

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1 DOCKET NUMBER (2) 0 5 0 0 0 3 1 2 7 1 OF 0 2
TITLE (4)

Inadvertent ABI During Calibration Of RM-90-101

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)
04	04	85	85	014	00	05	01	85	Sequoyah, Unit 2	0 5 0 0 0 3 2 8
										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)
1	<input type="checkbox"/>	<input checked="" 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)
1 0 0	20.406(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vi)	<input type="checkbox"/>
	20.406(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(vii)(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)(vii)(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
Michael E. Frye, Compliance Section Engineer	611 5 817 101-1 61 716 1 7

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 checked="" type="checkbox"/>	<input type="checkbox"/>				

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

On April 4, 1985, an inadvertent Auxiliary Building Isolation occurred during the scheduled calibration of O-RM-90-101 (Auxiliary Building Stack Radiation Monitor). The isolation was identified and reset approximately one and one-half hours after the initial occurrence.

8505090553 850501
PDR ADDCK 05000327
S PDR

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 2 7 8 5 - 0 1 4 - 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)

On April 4, 1985, Auxiliary Building Isolation (ABI) was initiated when an instrument mechanic failed to follow the written sequence of SI-82 (Functional Test of Radiation Monitors). Approximately one and one-half hours passed before the ABI was identified and reset. Both Units 1 and 2 were operating at 100% reactor power. All equipment associated with the ABI system operated properly during the event.

Verifying the radiation monitor alarm setpoints in SI-82, requires that an ABI block hand switch be properly selected for the channel being tested on RM-90-101 (Auxiliary Building Stack Radiation Monitor) to prevent an ABI from occurring. While testing the trip setpoints on RM-90-101A (Auxiliary Building Stack Particulate Radiation Monitor), the channel high radiation alarm came in, as expected, but the associated annunciator did not light as required. The discrepancy was noted and the instrument mechanics proceeded to test the trip points on the RM-90-101B (Auxiliary Building Stack Noble Gas Radiation Monitor) channel which required moving the ABI block switch from the RM-90-101A position to RM-90-101B. The journeyman mechanic remembered that a 10-second time delay had been installed in the RM-90-101 channels and instructed the apprentice mechanic, actually performing SI-82, to retest RM-90-101A. The time delay had been installed in August of 1984, to prevent spurious ABI actuation due to electrical noise. The apprentice failed to return the ABI block switch to the RM-90-101A channel before retesting the annunciator. When the test simulated a high radiation signal the ABI occurred; however, neither the mechanics or control room operations personnel were aware of the isolation.

Several factors are involved with the delay in the operators' determination that an ABI had occurred. The high radiation alarm from RM-90-101 that signals an ABI for high radiation was expected during the performance of SI-82, and there is not a direct annunciator for an ABI available to the operators. Additionally all the indications for fans and dampers associated with the ABI are on a normally unmanned panel behind the main control room horseshoe.

While performing a vent of the Unit 2 containment to the annulus, the operator observed that the pressure relationship between the annulus and Auxiliary Building was not responding properly. Upon further investigation he discovered that an ABI had occurred. After properly verifying that the ABI was not necessary for existing plant conditions, the system was realigned per plant standard operating instructions.

SI-82 has been revised to reference the 10-second time delay for the applicable channels and should prevent any future confusion in that area. The journeyman instrument mechanic involved has received a verbal warning for failure to correctly follow procedure, the engineer responsible for preparation of SI-82 has been given a verbal warning for inadequacy of the procedure. A memorandum will be issued to all maintenance personnel defining plant policy on following procedures, and general actions to be taken if an employee accidentally gets out of sequence in a procedure. Design change request (DCR) 1717 has been submitted to have an annunciator installed inside the Unit 1 operating horseshoe to inform the unit operator when an ABI occurs.

This is the first event of an ABI associated with a personnel error of a craft personnel.

There was no effect on public health and safety.

TENNESSEE VALLEY AUTHORITY

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

May 1, 1985

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

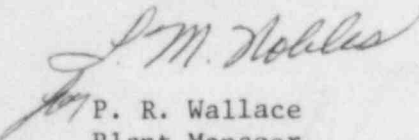
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/85014

The enclosed licensee event report provides details concerning an inadvertent Auxiliary Building Isolation. 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):

J. Nelson Grace, Regional Administrator
U.S. Nuclear Regulatory Commission
Suite 2900
101 Marietta Street, NW
Atlanta, Georgia 30323

Records Center
Institute of Nuclear Power Operations
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

NRC Inspector, NUC PR, Sequoyah

*IE22
1/1*