



Tennessee Valley Authority, Post Office Box 2000, Safety, Dams, Tennessee 37202

J. L. Wilson
Vice President, Sequoyah Nuclear Plant

February 18, 1992

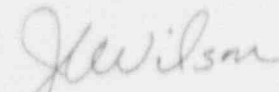
U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1- DOCKET
NO. 50-327 - FACILITY OPERATING LICENSE DPR-77 - LICENSEE EVENT REPORT
(LER) 50-327/92002

The enclosed LER provides details concerning an event wherein a
containment ventilation isolation occurred as the result of a containment
purge exhaust radiation monitor actuation from an indeterminate source.
This event is being reported in accordance with 10 CFR 50.73(a)(2)(iv) as
an engineered safety feature actuation.

Sincerely,


J. L. Wilson

Enclosure
cc: See page 2

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PDR ADDCK 05000327
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Handwritten initials/signature

U.S. Nuclear Regulatory Commission
Page 2
February 18, 1992

cc (Enclosure):

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah Nuclear Plant, Unit 1 [DOCKET NUMBER (2) | PAGE (3)]
[015101013 | 2 | 7 | 1101] 014

TITLE (4)
A containment ventilation isolation occurred as a result of a spurious actuation of a radiation alarm.

EVENT DAY (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES			DOCKET NUMBER(5)
01	11	92	0	0	11	01	92				01510101 1

OPERATING MODE (9) | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following)(11)

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LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
J. W. Proffitt, Licensing Engineer	6 1 5 8 4 3 - 6 6 5 1

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)

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[]	[]	[]	[]

EXPECTED SUBMISSION DATE (15)

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

At 1358 Eastern standard time (EST) on January 18, 1992, with Unit 1 operating at 100 percent power, a B train containment ventilation isolation (CVI) occurred because of a spurious actuation of containment purge exhaust radiation monitor (RM) 1-RM-90-131. A purge was not being performed at the time of the isolation. Operations verified that high radiation conditions did not exist and recovered from the CVI. No problems with the RM were identified during subsequent troubleshooting and the RM was returned to service. The root cause of this event is indeterminate.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)															
		YEAR	NUMBER	REVISION NUMBER																
Sequoyah Nuclear Plant Unit 1		015	010	013	12	17	19	12	--	0	0	2	--	0	0	0	12	10F	0	14

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

I. Plant Conditions

Unit 1 was operating at approximately 100 percent reactor thermal power.

II. Description of Event

A. Event

On January 18, 1992, at 1358 EST, a CVI (EISS code JM) occurred on Unit 1. The CVI was initiated from the B train noble gas containment purge exhaust radiation monitor (RM) 1-RM-90-131 high radiation alarm (EISS Code RA). A purge was not being performed at the time of the isolation. Limiting Conditions for Operation (LCOs) 3.3.2.1, 3.3.3.1, and 3.4.6.1 were entered as a result of the CVI isolating the upper and lower containment RMs. Operations responded to the alarm and noted that no alarms were indicating locally on the RM. Operations verified that high radiation conditions did not exist and proceeded to recover from the CVI. At the time of the event no maintenance activity was in progress that could be identified that could have caused the event. Upon completion of the recovery from the CVI, LCOs 3.3.2.1, 3.3.3.1, and 3.4.6.1 were exited at 1430 EST.

RM 1-RM-90-131 remained blocked for troubleshooting. At 1820 EST, another high radiation alarm was received on 1-RM-90-131. No CVI occurred because the RM was blocked. Local inspection of 1-RM-90-131 revealed the high radiation alarm was indicating. Extensive troubleshooting of the RM continued; no abnormalities were identified.

B. Inoperable Structures, Components, or Systems that Contributed to the Event

None

C. Dates and Approximate Times of Major Occurrences

1. January 18, 1992 at 1358 EST CVI occurred on Unit 1. LCOs 3.3.2.1, 3.3.3.1, and 3.4.6.1 were entered.
2. January 18, 1992 at 1430 EST Operations completed recovery from the CVI and exited the LCOs.
3. January 18, 1992 at 1820 EST Received another high radiation alarm on 1-RM-90-131.
4. January 30, 1992 at 1315 EST Following extensive troubleshooting, 1-RM-90-131 was returned to service.

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Sequoyah Nuclear Plant Unit 1		1992	002	00	013	of	014

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

D. Other Systems or Secondary Functions Affected

As a result of the CVI, the upper and lower containment radiation monitors sample lines automatically isolated as designed causing these monitors to actuate malfunction alarms.

E. Method of Discovery

The event was discovered by Operations personnel observation of an alarm in the main control room.

F. Operator Actions

Upon receipt of the alarm Operations personnel verified that the CVI was not a result of an actual high radiation condition and initiated recovery from the CVI in accordance with plant procedures.

G. Safety System Responses

As a result of the high radiation alarm, a CVI occurred.

III. Cause of the Event

A. Immediate Cause

The immediate cause of this event was that a high radiation alarm actuated on 1-RM-90-131, resulting in the CVI.

B. Root Cause

The root cause of this event could not be determined. A spurious high radiation alarm occurred, resulting in the CVI.

IV. Analysis of the Event

This event is reportable in accordance with 10 CFR 50.73, paragraph (a)(2)(iv) as an engineered safety feature (ESF) actuation, which was not part of a preplanned sequence of steps. The equipment required to actuate on a CVI signal performed as designed. Operations personnel verified that an actual high radiation condition did not exist and took appropriate actions to recover from the event. No adverse safety consequences resulted from this event. Since this was an inadvertent CVI actuation and no actual high radiation condition existed, there was no threat to plant personnel or to the general public.

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

V. Corrective Actions

- 1) Operations responded to the alarm and verified that a high radiation condition did not exist.
- 2) Operations recovered from the event.
- 3) Troubleshooting of the RM did not reveal any abnormalities and the RM was returned to service.

VI. Additional Information

There have been several previous reports involving spurious CVIs. However, since the addition of shielding tape to the RMs as a corrective action for LER 50-327/90028, this is the first CVI that has occurred that has been attributed to a spurious actuation.