NRC Form (9-83)	366						_				LIC	ENS	EF	EV	EN	TRE	POR	T	LER			U	A	PPRO	VED		ORY CO 0. 3150-		
FACILITY	NAME (		Ini	+ 1																	1000	5   0			31	2.17	T	DFO	
TITLE (4)			JUL	<u>L 1</u>									-							-		010	10		21	211	1.1	10	14
and the second se	Itrol	and the state of the	om	Iso				MBER	. (8)			-	25.9/	ORTO	ATE	. 1	_			OTHER	EAC	ILITIES	INVO	VED	(8)				
MONTH	DAY	YEAR	8 1	TEAR	Ī	SE	QUE	ENTIA	ALT	REV	VISION	MONT	-	DAY	-	EAR			FAC	LITY NA						NUMBE	R(S)		
						T			-	T			T		T									0	5	0   0	101	1	1
0 9	1 8	8	4 8	14	-	0	1	61	2 -	- 0	olo	1 10		16	8	14								0 1	51	0 1 0	101	ì.	
OPE	RATING		-		POR	TIS	-	-	_	1	1	TO THE	REG	-	-		O CFR	§: 10	heck on	or more	of th	e tollowi	ng) (11	_			1 1	-	_
POWEI	IDE (9)	1	1	-	4020	(b) (a)(1)					-	20.40						XX		a)(2)(iv) a)(2)(v)				_		71(b) 71(c)			
LEVEI (10)		1 010	b	-		(a)(1)					-	50.3					ł	-		a)(2)(vii)				-	OTI	HER ISA	ecity in	Abstra	ect.
				20	406	(a)(1)	)(101)					80.7	3(a)(	23(1)			[		50.73	a)(2)(viii)	(A)				366		n Taxs, A	VAC P	'orm
			+	-		(a)(1)					-	80.73 80.73					+	-		<pre>&gt;)(2)(viii) =)(2)(x)</pre>	(8)								
				1				_			1			-	CT FC	R THIS	LER (	12)			-	-					_		
NAME																						AREA C	ODE	TELE	PHON	NE NUN	BER	-	
Gle	enn E	. Di	ugg	in,	C	om	p1	ia	nce	Se	ecti	ion	En	gin	eet							6 1 1	15	81	71	0 [-	161	1 14	16
						C	OM	PLET	E ON	ELIN	E FOR	EACH	CON	APONE	NT F	AILURE	DESCR	IBE	D IN TH	IS REPO	RT (1	3)	_	-					
CAUSE	SYSTEM	CON	APON	ENT	_		AREP			EPORT					_	CAUSE	SYST	EM	COMP	ONENT	+	MANUF			POR1	ABLE			
	-	1	1	1	-	1	1	1	+							_	-	-	-	11	+	1.1	1	+		_			
	1		1	1		1	1	1									1		1	11		11	1		_				
							SUP	PLEN	MENTA	AL RE	EPORT	EXPEC	TEC	(14)							-	EX	PECTE	D N	+	MONTH	DAY	Y	YEAR
YES	ill yes, c	-			_	_		_	_				XX	NO			<u>ili</u>	2				DA	TE (11	5)		1			1
whe whe spu cau rad	contr en th en a uriou used liati l bot	e te capa s el the on n	est aci lec mo nor	sw tor tro nit ch	it na or lo	ch ea gn t ri	o d et o ne	n t car ic spi	the me in ike eve	ch loo ter en ls	nlon ose rfen noug wen	on renc gh t re a	d e o bo	ete rad (EM act ve	ial lial lial lial ual noi	or w tion whe te t cmal	as a mon n th he h dui	act nit ne nig rir	tuat tor of reco gh ra ng th	ed. chart orden adiat nis t	An t d t w tio	othe rive as m n al e.	r C mo love arm The	RI d.	oc r a Ne RIs	cur ind he ith we	red gene EMI er re r	rat	
NRC Form	-	84 PD S	I I O R	31( AD(	26	16	0	34	003	16 327 DR	Ĩ													Ĩ	È	22	2		

NRC Form 366A (9-83)	EE EVENT REPORT (LER) TEXT CON	TINUATION	U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO: 3150-0104 EXPIRES 8/31/85				
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUM	BER (6)	PAGE (3)			
		YEAR SEQUE	NTIAL REVISION				

This LER involves two separate incidents. The first control room isolation (CRI) occurred at 0930 CST on 09/18/84, while unit 1 was in mode 1 (100 percent power, 2235 psig, 579 degrees F) and unit 2 was in mode 1 (100 percent power, 2235 psig, 578 degrees F). The CRI was reset and the chlorine detector was returned to service at 0935 CST on 09/18/84. The second CRI occurred at 2310 CST on 09/29/84, while unit 1 was in mode 1 (30 percent power, 2235 psig, 557 degrees F) and unit 2 was in mode 4 (0 percent power, 375 psig, 332 degrees F). The CRI was reset at 2320 CST on 09/29/84. The radiation monitor (RM) chart drive motor was repaired at 2320 CST on 10/10/84. The RM was operable during this time. All associated equipment and personnel responded and performed as expected during the CRIs. The operator responded to the alarms (RM-90-125) and the chlorine detector (CL-43-205) and determined that a spurious actuation had occurred. The CRIs were reset, the ventilation system realigned to normal, and the actuating equipment returned to normal. Neither a high radiation level nor a high chlorine level existed during this time.

0 |5 |0 |0 | 3 | 2 | 7 | 8 | 4 - 0 | 6 | 2 - 0 | 0 | 0 | 2 | 0F | 0 | 2

In the first incident, an assistant unit operator (AUO) pushed the test button on the chlorine detector without first placing the chlorine analyzer in the test position. The AUO was attempting to correct the drip rate on the detector. The AUO immediately realized what had happened and notified the unit operator to reset the CRI and realign the ventilation system. Instrument maintenance was notified to correct the drip rate on the detector and verify the detector's operability. No problem was found with the chlorine detector. Instructions are written and a warning signal is posted to warn personnel about this type of error. Personnel failed to heed the warning in this instance. A yellow caution sign is being added to the detector that is more visible and gives a more explicit warning to personnel.

In the second incident, the high radiation alarm on the radiation monitor (RM) was actuated by a spike. The spike was caused by the generation of electromagnetic interference (EMI) when the recorder chart drive motor was moved. The recorder is periodically pulled out from the RM to change the chart paper. The EMI was generated due to a lead on a capacitor being loose. The loose capacitor lead caused an intermittent connection when the recorder was moved. The operation of the RM was not affected as long as the recorder was not moved. The capacitor lead was resoldered to correct the EMI problem. No other problem was found and the RM was returned to service.

There was no effect on public health or safety and no plant safety margins were exceeded. Neither radiation nor chlorine levels were above normal during this time.

Previous occurrences of CRIs in 1984 - SQR0-50-327/84004, 34039, 84050.

Sequoyah, Unit 1 TEXT IN more space in required, use additional NAC Form 306A's) (17)

## TENNESSEE VALLEY AUTHORITY

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

October 16, 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 SQR0-50-327/84062

The enclosed licensee event report provides details concerning the two control room isolations. One occurred due to a spike on a radiation monitor and ark ther due to a personnel error. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.iv.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

P.R. Wallas

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

An Equal Opportunity Employer

IE22

11,