

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)
Sequoyah, Unit 2

DOCKET NUMBER (2)

0 5 0 0 0 3 2 8 1 OF 0 2

PAGE (3)

TITLE (4)

Containment Building Ventilation Isolations

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 7	8 4	8 4	0 0 3	0 0	0 3	2 7	8 4		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																					
POWER LEVEL (10)	1 1 0 0	20.402(b)	20.405(a)(1)(i)	20.405(a)(1)(ii)	20.405(a)(1)(iii)	20.405(a)(1)(iv)	20.405(a)(1)(v)	20.406(c)	50.36(c)(1)	50.36(c)(2)	50.73(a)(2)(i)	50.73(a)(2)(ii)	50.73(a)(2)(iii)	50.73(a)(2)(iv)	50.73(a)(2)(v)	50.73(a)(2)(vi)	50.73(a)(2)(vii)	50.73(a)(2)(viii)(A)	50.73(a)(2)(viii)(B)	50.73(a)(2)(ix)	73.71(b)	73.71(c)	OTHER (Specify in Abstract below and in Text, NRC Form 386A)

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 NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

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 vital inverter failed due to a blown fuse when personnel performed an incorrect connection which caused a containment ventilation isolation (CVI) to occur. Another CVI occurred when a block switch on a radiation monitor was actuated. Radiation levels were not above normal during this time.

The CVIs were reset and the inverter and the switch were returned to service. Nothing was found wrong with the switch, but the inverter had to be repaired.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED ON: 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 3	— 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 2028C on 02/27/84 while unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 2040C on 02/27/84. The second CVI occurred at 1915C on 03/01/84 while unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 1934C on 03/01/84. All associated equipment and personnel responded and performed as expected during the CVI. The operator responded to the alarm and determined that the alarm was not caused by a high radiation level and reset the CVI.

In the first incident, vital inverter 1-II failed resulting in a CVI, auxiliary building isolation (ABI), control room isolation (CRI), and causing other equipment fed from this board to lose power. The inverter board was then powered from the maintenance supply until the inverter could be fixed. This incident was due to personnel shorting leads together while attempting to connect an oscilloscope to the inverter to adjust the frequency on the synchronization card. Four fuses were replaced as well as an oscillator card before the inverter was placed back in service at 0305C on 02/28/84.

In the second incident, a spurious signal associated with radiation monitor 106 initiated a partial CVI on train 'A'. A block switch was operated at the same time and was considered the signal source. However, the switch was checked and tested, and nothing was found to be wrong with it. This monitor has no recorder and no radiation alarms were actuated. No further investigation is required.

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.

TENNESSEE VALLEY AUTHORITY

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

March 27, 1984

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

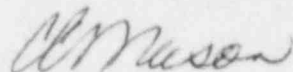
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET NO.
50-328 - FACILITY OPERATING LICENSE DPR-79 - REPORTABLE OCCURRENCE REPORT
SQRO-50-328/84003

The enclosed licensee event report provides details concerning the inadvertent containment building ventilation isolations due to personnel error. 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 2000
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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