

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 2 7 1				PAGE (3) 1 OF 0 2										
TITLE (4) Main Control Room 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	8	2	7	8	5	8	5	0	3	3	0	0	0	9	2	3	8	5	0	5	0	0	0	
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																						
5		20.402(b)				20.405(c)				XX 50.73(a)(2)(iv)				73.71(b)										
POWER LEVEL (10)		20.405(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)										
0 10 10		20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)										
		20.405(a)(1)(iii)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(A)														
		20.405(a)(1)(iv)				50.73(a)(2)(ia)				50.73(a)(2)(viii)(B)														
		20.405(a)(1)(v)				50.73(a)(2)(ib)				50.73(a)(2)(ix)														
LICENSEE CONTACT FOR THIS LER (12)																								
NAME Heyward R. Rogers, Compliance Section Engineer										TELEPHONE NUMBER 6 1 5 8 7 0 - 6 1 4 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)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR								
YES (If yes, complete EXPECTED SUBMISSION DATE)												XX NO												

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

On August 27, 1985, with both units in cold shutdown, a main control room isolation occurred as a result of a personnel error. During the performance of train 'B' chlorine detector function testing, an instrument mechanic failed to follow procedures and did not put the channel in "test" prior to performance of the surveillance. After the event, operations reset the main control room ventilation system, and the surveillance was completed without further incident. There was no effect upon public health and safety.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES: 9/31/85

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 2 7 8 5 -	LER NUMBER (6)			PAGE (3) 0 2 OF 0 2		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0 3 3	-	0 0			

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

On August 27, 1985, at 1840 CST, an engineered safety feature actuation occurred for main control room isolation. Both units were in mode 5 (cold shutdown) at the time of the event. The actuation occurred from the train 'B' chlorine detector and was a result of a personnel error during the weekly functional testing of the detector. Surveillance Instruction (SI)-240, "Functional Test of Control Room Air Intake Chlorine Detection System," requires that the instrument maintenance personnel place the detector's handswitch in the test position during the performance of the instruction. However, this was not done, and subsequently a main control isolation was inadvertently initiated from the chlorine detector.

The main control room chlorine detection system is designed to ensure that sufficient capability is available to promptly detect and initiate protective action in the event of an accidental chlorine release in order to protect control room personnel. Technical Specification LCO 3.3.3.6 requires a channel functional test at least once per 31 days. Presently, SI-240 is performed on each train on a weekly basis. A review of surveillance history has not indicated any similar previous occurrences, and this event is considered an isolated case.

Operations personnel verified that the isolation was inadvertent and secured the system. Disciplinary action was taken against the individual involved including formal counseling from plant supervisors and a warning letter in the personnel files.

No other actuation occurred as a result of this event, and the surveillance was completed without further incident. There have been no previous occurrences, and there was no effect upon public health and safety.

TENNESSEE VALLEY AUTHORITY

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

September 23, 1985

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

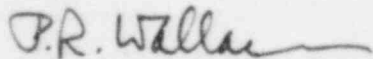
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/85033

The enclosed licensee event report provides details concerning an inadvertent main control room isolation occurring on August 27, 1985. 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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NRC Inspector, NUC PR, Sequoyah

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