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J. L. Wilson
Vice President, Sequoyah Nuclear Plant

April 6, 1992

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO. 50-327 - FACILITY OPERATING LICENSE DPR-77 - LICENSEE EVENT REPORT (LER) 50-327/92008

The enclosed LER provides details concerning an inadvertent containment ventilation isolation. This event is being reported in accordance with 10 CFR 50.73(a)(2)(iv) as a condition that resulted in the actuation of an engineered safety feature.

Sincerely,

J. L. Wilson

Enclosure
cc: See page 2

IE22

cc (Enclosure):
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NRC Form 366 (6-89) | U.S. NUCLEAR REGULATORY COMMISSION | Approved OMB No. 3150-0104 Expires 4/30/92

LICENSEE EVENT REPORT (LER)

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Sequoyah Nuclear Plant, Unit 1	0 5 0 0 0 3 2 7 1	0F 0 5

TITLE (4)

Inadvertent Containment Ventilation Isolation During Radiation Monitor Testing

EVENT DAY (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 3	0 7	9 2	9 2	0 0 8	0 0	0 4	0 6	9 2		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 8 1	20.402(b)	20.405(c)	XX 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)
Jan Bajraszewski, Compliance Licensing	6 1 5 6 4 3 - 7 7 4 9

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
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On March 7, 1992, at approximately 0634 Eastern standard time, with both units in power operation (Unit 1 at 81 percent and Unit 2 at 75 percent), an inadvertent containment ventilation isolation (CVI) occurred on Unit 1 when an instrument mechanic (IM) unintentionally alarmed the wrong radiation monitor (RM) during performance of a postmaintenance test (PMT) for a Unit 2 RM. Upon actuation, Operations' personnel verified that the CVI was not required, reset the CVI, and returned the Unit 1 RMs to service. Unit 1 was not purging at the time of the event and, therefore, the actuation only closed isolation valves to the Unit 1 containment RMs. The Unit 2 PMT was completed without further incident. The inadvertent CVI occurred because of the IM's failure to repeat the self-check process after losing visual contact with the component to be manipulated. The event will be discussed with Instrument Maintenance personnel to stress the importance to repeat the self-check process upon loss of visual contact or interruption of work and to heighten their awareness of the proximity of Unit 1 and Unit 2 RM modules.

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

I. PLANT CONDITIONS

Unit 1 was in power operation at approximately 81 percent. Unit 2 was in power operation at approximately 75 percent in coast down for a refueling outage.

II. DESCRIPTION OF EVENT

A. Event:

On March 7, 1992, at approximately 0634 Eastern standard time (EST), an inadvertent containment ventilation isolation (CVI) (EIIS Code-JM) occurred on Unit 1 when an instrument mechanic (IM) unintentionally alarmed the wrong radiation monitor (RM) (EIIS Code-IL) during performance of a postmaintenance test for a Unit 2 RM. Earlier, in accordance with procedure, the high radiation relays were removed on a Unit 2 RM module, and the appropriate RM block switches were placed in the block position to prevent a CVI event during performance of scheduled maintenance. Upon completion of the required maintenance, the high radiation relays were reinstalled and were to be tested to verify proper operation. During performance of the postmaintenance test, the IM knelt down at the control room panel and located the correct Unit 2 RM module. He then stood up, turned to the operator, and notified the operator that the associated annunciators would alarm. The IM turned to the control room panel, mistakenly to a Unit 1 RM module and manipulated a control knob that alarmed the Unit 1 RM. Unit 1 was not purging at the time of the event; therefore, the actuation only closed isolation valves to the Unit 1 containment RMs.

B. Inoperable Structures, Components, or Systems That Contributed to the Event:

None.

C. Dates and Approximate Times of Major Occurrences:

March 6, 1992 at 1710 EST	A Unit 2 RM was removed from service for scheduled maintenance. Associated high radiation relays were removed.
March 7, 1992 at 0634 EST	An IM inadvertently manipulated the wrong RM, causing a Unit 1 CVI. Limiting Conditions for Operation (LCOs) 3.3.2.1, 3.3.3.1, and 3.4.6.1 were entered.
March 7, 1992 at 0656 EST	Operators reset the CVI, returned the Unit 1 RMs to service, and exited LCOs 3.3.2.1, 3.3.3.1, and 3.4.6.1.

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

D. Other Systems or Secondary Functions Affected:

None.

E. Method of Discovery:

The CVI was annunciated on the main control room panels.

F. Operator Actions:

Operators immediately entered LCOs 3.3.2.1, 3.3.3.1, and 3.4.6.1. The CVI was evaluated and the cause determined. Operators recovered from the CVI and returned the RMs to service.

G. Safety System Responses:

Unit 1 was not purging; therefore, the only actuation was the closure of isolation valves to the Unit 1 containment RMs.

III. CAUSE OF THE EVENT

A. Immediate Cause:

A Unit 1 RM was placed in alarm by injecting a test signal above the alarm setpoint.

B. Root Cause:

IMs failed to repeat the self-check process after losing visual contact with the component to be manipulated.

C. Contributing Factors:

The Unit 1 and Unit 2 RM modules are located approximately 30 inches apart on one main control room panel. Additionally, the RM modules are similar in appearance.

IV. ANALYSIS OF THE EVENT

Upon receipt of the CVI signal, the equipment required to actuate on a CVI signal performed as designed. Following the CVI, Operations' personnel verified that an actual high-radiation condition did not exist and took appropriate actions to recover from the CVI. The RM system performed as expected; Unit 1 was not purging containment; therefore, the only actuation was the closure of RM isolation valves. There were no adverse consequences to the health and safety of plant personnel or the general public as a result of this event.

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V. CORRECTIVE ACTIONS

A. Immediate Corrective Actions:

Operators recovered from the CVI and returned the RMs to service.

B. Corrective Action to Prevent Recurrence:

1. The event will be discussed with Instrument Maintenance personnel to stress the importance to repeat the self-check process upon loss of visual contact or interruption of work and to heighten their awareness of the proximity of Unit 1 and Unit 2 RM modules.

2. Instrument Maintenance will develop a method to provide enhanced visual identification of the control room RM module during performance of maintenance activities for RMs that have the potential to initiate a CVI. This method of identification will be implemented by a site maintenance manager directive (SMMD).

3. As part of the control room design review (CRDR), a human engineering deficiency was identified with the associated RM panel. This review concluded that relabeling and changes in demarcation are necessary to more clearly identify specific RM modules.

VI. ADDITIONAL INFORMATION

A. Failed Components:

None.

B. Previous Similar Events:

A review of previous events identified four LERs associated with inadvertent CVI actuation because of wrong component manipulation (LERs 327/85039 and 88006; 328/90003 and 90005). With the exception of the CRDR upgrades described above, corrective actions were focused at performance of specific organizations and/or personnel involved in the events. The CRDR upgrade is scheduled for the Cycle 6 refueling outage.

VII. COMMITMENTS

1. The event will be discussed with Instrument Maintenance personnel to stress the importance to repeat the self-check process upon loss of visual contact or interruption of work and to heighten awareness of the proximity of Unit 1 and Unit 2 RM Modules by May 8, 1992.

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2. A method will be developed to provide enhanced visual identification of the control room RM module during performance of maintenance activities for RMs that have the potential to initiate a CVI by May 18, 1992.

3. An SMMD will be issued by June 12, 1992, providing guidance for enhanced visual identification of control room RM modules during performance of maintenance activities on RMs that have the potential to initiate a CVI.