NRC Form (9-83)	366							LIC	ENSE	E EVE	NT REI	PORT	(LER)			APPR	EAR REGULATO OVED OMB NO RES 8/31/85	0RY COM-#ISSION 3150-0104
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ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single space typewritten lines/ (16)

YES (If yes complete EXPECTED SUBMISSION DATE)

On February 1, 1985, a containment ventilation isolation occurred on the train 'B' valves only. It was found that a power supply to a containment purge air exhaust monitor had failed causing the isolation. The power supply was replaced and the containment ventilation isolation reset.

XII NO

SUPPLEMENTAL REPORT EXPECTED (14)

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EXPECTED SUBMISSION DATE (15) DAY

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

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

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

During normal power operations with unit 1 at 100 percent reactor power, a train 'B' containment ventilation isolation occurred at 2040 CST on February 1, 1985. At the time of the isolation, there were no purging activities in progress, and only the train 'B' isolation valves to the upper and lower containment radiation monitors RM-90-106 and -112 were affected. These valves closed upon demand as designed, and no anomalies were noted.

The containment ventilation isolation system is an engineered safety features system for Sequoyah and is designed to isolate the containment purge lines in the event of a loss of coolant accident (LOCA) during purging operations to ensure that the site boundary dose guidelines of 10 CFR Part 100 are not exceeded. Presently, the containment isolation valves for the upper and lower compartment radiation monitors are included as part of this isolation feature. An isolation signal can be initiated from either a phase 'A', phase 'B', safety injection, high radiation from upper or lower containment radiation monitors, or high radiation from the containment purge air exhaust monitors.

Prior to the event, Electrical Maintenance personnel received permission from the shift engineer to troubleshoot an indicator light problem on upper containment radiation monitor 1-RM-90-112. This work was being performed on routine maint nance request A301214, which entailed the repairing of a power light module for the number two pump for the monitor. At the occurrence of the isolation, it was thought that work being performed by the electricians had caused the train 'B' isolation, and this suspicion was initially reported to the NRC duty specialist during a phone call in accordance with 10 CFR 50.72.b.2.ii.

Followup investigations including a review of TVA and vendor drawings and discussions with the electricians involved revealed that the containment ventilation isolation was not related to any work being performed by this work request. First, a review of associated drawings show that had monitor RM-90-112 been the source of the isolation signal, both train 'A' and 'B' valves would have closed; however, only train 'B' valves closed. Secondly, Instrument Maintenance personnel found a power supply failure to the control circuit for the purge air exhaust radiation monitor RM-90-131. This monitor isolates only train 'B' valves and was the source of the containment ventilation isolation. A failure of the General Atomic Model RP-23 power supply output voltage will initiate a high radiation (fail-safe) signal and cause the isolation of the monitor's associated valves.

Following the determination of the cause of the containment ventilation isolation, a followup phone call was made pursuant to 10 CFR 50.72.c.2 to clarify the event. The power supply module was replaced, and following acceptable results of post-maintenance testing (Surveillance Instruction 82), monitor 1-RM-90-131 was returned to service at 1600 CST on February 2, 1985.

NRC Form 366A

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) PAGE (3)	PAGE (3)					
		YEAR SEQUENTIAL REVISION NUMBER						
Sequoyah, Unit 1	0  5   0   0   0   3   2   7	7 8 5 0 1 0 0 0 0 3 OF 0	13					

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

Work on the upper containment radiation monitor pump power light module was completed without incident and was also returned to service on February 2, 1985. A review of maintenance history has not indicated any trend of failures of this model power supply, and no further corrective action is planned.

There was no effect upon public health or safety, and this is the first containment ventilation isolation for 1985.

## TENNESSEE VALLEY AUTHORITY

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

March 2, 1985

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 SQR0-50-327/85010

The enclosed licensee event report provides details concerning a containment ventilation isolation which occurred on February 1, 1985. 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):

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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