NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Sequoyah, Unit 1	0 5 0 0 0 3 2 7	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 5 0 0 0
0 2	2	0 8 4	8 4	0 1 5	0 0	0 3	1 6	8 4		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)			
POWER LEVEL (10)	0 9 7	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
		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	TELEPHONE NUMBER
	AREA CODE
Glenn Duggin, Compliance Section Engineer	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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
C	NA*	R I	G 0 6 3	No							

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X 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 voltage spike occurred as a result of electromagnetic interference (EMI) generated by breaker actuation in the plant. Radiation levels were not above setpoint during this time.

The independent high radiation alarm was reset and the monitor was returned to service. EMI protection has been installed to help prevent more spurious spikes on the radiation monitor. Several long-term corrective actions are still being investigated.

IE22
1/1

*NA - Not available - IEEE 805-1983 still being printed.

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 1 5	— 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 auxiliary building isolation (ABI) occurred at 0052C on 02/20/84 while unit 1 was in mode 1 (97% power, 2235 psig, 577 degrees F) and was returned to service at 0120C on 02/20/84. The second ABI occurred at 1829C on 02/21/84 while unit 1 was in mode 4 (0% power, 690 psig, 311 degrees F) and was returned to service at 1844C on 02/20/84. All associated equipment and personnel responded and performed as expected during the ABI. The operator responded to the alarm (RM-90-101) and determined that the alarm was in fact due to an inadvertent spike and not a high radiation level.

In the first incident, EMI was generated when a motor-operated disconnect (MOD) was operated in the switchyard. This caused a very short duration spike to occur on the radiation monitor and actuate the ABI.

In the second incident, a momentary loss of coil voltage to an isolation relay during a unit board switchover caused an ABI.

Recent corrective actions show a substantial reduction in ABIs 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) Instrumentation will add a time delay to the actuation signal to allow spike decay time; (3) NCO will evaluate and specify a filter for the AC cables to the monitors; and (4) Engineering Design will begin preliminary work on implementing a time delay on ABI and also changing the flow alarm circuit from AC to DC power. 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 setpoint during this time.

Previous occurrences - SQRO-50-327/84010, SQRO-50-327/84002.

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-50-327/84015

The enclosed licensee event report provides details concerning the auxiliary building ventilation isolation (ABI) caused by an inadvertent spike on 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

IE22
1/1