NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

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)

Auxiliary 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 5 0 0 0
0 5	0 7	8 4	8 4	0 2 9	0 0	0 5	3 0	8 4		0 5 0 0 0

OPERATING MODE (9)	5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 0 0	20.402(b)	20.405(c)	XX 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Glenn Duggin, Compliance Section Engineer	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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

A high radiation alarm was actuated which caused an auxiliary building isolation (ABI) to occur. Investigation revealed that in two incidents, because detector output is not stable and the radiation level is so close to the setpoint, normal fluctuations of the detector tripped the alarm. In another incident, the power source for a radiation monitor was transferred from one board to another which caused an alarm. Radiation levels were not above normal during this time.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Sequoyah, Unit 1	0 5 0 0 0 3 2 7	8 4	— 0 2 9	— 0 0	0 2 OF 0 2

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

This LER involves three separate incidents. The first auxiliary building isolation (ABI) occurred at 1205C on 05/07/84 while unit 1 was in mode 5 (0% power, 0 psig, 128 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to normal at 1230C on 05/07/84. The second ABI occurred at 2341C on 05/07/84 while unit 1 was in mode 5 (0% power, 0 psig, 129 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 2400C on 05/07/84. The third ABI occurred at 0828C on 05/08/84 while unit 1 was in mode 5 (0% power, 0 psig, 125 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 0900C on 05/08/84. All associated equipment and personnel responded and performed as expected during the ABI. The operator responded to the alarm (RM-90-101, -103) and determined that the alarm was in fact an inadvertent spike and not 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, a momentary loss of power to the radiation monitor occurred when power was transferred from shutdown board 1A to shutdown board 2A. The radiation monitor goes into alarm on loss of power. This transfer was done as part of a performance of special maintenance instruction (SMI) 1-SD-480 to test the breaker transfer scheme. This instruction will be revised to alert personnel to the possibility of an ABI. No failure was found associated with the monitor, and it was reset.

In the second and third incidents, the radiation level in the spent fuel pit (SFP) was near the setpoint of the radiation monitor. The Geiger-Mueller (G-M) tube used in the radiation monitor does not give a smooth constant output. Occasionally, the G-M tube will fluctuate naturally enough to set off the alarm. The SFP water cooling system was run through a demineralizer bed and was able to lower the radiation level approximately 2 mrem/hr. A technical specification change is being submitted to raise the setpoint of the monitor to a higher level.

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 - SQRO-50-327/84002, SQRO-50-327/84010, SQRO-50-327/84015.

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

May 30, 1984

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-50-327/84029

The enclosed licensee event report provides details concerning the auxiliary building ventilation isolation (ABI) caused by an inadvertent spike on the radiation monitor. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.iv.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

C C Mason

C. C. Mason
Power Plant Superintendent

Enclosure
cc (Enclosure):

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NRC Inspector, NUC PR, Sequoyah

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