

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 3
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During Performance Of A Special Test Instruction A Control Room Isolation Was Inadvertently Initiated Due To An Indeterminate Cause

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)
08	15	87	87	057	000	09	15	87	Sequoyah, Unit 2		0 5 0 0 0 3 2 8
											0 5 0 0 0

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 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)							

LICENSEE CONTACT FOR THIS LER (12)	
NAME K. E. Meade, Plant Operations Review Staff	TELEPHONE NUMBER 6 1 5 8 7 0 - 6 2 5 0

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
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	

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

On August 15, 1987, with units 1 and 2 in mode 5 (0 percent power, 3 psig, 131 degrees F and 0 percent power, atmospheric pressure, 130 degrees F, respectively), a control room isolation occurred from the train A chlorine monitor while setting up to perform a functional test for Special Test Instruction (STI)-30, "DC High Voltage Test for Selected 1E Cable with Potential for Cable Pullby Damage for Conduit MC 1607A." After verification that the signal was spurious, the control room isolation was subsequently cleared by the assistant shift engineer by pushing the reset button on the chlorine detector, and the control room ventilation system was returned to normal. The cause of this event is indeterminate. An attempt was made to reproduce the control room isolation by simulation of conditions and events before the isolation and additional troubleshooting. However, a recurrence of the event could not be initiated. All systems performed as required by plant design during the control room isolation. This event was not caused by an actual chlorine release; thus, there was no threat to control room operators. No further corrective action is planned as specific failures or noncompliances have not been identified.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
			- 0 5 7	- 0 0	0 2	OF

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

DESCRIPTION OF EVENT

On August 15, 1987, with units 1 and 2 in mode 5 (0 percent power, 3 psig, 131 degrees F and 0 percent power, atmospheric pressure, 130 degrees F, respectively), a control room isolation occurred from the train A chlorine monitor while setting up to perform a functional test for Special Test Instruction (STI)-30, "DC High Voltage Test for Selected 1E Cable with Potential for Cable Pullby Damage for Conduit MC 1607A." To perform the test, the door to local junction box 0-L-450 was opened at which time a chlorine detection signal inadvertently alarmed in the main control room, and a control room isolation was automatically initiated. This junction box is the control room chlorine detector panel.

After verification that the signal was spurious, the control room isolation was subsequently cleared by the assistant shift engineer by pushing the reset button on the chlorine detector, and the control room ventilation system was returned to normal.

ANALYSIS OF EVENT

This event is being reported under 10 CFR 50.73, paragraph a.2.iv, as an automatic engineered safety feature actuation.

This event caused an inadvertent chlorine detector control room isolation. The control room emergency ventilation system (CREVS) started and isolations occurred. However, the CREVS was inoperable at this time as previously reported in LER SQRO-50-327/87039. This event was not caused by an actual chlorine release; thus, there was no threat to control room operators.

A request to delete the chlorine analyzers from technical specifications was transmitted to NRC on January 21, 1987, based on analysis which indicates that the detectors provide no significant margin of safety. Informal conversations with NRC have concluded the technical specification change will be approved. The safety evaluation report for the technical specification change has been written and approved by NRC.

CAUSE OF EVENT

The cause of this event is indeterminate. An attempt was made to reproduce the control room isolation by simulation of conditions and events before the isolation and additional troubleshooting. However, a recurrence of the event could not be initiated.

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

CORRECTIVE ACTION

Immediately after the control room isolation, the assistant shift engineer cleared the isolation by verifying the signal was spurious, pressing the reset button on the chlorine detector, and returning the ventilation system to normal. No corrective action is planned as specific failures or noncompliances have not been identified.

ADDITIONAL INFORMATION

There have been five previous LERs written on inadvertent control room isolations - SQRO-50-327/84050, 84062, 85033, 86021, and 87032.

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TENNESSEE VALLEY AUTHORITY

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

September 15, 1987

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

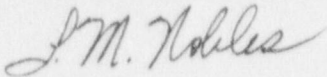
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/87057

The enclosed licensee event report provides details concerning a control room isolation that was inadvertently initiated due to an indeterminate cause during performance of a special test instruction. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.iv.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



L. M. Nobles
Plant Manager

Enclosure
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