

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 2 7										PAGE (3) 1 OF 0 2																													
TITLE (4) Auxiliary Building Ventilation Isolation																																																	
EVENT DATE (5) 0 9 0 8 8 5 8 5										LER NUMBER (6) 0 3 8 0 0										REPORT DATE (7) 1 0 0 7 8 5										OTHER FACILITIES INVOLVED (8) Sequoyah, Unit 2																			
MONTH DAY YEAR										YEAR SEQUENTIAL NUMBER REVISION NUMBER										MONTH DAY YEAR										FACILITY NAMES DOCKET NUMBER(S) 0 5 0 0 0 3 2 8																			
OPERATING MODE (9) 5										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																																							
POWER LEVEL (10) 0 0 1 0										20 402(b)										20 406(c)										XX 50 73(a)(2)(iv)										73.71(b)									
										20 406(a)(1)(i)										50 36(c)(1)										50 73(a)(2)(v)										73.71(c)									
										20 406(a)(1)(ii)										50 36(c)(2)										50 73(a)(2)(vi)										OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
										20 406(a)(1)(iii)										50 73(a)(2)(i)										50 73(a)(2)(vii)(A)																			
										20 406(a)(1)(iv)										50 73(a)(2)(ii)										50 73(a)(2)(viii)(B)																			
										20 406(a)(1)(v)										50 73(a)(2)(iii)										50 73(a)(2)(ix)																			
LICENSEE CONTACT FOR THIS LER (12)																																																	
NAME Glenn Duggin, Compliance Section Engineer																				TELEPHONE NUMBER 6 1 1 5 8 7 0 - 6 5 4 8																													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																																	
CAUSE										SYSTEM										COMPONENT										MANUFACTURER										REPORTABLE TO NRC									
SUPPLEMENTAL REPORT EXPECTED (14)																				EXPECTED SUBMISSION DATE (15)										MONTH DAY YEAR																			
YES (If yes, complete EXPECTED SUBMISSION DATE)																				XX NO																													

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

An Auxiliary Building ventilation isolation (ABI) occurred due to a spike on a spent fuel pool (SFP) radiation monitor (RM). The SFP filter had been taken out of service so that the filter could be changed out. This action resulted in the radiation background level increasing from a range of 1 to 7 mrem per hour to a range of 1.4 to 9 mrem per hour. The technical specification alarm set point is 15 mrem per hour, but actual set point is 10 mrem per hour to allow for instrument tolerance. Spikes occur frequently due to work such as welding, and since the background was higher than usual, small spikes were enough to cause an ABI. After filter changeout was complete, flow was increased through the SFP and demineralizer, and the level of the SFP was raised. A technical specification change has been requested to raise the set point on the SFP RM to 200 mrem per hour. No personnel were contaminated, and no abnormal radiation was released to the public.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

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 5	— 0 3 8	— 0 0	0 2	OF	0 2

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

Unit 1 was in mode 5 (0 percent power, 0 psig, 100 degrees F) and unit 2 was in mode 5 (0 percent power, 0 psig, 140 degrees F) during this event.

At 2245 CST on September 8, 1985, an Auxiliary Building ventilation isolation (ABI) occurred due to a spike on a spent fuel pool (SFP) radiation monitor (RM). This RM (RM-90-102) is a Geiger-Muller (GM) tube which is positioned directly above the water in the SFP. The characteristics of a GM tube cause it to give a wide band output with frequent spikes in both directions. Some of these spikes can also be attributed to welding, grinding, and drilling. The SFP filter was taken out of service to change out the filter which caused the radioactivity level to increase due to increased contaminants in the water. This background increase raised the output band of radioactivity seen by the GM tube a normal range of 1 to 7 mrem per hour to a range of 1.4 to 9 mrem per hour. The technical specification set point is 15 mrem per hour, but the RM is set at 10 mrem per hour due to instrumentation tolerances. The spikes on the output band are normally 1 to 3 mrem per hour; therefore, the increase in background plus the spikes caused the ABI to initiate. This RM initiates "A" train of ABI equipment only, and all fans and dampers of "A" train performed correctly except for the Auxiliary Building gas treatment system (ABGTS). The ABGTS for "A" train was tagged out for maintenance; therefore, it did not start. ABGTS "B" train did not start and was not required to start. All personnel responded and performed as expected during the ABI. No radiation was released offsite, and no personnel were contaminated.

Actions taken to reduce the background to normal levels included (1) raising the level of the SFP to the maximum level, (2) putting the filter back in service, and (3) increasing flow through the demineralizer. These actions reduced the output band of the GM tube back to the 1 to 7 mrem per hour range. A technical specification revision has been requested to raise the set point of RM-90-102 to 200 mrem per hour. This change would eliminate unnecessary challenges to the engineered safeguard features (ESF) system such as this occurrence and still allow the monitor to perform its intended function in the event of a fuel handling accident.

This event occurred at 2245 CST on September 8, 1985, but it was not reported (called in to NRC) until 0830 CST on September 9, 1985. Due to the plant conditions that existed at the time of the event, the shift engineer (SE) determined that no ESF actuation actually occurred, and no notification was required. The event was discussed with plant management and the Compliance Staff the next morning, and the determination was made to report this event as an ESF actuation. Since the RM actuates a set of relays that actuates logic for radiation detection in the refueling area and not an ABI, it was not believed to be an ESF. However, the logic from the RM actuates the same equipment that an ABI would, including the ABGTS, therefore constituting an ESF actuation.

No radiation was released to the public, and no personnel received an abnormal dose or were contaminated as a result of this event. There was no effect on plant safety during this event.

Previous occurrences due to high background in the SFP - two - SQRO-50-327/84029 and 84037.

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant
Post Office Box 2000
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October 4, 1985

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

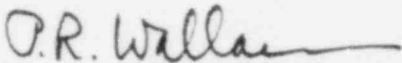
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/85038

The enclosed licensee event report provides details concerning the Auxiliary Building ventilation isolation that occurred due to an inadvertent spike. 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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NRC Inspector, NUC PR, Sequoyah

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