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U. S. NUCLEAR REGULATORY COMMISSION

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0 1	SOURCE LIG 0 50 0 0 3 2 7 0 0 5 1 5 8 0 8 0 5 8 8 0 6
0 2	At 0100 CDST with Unit 1 in Mode 3, it was discovered that the test switches
0 3	on the containment purge exhaust radiation monitors were in the test positib
011	making the monitors inoperable (TS LCO 3,3.3.1 requires one monitor
0 5	operable in all modes) making them unable to provide a containment vent
06	isolation signal. Since Unit 1 had not yet achieved initial criticality
0 7	there were no radiation releases. Therefore there was no danger to the
08	health and safety of the public.
0 9	SYSTEM CAUSE SUBCODE S
	THE ACTION FUTURE FEECT SHUTDON HOURS (22) SUBMITTED FORMING SUBMI
	TAKEY ACTION ON PLANT WENDS WOURS (22) SUBMITTED FORM SUB SUPPLIER WANT FACTURER IN CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
10	Operator error in placing both trains of radiation monitors in test at the
	same time. Upon discovery the radiation monitors were immediately re-
12	turned operable.
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(III)	
15	TATUS SPOWER OTHER STATUS (30) METHOD OF DISCOVERY OF OSCINETION (30) B (30) (0) (0) (0) (0) (0) (0) (0) (0) (0) (
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	MAME OF PREPAREN GATY W. GAULT PHONE: (615) 842-0295

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POOR ORIGINAL

Tennesses Valley Authority Sequoyah Nuclear Plant

LER SUPPLEMENTAL INFORMATION

SQRO-50-327/ 8048 Technical Specification Involved 3.3.3.1

Reported Under Technical Specification Section 6.9.1.12.i

Date of Occurrence 5/15/80 Time of Occurrence: 0100 CDST Unit 1

Identification and Description of Occurrence

Containment purge air exhaust monitors test switches were discovered to be in the test position making the monitors inoperable. LCO 3.3.3.1 requires at least one monitor be operable. Action 26 of the LCO requiring closure of penetrations which provide direct access from the containment atmosphere to the outside atmosphere was not met. The inoperable containment purge air exhaust radiation monitors would not have provided a containment ventilation isolation signal, however, isolation was still functional from containment upper and lower radiation monitors and safety injection signals.

Conditions Prior to Occurrence

Unit 1 in Mode 3. Preoperational Testing

Action specified in the Technical Specification Surveillance Requirements met due to inoperable equipment.

N/A

Apparent Cause of Occurrence

Personnel error.

Analysis of Occurrence

There was no hazard to the public health and safety.

Corrective Action

Monitors were immediately removed from test mode upon discovery. Administrative Instruction (AI-5) system status checklist was revised to require that each oncoming shift verify that the test switches are in the off position.

Failure Data

N/A