NRC Form 386 (9-83) LICENSEE EVENT REPORT (LER)												U.S. NUCLEAR REQUIATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85											
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A high radiation alarm was actuated which caused an auxiliary building ventilation isolation (ABI) to occur. Investigation revealed that a spike occurred on the spent fuel pool (SFP) radiation monitor. The background radiation level is so close to the setpoint that normal fluctuations of the detector can trip the alarm. Radiation levels were not above normal during this time.

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NRC Form 366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)			LE	R NUMBER (PAGE (3)					
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TEXT Iff 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 0444C on 05/31/84 while unit 1 was in mode 3 (0% power, 2235 psig, 547 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to normal at 0504C on 05/31/84. The second ABI occurred at 1550C on 06/02/84 while unit 1 was in mode 1 (50% power, 2235 psig, 563 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 1605C on 06/02/84. The third ABI occurred at 2253C on 06/04/84 while unit 1 was in mode 3 (0% power, 2235 psig, 520 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to service at 2307C on 06/04/84. All associated equipment and personnel responded and performed as expected during the ABI. The operator responded to the alarm (RM-90-103) and determined that the alarm was in fact an inadvertent spike and not a high radiation level. Personnel were notified to check the monitor, reset the alarm in the control room, and repair or reset the monitor.

In all three incidents, the radiation level in and around 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 enough naturally to set off the alarm. The movement of contaminated material in the SFP area could also have set off the alarm. The SFP area was cleaned up, and the background was lowered to the 1-2 millirem/hr range.

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, and SQRO-50-327/84029.

TENNESSEE VALLEY AUTHORITY

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

June 26, 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 SQR0-50-327/84037

The enclosed licensee event report provides details concerning the auxiliary building ventilation isolation 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

P. R. Wallace Plant Manager

Enclosure cc (Enclosure):

James P. O'Reilly, Director U.S. Nuclear Regulatory Commission Suite 2900 101 Marietta Street, NW Atlanta, Georgia 30323

Records Center Institute of Nuclear Power Operations Suite 1500 1100 Circle 75 Parkway Atlanta, Georgia 30339

NRC Inspector, NUC PR, Sequoyah

IE22