

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 2 7	PAGE (3) 1 OF 0 2
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TITLE (4)
Control Room 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	2 7	8 4	8 4	0 3	9 0	0 0	6 2	5 8				0 5 0 0 0
												0 5 0 0 0

OPERATING MODE (9) 3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)										
	20.402(b)	20.406(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)						
POWER LEVEL (10) 0 0 0	20.406(a)(1)(i)	50.38(c)(1)	<input type="checkbox"/>	50.73(a)(2)(v)	73.71(c)						
	20.406(a)(1)(ii)	50.38(c)(2)	<input type="checkbox"/>	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
20.406(a)(1)(iii)	50.73(a)(2)(ii)	<input type="checkbox"/>	50.73(a)(2)(viii)(A)								
20.406(a)(1)(iv)	50.73(a)(2)(iii)	<input type="checkbox"/>	50.73(a)(2)(viii)(B)								
20.406(a)(1)(v)	50.73(a)(2)(iii)	<input type="checkbox"/>	50.73(a)(2)(ix)								

LICENSEE CONTACT FOR THIS LER (12)			
NAME Glenn Duggin, Compliance Section Engineer		TELEPHONE NUMBER 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	
X	I L	- - - P	G O 4 6	YES						

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO						

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

A high radiation alarm was actuated which caused a control room ventilation isolation (CRI) to occur. Investigation revealed that in one incident, a vacuum pump failed and generated a spurious high radiation spike which actuated the alarm. In another incident, while the chart paper in the recorder was being changed, a spurious spike (electromagnetic interference - EMI) was inadvertently generated which caused the high radiation alarm to actuate. Radiation levels were not above normal during this time.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

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

This LER involves two separate incidents. The first control room isolation (CRI) occurred at 1950C on 05/27/84 while unit 1 was in mode 3 (0% power, 1800 psig, 450 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to normal at 2300C on 05/27/84. The second CRI occurred at 0543C on 06/11/84 while unit 1 was in mode 1 (100% power, 2235 psig, 578 degrees F) and unit 2 was in mode 1 (100% power, 2235 psig, 578 degrees F) and was returned to normal at 0550C on 06/11/84. All associated equipment and personnel responded and performed as expected during the CRI. The operator responded to the alarm (RM-90-125) 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, the vacuum (sample) pump's bearings froze and caused the pump to fail. This failure caused some spurious electromagnetic interference (EMI) to be generated and put a high voltage spike on the monitor. The pump's bearings and vanes were replaced and the pump and monitor were returned to service. This pump failure occurred from normal wear as a result of continuous operation.

In the second incident, the chart paper on the chart recorder was being changed out which caused an inadvertent EMI spike to set off the alarm. The inadvertent high radiation alarm was cleared and the monitor was returned to service. A time delay is being incorporated into the monitor logic as soon as the parts arrive on site. This will help prevent the recurrence of both of the above incidents.

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

Previous occurrences - SQRO-50-327/84004.

TENNESSEE VALLEY AUTHORITY

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

June 25, 1984

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

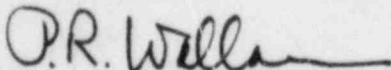
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/84039

The enclosed licensee event report provides details concerning two control room isolations caused by an inadvertent signal generated first by a vacuum pump failure and again by changing the chart paper. 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):

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NRC Inspector, NUC PR, Sequoyah

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