

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 6 2 7 1	PAGE (3) 1 OF 0 2
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TITLE (4) CVI and ABI Due to Defective Terminal Strip											
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		
0 8	3 0	8 4	8 4	0 5 6	0 0	0 9	2 7	8 4	DOCKET NUMBER(S) 0 5 0 0 0		

OPERATING MODE (9) 1	POWER LEVEL (10) 0 1 3 1 0	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)							
		20.402(b)	20.406(i)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)			
		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 365A)			
		20.406(a)(1)(iii)	50.73(a)(2)(i)	<input type="checkbox"/>	50.73(a)(2)(viii)(A)				
		20.406(a)(1)(iv)	50.73(a)(2)(ii)	<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 Heyward R. Rogers, Compliance Section Engineer							TELEPHONE NUMBER		
							AREA CODE 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 NFRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NFRDS		
X	I K	R J X	G 0 6 3	N							

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)

At 0818 CST on 08/30/84, Sequoyah Unit 1 experienced an inadvertent containment vent isolation simultaneous with an auxiliary building isolation. All engineered safeguard features associated with the CVI and ABI actuated as designed and no other unusual occurrences were observed. The cause for the isolations was attributed to an inadvertent loss of train 'A' power to main control room panel 0-M-12 for radiation monitors 1-RM-90-106 and 0-RM-90-102. Power to the panel was lost when the breaker to 0-M-12 from 120 VAC vital board I-II tripped. Upon loss of power the breaker was closed and the CVI and ABI reset returning the safeguard systems to normal.

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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	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 4	0 5 6	0 0	0 2	OF 0 2

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

With unit 1 in mode 1 at 30% power and unit 2 in mode 1 at 10% power, instrument mechanics were working on the iodine channel to unit 1 lower compartment radiation monitor (1-RM-90-106C). The train 'A' power to panel C-M-12 was lost due to its power breaker on 120 VAC vital board 1-II opening. The loss of train 'A' power to this panel caused an inadvertent containment ventilation isolation from monitor 1-RM-90-106 and an auxiliary building ventilation isolation from the spent fuel pool radiation monitor (0-RM-90-102) which is powered from this same source. All safety systems actuated as designed when the signal was present and no abnormal actions occurred. Immediate communications between the instrument mechanics working on the monitor and Operations personnel allowed for quick identification of the breaker trip and action was taken to restore power to the panel and to reset the CVI and ABI features.

Investigation revealed that as the mechanics were troubleshooting (Maintenance Request A121559) the power supply module to the iodine channel of the 1-RM-90-106C, a short occurred when a test probe was placed on a terminal strip on the General Atomic, Model No. RP-23, power supply module. This short circuit resulted in the 120 VAC vital board 1-II breaker trip and the loss of train 'A' power to the spent fuel pool radiation monitor (0-RM-90-102) and lower compartment radiation monitor (1-RM-90-106). When the power supply module to 1-RM-90-106C was removed it was noted that its terminal strip had a broken separator between the 120 VAC leads. The cause for the broken separator is unknown. A review of other similar power supply modules and the occurrence of no deficiencies indicates this is an isolated incident.

Immediate corrective actions were to close the power breaker and clear the CVI and ABI. The monitor 1-RM-90-106C power supply module was replaced and the monitor was returned to service at 1445 CST on 08/31/84. A review of safety system availability of the event indicate that all systems worked properly and there was no effect on public health and safety. There have been no previous occurrences due to a similar failure for 1984.

TENNESSEE VALLEY AUTHORITY

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

September 27, 1984

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

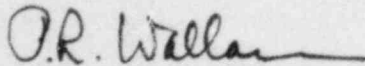
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/84056

The enclosed licensee event report provides details concerning the inadvertent containment ventilation isolation and auxiliary building isolation occurring on August 30, 1984. 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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