

Tennessee Valley Authority, Post Office Box 2000, Soddy-Dalsy, Tennessee 37379-2000.

Robert A. Fenech Vice President, Sequoyah Nuclear Plant

July 19, 1993

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET NO. 50-327 - FACILITY OPERATING LICENSE DPR-79 - LICENSEE EVENT REPORT (LER) 50-327/93016

The enclosed LER provides details concerning a manual Phase A isolation, an auxiliary building isolation, and containment ventilation isolation in accordance with plant procedures as a result of a fuel assembly not remaining upright after being released into position. This event is being reported in accordance with 10 CFR 50.73(a)(2)(iv) as an event that resulted in the manual actuation of an engineered safety feature.

Sincerely,

Pobert A. Fenech

Robert a. Feren

Enclosure cc: See page 2

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cc (Enclosure):

INPO Records Center Institute of Nuclear Power Operations 700 Galleria Parkway Atlanta, Georgia 30339-5957

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NRC Resident Inspector Sequoyah Nuclear Plant 2600 Igou Ferry Road Soddy-Daisy. Tennessee 37379-3624

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)				DOCKET NUMBE	R (2) PAGE (3)	
Sequoyah Nuclear Plant, Unit 1					12 17 11 OF 0 4	
FIFLE (4) A Phase A Isolation, Auxiliary	Building Isolati	on, and Conta	inment Vent	lation Isolati	ion Were	
Manually Initiated as a Result of Fuel A	Assembly Failing	to Remain in	an Upright !	osition After	Being Released	
EVENT DAY (5) LER NUMBER (6)	REPOR	T DATE (7)	OTHER FA	ACILITIES INVOL	VED (8)	
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OPERATING THIS REPORT IS SUBMITTE	D PURSUANT TO TH	E REQUIREMENT	S OF 10 CFR	5:		
MODE (Check one or more of	the following)(11)				
(9) [6] [20.402(b) [_[20.405(c)	XX 50.73((a)(2)(iv) [73.71		(b)	
POWER _ [20.405(a)(1)(i)	_[50.36(c)(1)	50.73((a)(2)(v) 73.71(c)	
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[[20.405(a)(1)(iv)]	[50.73(a)(2)(ii) [50.73(73(a)(2)(viii)(B) Text, NRC For		NRC Form 366A)	
[20.405(a)(1)(v)]	[50.73(a)(2)(ii	1) 50.73(a)(2)(x)			
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J. W. Proffitt, Compliance Licensing			6 1 5	8 4 3 1 -	- 6 6 5 1	
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ABSTRACT (Limit to 1400 spaces, i.e., app	proximately fifte	en single-spa	ace typewrit	ten lines) (16		

On June 19, 1993, at 1054 Eastern daylight time (EDT), during fuel loading activities, a fuel assembly immediately tilted over after being released into position. The fuel assembly came to rest against the south core baffle plate leaning at an angle approximately 18 degrees from vertical. At 1154 EDT, a Phase A isolation, auxiliary building isolation, and containment ventilation isolation were manually initiated in accordance with abnormal operating procedures in response to the fuel-handling event.

MRC Form 366A (6-89) *

U.S. NUCLEAR REGULATORY COMMISSION

Approved OMB No. 3150-0104 Expires 4/30/92

LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER I	NUMBER (6)	1	PAGE	(3)
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Sequoyah Nuclear Plant, Unit 1		IYEAR				
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TEXT (If more space is required, use additional NRC form 366A's) (17)

I. PLANT CONDITIONS

Unit 1 was in Mode 6 in a refueling outage with core-loading activities in progress with 43 fuel assemblies in the core.

II. DESCRIPTION OF EVENT

A. Event

On June 19, 1993, at 1054 Eastern daylight time (EDT), a fuel assembly immediately tilted over after being released into position. The fuel assembly came to rest against the south-core baffle plate leaning at an angle approximately 18 degrees from vertical. At 1154 EDT, a Phase A isolation, auxiliary building isolation (ABI), and a containment ventilation isolation (CVI) were manually initiated in accordance with abnormal operating procedures in response to the fuel-handling event.

B. Inoperable Structures, Components, or Systems That Contributed to the Event None.

C. Dates and Approximate Times of Major Occurrences

June 19, 1993	Core-loading activities were in progress with 43 fuel assemblies in the core.
June 19, 1993 at 1054 EDT	The next fuel assembly loaded immediately tilted over after being released into position.
June 19, 1993 at 1055 EDT	All fuel movement was stopped, the manipulator crane was positioned over the internals set-down area, and power was secured.
June 19, 1993 at 1154 EDT	A Phase A isolation, ABI, and CVI were manually initiated in accordance with abnormal operating procedures.

D. Other Systems or Secondary Functions Affected
None.

E. Method of Discovery

The fuel assembly was observed by Operations personnel during performance of core-loading activities.

NRC Form 366A (6-89) *

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Sequoyah Nuclear Plant, Unit 1	SEQUENTIAL REVISION	187
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TEXT (11 more space is required, use additional NRC Form 366A's) (17)

F. Operator Action

Upon discovery of the leaning fuel assembly, Operations personnel stopped all fuel movement, the manipulator crane was positioned over the internals set-down area, and power was secured. A notice of unusual event was declared and the a Phase A isolation, ABI, and CVI were manually initiated.

G. Safety System Response

The equipment required to operate after the manual Phase A isolation, ABI, and the CVI performed as expected.

III. CAUSE OF EVENT

Cause

The Phase A isolation, ABI and CVI were manually initiated in accordance with abnormal operating procedures following discovery of the leaning fuel assembly.

IV. ANALYSIS OF EVENT

Plant equipment required to operate after the manual Phase A isolation, ABI, and the CVI performed as expected. There was no radiological release as a result of the event and the event is bounded by the Final Safety Analysis Report. Therefore, it can be concluded that there were no adverse consequences to the plant personnel or to the public as a result of this event.

V. CORRECTIVE ACTION

A. Immediate Corrective Action

Upon discovery of the leaning fuel assembly, Operations personnel stopped all fuel movement, the manipulator crane was positioned over the internals set-down area, and power was secured. A Phase A isolation, ABI, and CVI were manually initiated.

B. Action to Prevent Recurrence

None

NRC Form 366A (6-89). •

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TEXT CONTINUATION

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Sequoyah Nuclear Plant, Unit 1		
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TEXT (If more space is required, use additional NRC Form 366A's) (17) VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

Although there have been previous engineered safety feature actuations (ESF), there were no previous similar reportable events associated with a fuel-handling event resulting in an ESF.

C. Other

The cause of the fuel-handling event was that the fuel-handling instruction was not completely followed when the fuel assembly was inappropriately unlatched from the manipulator crane. The refueling senior reactor operator relied on visual inspections and other indications rather than the required indication.

A contributing cause to this event was that the fuel-handling instruction did not contain sufficient criteria for determining when the fuel assembly could be unlatched.

The appropriate fuel-handling instruction has been revised to include appropriate criteria for unlatching of a fuel assembly.

VII. COMMITMENT

None.