NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Sequoyah, Unit 1	0 5 0 0 0 3 2 7	1 OF 0 2

TITLE (4)

Auxiliary Building Ventilation 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)
1 1	0 4	8 4	8 4	— 0 6 8	— 0 0	1 1	3 0	8 4	Sequoyah, Unit 2	0 5 0 0 0 3 2 8
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Glenn E. Duggin, Compliance Section Engineer	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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

An inadvertent relay actuation caused an auxiliary building ventilation isolation (ABI) to occur. Investigation revealed that a relay was jarred while personnel were working inside a cabinet in the main control room (MCR). The relay was found to be not fully seated in its terminal block. This relay gives a high radiation signal for the spent fuel pool radiation monitor, which causes an ABI. Radiation monitors were checked and no abnormal levels or spikes were found. The ABI was reset and the system returned to normal. Radiation levels were not above normal during this time.

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

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

This auxiliary building isolation (ABI) occurred at 1228 CST on 11/04/84 while unit 1 was in mode 1 (100 percent power, 2235 psig, 578 degrees F) and unit 2 was in mode 6 (0 percent power, 0 psig, 95 degrees F). The ABI was reset at 1255 CST on 11/04/84. All associated equipment and personnel responded and performed as expected during the ABI. The operator responded to the alarm and determined that the alarm was in fact caused by inadvertent relay actuation and not by a high radiation level and reset the ABI. Radiation monitors were checked and no abnormal levels or spikes were found.

Modifications personnel were working in main control room (MCR) cabinet, 0-M-12, when the ABI occurred. They were connecting wiring between the Technical Support Center (TSC) and the Post Accident Sampling radiation monitors per an approved workplan. Personnel jarred a relay (R102) which actuated the high radiation signal for radiation monitor 102, the spent fuel pool (SFP) radiation monitor. The relay was subsequently found not fully seated in its terminal block. The relay contacts made up momentarily when it was jarred. The relay was placed back into its correct position, the ABI reset, and the ventilation system returned to normal. Radiation levels were not above normal during this time.

Personnel have been cautioned to be extremely careful when terminating wires due to potential spurious relay actuation.

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

Previous occurrences of ABIs in 1984 on unit 1 - 14. This is the first ABI caused by this particular event.

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

November 30, 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-50-327/84068

The enclosed licensee event report provides details concerning the auxiliary building ventilation isolation caused by an inadvertent signal in a radiation monitor circuit. 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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Records Center
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Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 3033º

NRC Inspector, NUC PR, Sequoyah

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