

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 2 8	PAGE (3) 1 OF 0 2
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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	7	1	3	8	4	8	4	—	0	1	1	—	0	0	0	8	1	0	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) 1 0 0	20.402(b)	20.406(c)	X	50.73(a)(2)(iv)	73.71(b)																
	20.406(a)(1)(i)	50.36(e)(1)		50.73(a)(2)(v)	73.71(c)																
	20.406(a)(1)(ii)	50.36(e)(2)		50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)																
	20.406(a)(1)(iii)	50.73(a)(2)(i)		50.73(a)(2)(vii)(A)																	
	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)		TELEPHONE NUMBER	
NAME 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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

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 a containment ventilation isolation (CVI) to occur. Investigation revealed that a voltage spike occurred as a result of electromagnetic interference (EMI) which was spuriously generated by the low flow alarm switch in one incident and the source is unknown in two other incidents. Radiation levels were not above normal during this time.

The spurious radiation alarms were reset, and the monitor was returned to service. A time delay is being added to the actuation signal to prevent short duration spikes on the radiation monitor from causing future CVIs.

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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)  Sequoyah, Unit 2	DOCKET NUMBER (2)  0 5 0 0 0 3 2 8 8 4 — 0 1 1 — 0 0 0 2 OF 0 2	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

This LER involves three separate incidents. The first containment ventilation isolation (CVI) occurred at 0124C on 07/13/84 while unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was reset at 0149C on 07/13/84. The second CVI occurred at 0744C on 07/14/84 while unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was reset at 0800C on 07/14/84. The third CVI occurred at 0158C on 07/15/84 while unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was reset at 0159C on 07/15/84. All associated equipment and personnel responded and performed as expected during the CVI. The operator responded to the alarm (RM-90-112 for all three incidents) and determined that the alarm was in fact caused by a spurious 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, an EMI spike was generated when the low flow switch was actuated due to the filter paper running out. No failure was found associated with the monitor and it was reset. Instrumentation is adding a time delay to the actuation signal to allow time for the spike to decay and prevent spurious CVI initiation.

In the second and third incidents, an EMI spike occurred due to an unknown source. The transient was too short to be recorded.

Recent reductions in the number of CVIs can be attributed to the monitor setpoint being raised, flow switches being mounted on rubber mounts, revised instructions, better communications between personnel, and other EMI protection. The only long-term action still in progress at this time is to install an upper level discriminator to help eliminate a high voltage spike from causing a CVI. Other long-term actions that were evaluated but are not planned to be implemented include: (1) changing out the flow switch with a different type; (2) adding a filter to the AC cable on the monitors; (3) changing the flow alarm circuit from AC to DC power; and (4) interlocking the CVI signal with the purge air and vent dampers to inhibit a CVI when dampers are closed. Items 1 and 2 did not help reduce CVIs and items 3 and 4 were determined to be too expensive for the expected benefit.

There was no effect upon public health or safety, and no plant safety margins were exceeded. Radiation levels were not shown above normal during this time.

Previous occurrences - SQRO-50-328/84001, SQRO-50-328/84002, SQRO-50-328/84003, and SQRO-50-328/84006.

TENNESSEE VALLEY AUTHORITY

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

August 10, 1984

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

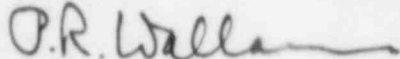
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET NO.  
50-328 - FACILITY OPERATING LICENSE DPR-79 - REPORTABLE OCCURRENCE REPORT  
SQRO-50-328/84011

The enclosed licensee event report provides details concerning the inadvertent containment building ventilation isolations caused by spurious spikes on a radiation monitor. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.iv.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



P. R. Wallace  
Plant Manager

Enclosure  
cc (Enclosure):

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