

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)										DOCKET NUMBER (2)										PAGE (3)									
Sequoyah, Unit 1										0 5 0 0 0 3 2 7										1 OF 0 2									
TITLE (4)										OTHER FACILITIES INVOLVED (8)																			
Auxiliary Building Ventilation Isolations										Sequoyah, Unit 2																			
EVENT DATE (5)										LER NUMBER (6)										REPORT DATE (7)									
MONTH DAY YEAR										MONTH DAY YEAR										MONTH DAY YEAR									
0 5 3 0 8 5										0 2 3 0 0 6 2 7 8 5										0 5 0 0 0 3 2 8									
OPERATING MODE (9)										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (11)										73.71(b)									
4										20.402(b)										XX 50.73(a)(2)(iv)									
POWER LEVEL (10)										20.405(a)(1)(i)										50.73(a)(2)(v)									
0 1 0 1 0										20.405(a)(1)(ii)										50.73(a)(2)(vi)									
										20.405(a)(1)(iii)										50.73(a)(2)(vii)									
										20.405(a)(1)(iv)										50.73(a)(2)(viii)									
										20.405(a)(1)(v)										50.73(a)(2)(ix)									
LICENSEE CONTACT FOR THIS LER (12)										TELEPHONE NUMBER																			
NAME										AREA CODE																			
Glenn E. Duggin, Compliance Section Engineer										6 1 5 8 7 0 - 6 5 4 8																			
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)																			
YES (If yes, complete EXPECTED SUBMISSION DATE)										XX NO																			
ABSTRACT (Limit to 1400 words, i.e., approximately fifteen single-space typewritten lines) (16)																													

This report provides details concerning four inadvertent Auxiliary Building ventilation isolations (ABIs). The first ABI was caused by electromagnetic interference (EMI) on spent fuel pool (SFP) radiation monitor (RM) 102. The second and third ABIs were caused by EMI also, but on SFP RM 101. Corrective actions taken include installing cables of RM 102 in conduit and raising the set point on RM 101. The fourth event occurred when maintenance personnel inadvertently bumped the time-delay relay on RM 102 dislodging it from its socket. All of these events were inadvertent, and no radiation levels above normal were detected.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 5/31/85

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 2 7 8 5	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		-0	123	-0	0	0	2 OF 0 2

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

At 1601C on May 30, 1985, an Auxiliary Building ventilation isolation (ABI) occurred while unit 1 was in mode 4 (0 percent power, 360 psig, 210 degrees F) and unit 2 was in mode 1 (100 percent power, 2235 psig, 578 degrees F). Another ABI occurred on May 31, 1985, at 0417C and again at 0449C while both units were in the same modes and conditions. The fourth event occurred on June 7, 1985, at 1955C while unit 1 was in mode 5 (0 percent power, 310 psig, 180 degrees F) and unit 2 was in mode 1 (100 percent power, 2235 psig, 578 degrees F). No radiation levels above normal were detected during any of these events. For each event the operator observed the radiation monitor (RM) annunciator in the alarm condition and verified that an ABI had occurred. After each of the ABIs, the operator verified that there was no abnormal radiation, reset the ABI, acknowledged the annunciators, and realigned the system. Maintenance requests (MRs) were written on the RMs in each event. All personnel and components responded and performed as expected during these events.

In the first event, May 30, 1985, the spent fuel pool monitor (RM-90-102) high radiation alarm actuated. Neither the red nor the amber high radiation trip lights were illuminated, but all ventilation systems operated as expected during an ABI. The trip lights come on if the ABI was generated by the RM itself. Since they did not light, this indicates electromagnetic interference (EMI) affected the cables at some other point. A workplan had been written to install the signal cables in conduit to prevent EMI from initiating a spurious signal and an ABI.

In the second event, May 31, 1985, at 0417C, the spent fuel pool monitor (RM-90-101) high radiation alarm actuated. Both the noble gas and particulate channels spiked, but only the particulate channel went above the ABI initiation set point. RM-90-119 spiked at the same time since the control circuit for the power supply is common to both RMs. The spike was probably caused by EMI generated by a combination of operation of the motor operator disconnect (MODs) switches in the switchyard and the replacement of filter paper in the RM.

In the third event, May 31, 1985, at 0449C, the ventilation system was being realigned after the second event which caused a spike on RM-90-101A (particulate). The set point at the time of the spike was 1340 cpm and the magnitude of the spike was 2000 cpm. The set point has been reevaluated per Technical Instruction (TI)-18, "Radiation Monitoring," and raised the 11,040 cpm. This new set point should help prevent spikes from EMI causing an ABI. The Final Safety Analysis Report (FSAR) formerly based the particulate set point on Iodine 131. The particulate is now based on Cobalt-58 allowing the set point to be changed.

In the fourth event, June 7, 1985, electrical maintenance personnel were working on a plug mold inside a cabinet in the main control room (MCR). Personnel inadvertently bumped a high radiation time-delay relay. Subsequent vibration from working on the plug mold caused the relay to fall out of its socket causing an ABI on the spent fuel pool radiation monitor RM-90-102. The relay is a plug-in type which deenergizes to trip. The relay was inspected for damage, placed back in its socket, and the ABI reset. This relay and other similar relays in the same cabinet are being evaluated by the Office of Engineering to determine if any type of retaining clips are needed to prevent a similar occurrence in the future.

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

Previous occurrences: two LER's involving inadvertent ABIs in 1985 - SQRO-50-327/85014 and 85017.

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant
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June 27, 1985

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

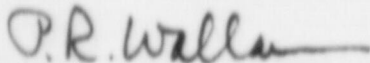
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/85023

The enclosed licensee event report provides details concerning the inadvertent Auxiliary Building ventilation isolations. 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

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