

## 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)

Containment 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	3	0	8	4	0	2	0	0	0	4	0	5	0	0	0
0	3	0	8	4	0	2	0	0	0	4	0	5	0	0	0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

OPERATING MODE (9)	20.402(b)	20.406(c)	50.73(a)(2)(iv)	73.71(b)
6	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
POWER LEVEL (10)	20.406(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 1 0 0	20.406(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	<input type="checkbox"/>
	20.406(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	OTHER (Specify in Abstract below and in text, NRC Form 366A)
	20.406(a)(1)(iv)	50.73(a)(2)(ii)	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	TELEPHONE NUMBER
Clenn 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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/>	<input checked="" type="checkbox"/>				

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) generated by switch actuation of the low flow alarm and by the opening of the motor-operated disconnects (MOD) in the switchyard due to a breaker failure. Radiation levels were not above setpoint during this time.

The inadvertent high radiation alarm was reset and the monitor was returned to service. Some EMI protection has been installed, and more protection is being implemented to help prevent future spurious spikes.

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PDR ADOCK 05000327  
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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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 0	0 0	0 2	OF 0 2

TEXT (If more space is required, use additional NRC Form 365A's) (17)

This LER involves two separate incidents. The first containment ventilation isolation (CVI) occurred at 0339C on 03/09/84 while unit 1 was in mode 6 (0% power, 0 psig, 96 degrees F) and was returned to service at 0354C on 03/09/84. The second CVI occurred at 0854C on 03/26/84 while unit 1 was in mode 6 (0% power, 0 psig, 95 degrees F) and was returned to service at 0911C on 03/26/84. All associated equipment and personnel responded and performed as expected during the CVI. The operator responded to the alarm (RM-90-106, -112) and determined that the alarm was in fact caused by an inadvertent 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, Surveillance Instruction (SI) 166.1, "Full Stroking of Category 'A' and 'B' Valves During Operation," was being run when valve 90-117 was stroked. When valve 90-117 closed, the flow through the radiation monitor was stopped; therefore, the low flow alarm came in. This switch actuation caused a spike (EMI) on the radiation monitor high enough to cause a high radiation alarm to be actuated. This procedure will be revised to block the radiation monitor when this test is performed to avoid future CVIs.

In the second incident, an EMI spike, generated by the loss of switchyard breaker 5028 (500 kV) and the opening of the appropriate motor-operated disconnects (MOD), caused the actuation of the high radiation alarm and a CVI. No failure was found associated with the monitor, and it was reset.

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) Instrumentation is adding 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; (4) Engineering Design will begin preliminary work on implementing a time delay of CVI and also changing the flow alarm circuit from AC to DC power; and (5) 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-50-327/84001, SQRO-50-327/84003, SQRO-50-327/84012, and SQRO-50-327/84014.

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant  
Post Office Box 2000  
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April 9, 1984

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

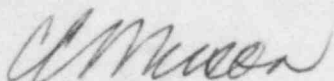
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.  
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT  
SQRJ-50-327/84020

The enclosed licensee event report provides details concerning the inadvertent containment building ventilation isolation caused by spikes 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):

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