

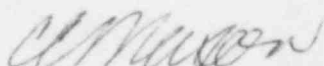
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/84016

The enclosed licensee event report provides details concerning the auxiliary building ventilation isolation due to moving of contaminated equipment out of the fuel transfer canal. 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

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