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Sequoyah Nuclear Plant

November 20, 2009

10 CFR 50.73

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555-0001

Sequoyah Nuclear Plant, Units 1 and 2
Facility Operating License Nos. DPR-77 and DPR-79
NRC Docket Nos. 50-327 and 50-328

Subject: Licensee Event Report 327 and 328/2009-007-00, "Failure to Perform a Technical Specification Action within the Required Timeframe"

The enclosed Licensee Event Report provides details concerning an event where Sequoyah Nuclear Plant failed to perform a Technical Specification (TS) action within the required timeframe. This report is being submitted in accordance with 10 CFR 50.73(a)(2)(i)(B).

Respectfully,

Timothy P. Cleary

Enclosure:

cc: NRC Regional Administrator – Region II
NRC Senior Resident Inspector – Sequoyah Nuclear Plant

JE22
NRK

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Sequoyah Nuclear Plant (SQN) Unit 1	2. DOCKET NUMBER 05000327	3. PAGE 1 OF 5
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4. TITLE:
Failure to Perform a Technical Specification (TS) Action within the Required Timeframe

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
09	23	2009	2009	007	00	11	20	2009	SQN Unit 2	05000328
									FACILITY NAME	DOCKET NUMBER

9. OPERATING MODE 1	10. POWER LEVEL 100	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)							
		<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)				
		<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)				
		<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)				
		<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)				
		<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)				
		<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)				
		<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)				
		<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER				
		<input type="checkbox"/> 20.2203(a)(2)(vi)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A				

12. LICENSEE CONTACT FOR THIS LER

NAME Donald Sutton	TELEPHONE NUMBER (Include Area Code) 423-843-6539
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EIPX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EIPX

14. SUPPLEMENTAL REPORT EXPECTED

YES (If yes, complete 15. EXPECTED SUBMISSION DATE) NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On September 23, 2009, at 0346 Eastern daylight time (EDT), Diesel Generator (DG) set 2B-B was declared inoperable because of scheduled surveillance testing. SQN Units 1 and 2 entered Technical Specification (TS) 3.8.1.1, Action b. With one DG set inoperable, TS 3.8.1.1 Action b requires the remaining AC electrical power sources to be demonstrated operable. Specifically for the offsite circuits required to be operable by TS Limiting Condition for Operation (LCO) 3.8.1.1.a, Action b requires, within one hour, that each of the two independent circuits between the offsite transmission network and the Class 1E distribution system be demonstrated operable by verifying correct breaker alignment and indicated power availability. At 0630 EDT, it was discovered that the required action for offsite circuits had not been performed. The TS action was performed and demonstrated the offsite circuits were operable. The cause of this event has been determined to be inadequate oversight by the Operations unit supervisor for the assignment, performance, and verification of the TS action. Corrective actions include Operations procedure revisions to enhance verification and ownership of implementation of TS actions and counseling of the Operations personnel involved.

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17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

I. PLANT CONDITION(S)

Units 1 and 2 were operating in Mode 1 at approximately 100 percent power when the condition was identified.

II. DESCRIPTION OF EVENT

A. Event:

On September 23, 2009, at 0346 Eastern daylight time (EDT), Diesel Generator (DG) set 2B-B (EIS code EK) was declared inoperable because of scheduled surveillance testing. Technical Specification (TS) 3.8.1.1, Action b, was entered. At 0630 EDT, it was discovered that TS 3.8.1.1, Action b, for demonstration of the operability of the required offsite circuits had not been performed within the required one hour timeframe. With one DG set inoperable, TS 3.8.1.1 Action b requires the remaining AC electrical power sources to be demonstrated operable. Specifically for the offsite circuits required to be operable by TS Limiting Condition for Operation (LCO) 3.8.1.1.a, Action b requires, within one hour, that each of the two independent circuits between the offsite transmission network and the Class 1E distribution system be verified operable by verifying correct breaker alignment and indicated power availability. In addition, Action b requires determining the operable DG sets are not inoperable due to common cause failure or running the DG sets. On September 23, 2009, at 0645 EDT, the TS action was performed and demonstrated the offsite circuits were operable and that the operable DG sets were not inoperable due to common cause failure. On September 25, 2009, at 0645 EDT, DG set 2B-B was restored to operable status and operations personnel exited TS 3.8.1.1, Action b.

B. Inoperable Structures, Components, or Systems that Contributed to the Event:

None.

C. Dates and Approximate Times of Major Occurrences:

Date	Description
September 23, 2009, at 0346 EDT	DG set 2B-B was declared inoperable for scheduled surveillance testing.
September 23, 2009, at 0545 EDT	The surveillance testing was completed.
September 23, 2009, at 0630 EDT	It was discovered that TS 3.8.1.1, Action b, had not been performed.

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September 23, 2009, at 0645 EDT TS 3.8.1.1 Action b was completed for the offsite circuits and showed the offsite circuits were operable and that the operable DG sets were not inoperable due to common cause failure.

September 25, 2009, at 0645 EDT DG set 2B-B was restored to operable status and Operations personnel exited TS 3.8.1.1, Action b.

D. Other Systems or Secondary Functions Affected:

No other systems or secondary functions were affected by this event.

E. Method of Discovery:

The condition was discovered during Operations shift turnover.

F. Operator Actions:

Upon discovery of the failure, the operators performed LCO 3.8.1.1, Action b for the offsite circuits required to be operable by LCO 3.8.1.1.a.

G. Safety System Responses:

There were no safety system responses as a result of this condition.

III. CAUSE OF THE EVENT

A. Immediate Cause:

The immediate cause of this event was determined to be inadequate communication during the pre-job brief of the roles and responsibilities for the completion of TS action requirements that would be required when DG set 2B-B became inoperable.

B. Cause:

The cause was determined to be inadequate oversight by the Operations unit supervisor for the assignment, performance, and verification of completion of the TS action.

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17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

IV. ANALYSIS OF THE EVENT

Units 1 and 2 were operating in Mode 1 at approximately 100 percent power when the failure to perform the required action occurred. After declaring DG set 2B-B inoperable because of scheduled surveillance testing, TS 3.8.1.1, Action b, which required verifying the remaining AC electrical power sources were operable was not performed in the required timeframe for the required offsite circuits. The action was performed and verified that each of the independent circuits between the offsite transmission network and the Class 1E distribution system were operable.

V. ASSESSMENT OF SAFETY CONSEQUENCES

Based on the subsequent performance of the required TS actions by the operators and the resultant demonstration that the required offsite circuits were operable during the time period when DG set 2B-B was inoperable, this event did not adversely affect the health and safety of plant personnel or the general public.

VI. CORRECTIVE ACTIONS

A. Immediate Corrective Actions:

Upon discovery of the failure to perform the required TS action, the TS action was completed. The performance of the TS action demonstrated that the required offsite circuits were operable.

B. Corrective Actions to Prevent Recurrence: - The corrective actions are being managed by the Sequoyah Nuclear Plant corrective action program.

Operations personnel have been counseled concerning supervisory and oversight responsibility, TS actions performance and verification, and pre-job brief standards and expectations. Actions have been established to ensure operability of redundant equipment prior to entry into TS actions, revise appropriate Operations procedures to conduct independent verification of implementation of TS actions prior to entry and review applicable TS actions and assign a responsible owner at the pre-job brief.

VII. ADDITIONAL INFORMATION

A. Failed Components:

None.

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17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

B. Previous LERs on Similar Events:

A review of previous reportable events identified one previous similar event within the last three years. The same TS action was missed during a dual unit trip event in March 2009. The cause of the March event was attributed to divided operator focus in response to an unexpected plant transient. Corrective actions implemented after the March event would not have been expected to prevent this event from occurring.

C. Additional Information:

None.

D. Safety System Functional Failure:

This event did not result in a safety system functional failure.

E. Unplanned Scram with Complications:

This condition did not result in an unplanned scram with complications.

VIII. COMMITMENTS

None.