NRC Form 306 (9-83)  LICENSEE EVENT REPORT (LER)								U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85													
FACILITY NAME (1)								Tooc	DOCKET NUMBER (2)						PAGE (3)						
Sequoyah, Unit 2								-				10131218									
TITLE (4)											14	-	-1	- 1.	-	1210		101	142		
Re	actor	and	Gene	rator Tri	on Ne	utral	Over	volta	00												
Reactor and Generator Trip on Neu											R FACILITIES INVOLVED (8)										
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POWER		20.	20.406(a)(1)(i)			60.36(c)(1)			50.73(a)(2)(v)				7:	3.71(c)							
(10) Q 9  7 20.406(a)(1)(ii)		50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract											
20.406(a)(1)(iii) 20.406(a)(1)(iv) 20.406(a)(1)(iv)			50.73(a)(2)(i)				80.73(a)(2)(viii)(A) 80.73(a)(2)(viii)(B)				below and in Text, NRC 366A)										
		20.	20.406(a)(1)((v)			50.73(a)(2)(ii)					14-6-1										
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Glenn E. Duggin, Compliance Sect					ion Engineer						6 11	1	5 8	17	0 1-	16	11	14 16			
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A reactor trip occurred due to a turbine trip which was caused by the generator neutral overvoltage relay actuating. The relay operation was verified as valid, and a megger test of the generator, isolated phase bus, and main and unit station service transformers indicated a ground on the system. The ground was found to be caused by a neoprene gasket/isolating strip that had fallen down onto the isolated phase (IPB). All the strips in the IPB were inspected, removed, and reinstalled with RTV as an adhesive. A preventative maintenance program is being implemented to inspect the isolated phase bus at each refueling outage. The unit stabilized at 547 degrees F following the reactor trip.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REQULATORY COMMISSION

APPROVED OMB NO 3150-0104

FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)							PAGE (3)			
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TEXT /// more space is required, use additional NRC Form 366A's/ (17)

On September 9, 1984 at 0803C the main generator neutral overvoltage relay operated, which tripped the turbine and then the reactor while the unit was operating at 97 percent power (mode 1, 2238 psig, 578 degrees F). The unit stabilized at 547 degrees after the event. All automatic actions were verified and immediate operator actions performed.

A grounded condition existed which caused the neutral overvoltage relay to operate. To find the ground it was necessary to break the generator, isolated phase bus (IPB), and main and unit station service transformers into components. The relay, unit station service transformers and the generator meggered good; therefore, the ground was on the IPB of the main transformers. To isolate the main transformers, the doghouses on each transformer were opened and the shunts to the low side bushings were removed. When the B phase doghouse was opened, a neoprene gasket/isolating strip was found laying at the end of the IPB enclosure at the X-1 bushings. This gasket was causing the grounded condition.

An inspection was made of all other gasket/isolating strips (six total) and none were found dislodged or grounding the IPB. It was noted that the gasket/isolating strips did not fit well between the IPB and the doghouse and most of the free ends of the strips (at the joints) were located at the 12 o'clock position where they could fall on the bus if not secured.

The system was reassembled, meggered acceptably, and returned to service. All strips were removed and reinstalled with RTV as an adhesive. All joints where strips join were located at the 6 o'clock position and all doghouse covers were resealed with RTV. A preventative maintenance program has been written to inspect and clean the isolated phase bus at each refueling outage. The transformers are suspected of settling, causing the poor gasket fit. A program has been instituted to determine the settling rate and corrective action. These corrective actions were implemented for both units.

Immediately after the above discussed reactor trip, a level control valve (LCV), 3-175, to the turbine driven auxiliary feedwater pump (TDAFWP) was discovered to be showing both the red and green lights. (The valve was verified to be closed locally.) The operator determined the problem to be a limit switch failure and declared the TDAFWP inoperable at 0810C on 09/09/84. Investigation revealed that the limit switch (position indicating) actuation arm was loose. The loose arm allowed the valve to change positions without actuating the position indicating limit switch. The loose arm was tightened, the valve functionally tested, and the valve was proved operable at 2300C on 09/10/84 while unit 2 was in mode 3 (O percent power, 2235 psig, 546 degrees F). The arm had probably vibrated loose during normal operation.

There was no effect on public health or safety, and no safety margins were exceeded.

Previous occurrences: one - SQRO-50-327/84036.

## TENNESSEE VALLEY AUTHORITY

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

October 9, 1984

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET NO. 50-328 - FACILITY OPERATING LICENSE DPR-79 - REPORTABLE OCCURRENCE REPORT SQR0-50-328/84016

The enclosed licensee event report provides details concerning the reactor and generator trip due to the actuation of the generator neutral overvoltage alarm. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.iv.

Very truly yours,

P.R. Wallan

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

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