Tennessee Valley Authority, Post Office Box 2000, Soddy-Daisy, Tennessee 37379-2000

Robert A. Fenech
Vice President, Sequoyah Nuclear Plant

July 30, 1993

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - DOCKET NOS. 50-327 AND 50-328 - FACILITY OPERATING LICENSES DPR-77 AND DPR-79 - LICENSEE EVENT REPORT (LER) 50-327/93017

The enclosed LER provides details of a technical specification (TS) limiting condition for operation action statement that was not complied with.

This event is being reported in accordance with 10 CFR 50.73(a)(2)(i)(b) as an operation prohibited by TSs.

Sincerely,

Robert A. Fenech

Robert A. Fenech

Enclosure
cc: See page 2

cc (Enclosure):

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NRC Form 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

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

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Sequoyah Nuclear Plant (SQN), Unit 1	0 5 0 0 0 3 2 7	1 OF 0 5

TITLE (4) Failure to Comply with Technical Specification Limiting Condition for Operation Action Statement and Notify NRC by Telephone Regarding the Auxiliary Building Fire Suppression System Being Nonfunctional

EVENT DAY (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)
									Sequoyah, Unit 2	0 5 0 0 0 3 2 8
0 6	2 1	9 3	9 3	0 1 7	0 0	0 7	3 0	9 3		0 5 0 0 0

OPERATING MODE (9)	6	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	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
C. H. Whittemore, Compliance Licensing	6 1 5 8 4 3 - 7 2 1 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
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On July 2, 1993, with Unit 1 in Mode 6 for the Cycle 6 refueling outage and Unit 2 in Mode 5 for a maintenance outage, it was discovered that a 24-hour telephone notification to NRC had not been carried out as required by Technical Specification (TS) Limiting Condition for Operation (LCO) 3.7.11.1 Action Statement (b)(2)(a). The TS requires that a backup suppression system be established and that NRC be notified any time the high pressure fire protection (HPFP) water suppression system is inoperable. A portion of the auxiliary building HPFP water suppression system had been taken out of service for a planned maintenance activity. Appropriate compensatory measures had been established. The cause of the event was personnel error because of an inadequate review of the LCO action statement. Upon discovery, the notification was made and an incident investigation was initiated. The maintenance activity was completed and the system was returned to service on July 3, 1993.

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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 for the Unit 1 Cycle 6 (U1C6) refueling outage (RFO) and Unit 2 was in Mode 5 for a maintenance outage.

II. DESCRIPTION OF EVENTS

A. Event

At approximately 1530 Eastern daylight time (EDT) on July 2, 1993, it was discovered that Limiting Condition for Operation (LCO) Action Statement 3.7.11.1.b.2 had not been completely complied with in that a notification to NRC, i.e., a 24-hour telephone call, had not been carried out as required by technical specifications (TSs). On June 21, 1993, Operations personnel tagged out a section of the auxiliary building high pressure fire protection (HPFP) system to allow maintenance to be performed on fire suppression piping. This section of piping contained several TS-required hose stations and sprinkler systems. LCOs 3.7.11.2 and 3.7.11.4 were entered, and compensatory measures in the form of fire watches and backup fire suppression were established at 2100 EDT on June 21, 1993, to reflect the hose stations and sprinkler systems being nonfunctional. LCO 3.7.11.1 for the fire protection suppression water system should also have been entered. However, the LCO was not entered, and the telephone call required by the LCO 3.7.11.1 action statement was not made. On June 22, 1993, at 1541 EDT, the day-shift assistant shift operations supervisor (ASOS) entered LCOs 3.7.11.1 and 3.7.11.4 to reflect an increased maintenance work scope; valves designated as isolation valves on the original action plan were leaking through. The LCO action statement requiring that NRC be notified by telephone was again not carried out. On July 2, 1993, when the day-shift shift operations supervisor (SOS) and Fire Protection Manager were discussing a related matter, the error was discovered. Upon discovery, the appropriate LCO action statement requirements were complied with.

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

None.

C. Dates and Approximate Times of Major Occurrences

June 21, 1993 at 2100 EDT	Initial hold tags were attached to isolation valves to isolate a section of piping that contained the pin hole leaks. LCOs 3.7.11.2 and 3.7.11.4 were entered. Appropriate compensatory measures were established. The telephone notification to NRC was not made because LCO 3.7.11.1 was not entered.

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

June 22, 1993 at 1541 EDT — An additional section of the fire suppression system was added to the original maintenance work order. LCOs 3.7.11.1 and 3.7.11.4 were entered for the additional section of the fire suppression system that was made nonfunctional. The telephone call was not made because this was considered an extension to the orginal LCOs.

June 22, 1993 at 1945 EDT — After reviewing the previous shift's log entry concerning the 3.7.11.1 entry and discussing the issue, the night shift ASOS entered 3.7.11.1 for the initial scope of maintenance activity. The LCO entry was noted as a late entry for June 21, 1993 (the telephone call was not made).

July 2, 1993 at 1000 EDT — The error of not making the telephone call on June 21, 1993, was discovered when two SOSs and the Fire Protection Manager were discussing the entry into LCO 3.7.11.1 for a similar issue.

July 2, 1993 at 1600 EDT — NRC was notified by telephone regarding the June 21, 1993, event where a section of the auxiliary building fire suppression system was taken out of service and rendered nonfunctional.

July 3, 1993 at 2048 EDT — After being repaired, the HPFP piping was returned to service, and LCOs 3.7.11.1, 3.7.11.2, and 3.7.11.4 were exited.

D. Other Systems or Secondary Functions Affected

None - No other system was involved.

E. Method of Discovery

The error was discovered when two SOSs and the Fire Protection Manager were discussing the entry of 3.7.11.1 for a similar issue.

F. Operation Action

Upon discovery of the error, the Operations Manager informed the appropriate personnel and notified NRC by telephone.

G. Safety System Responses

None - No safety system response was required.

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

III. CAUSE OF EVENT

A. Immediate Cause

The immediate cause of the event was the failure to comply with the LCO action statement in its entirety.

B. Root Cause

The root cause of this event is personnel error because of an inadequate review of the LCO action statement on the part of Operations' personnel.

C. Contributing Cause

TS 3.7.11.1 is written with the intent of notifying NRC when a major fire suppression header or pump is nonfunctional because of an unexpected loss of equipment or accident. However, literal compliance of the TS requires a 24-hour telephone call when any part of the fire suppression system (within the LCO description) is taken out of service and made nonfunctional even for a preplanned maintenance activity. The logic of this type of action is not consistent with the safety significance of the issue, nor with the action statements of other LCOs outside the Fire Protection arena.

IV. ANALYSIS OF EVENT

Maintenance was being performed via approved plant procedures with an action plan in effect. The appropriate TS LCO action statement compensatory measures were in place, with the exception of the 24-hour telephone call to NRC. Therefore, it can be concluded that there were no adverse consequences to plant personnel or to the public as a result of this event.

V. CORRECTIVE ACTIONS

A. Immediate Corrective Action

Upon discovery of the missed notification, NRC was informed by telephone of the condition of the fire suppression system in the auxiliary building and also of the missed notification. The telephone call was confirmed by facsimile on the next working day. Additionally, an incident investigation was initiated to determine the cause of the event and to formulate corrective action to prevent recurrence.

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

B. Corrective Action to Prevent Recurrence

The Operations Superintendent has issued a policy order to Operations personnel describing their responsibility to ensure TS compliance.

The Fire Protection Manager has submitted a training letter describing this event to Operations Training for issue to all ASOS/SOS personnel.

The Fire Protection Manager has submitted a TS change request to revise the fire protection TS action statement reporting requirements.

VI. ADDITIONAL INFORMATION

A. Failed Components

None - This was a planned work activity to repair through-the-wall pin hole leaks in the fire suppression piping.

B. Previous Similar Events

A search of the LER and the Nuclear Experience Review databases was conducted for previous or similar events. The results of this search revealed 29 items, only one of which occurred at SQN. This one item (LER 327/91014) was reviewed and found not to be relevant to the present event.

A search of the special reports generated at SQN from 1987 to the present was conducted. This search revealed that 112 reports had been submitted to NRC primarily for fire protection issues. Only 13 of the reports submitted to the commission involved TS LCO 3.7.11.1. Each of these 13 reports was reviewed for the purpose of establishing whether any of the reporting requirements had been untimely. Each and every report documented that the telephone and facsimile notifications had been timely and in compliance with the TS action statements.

In summary, this event can be classified as an isolated incident with no previous or similar issues involving corrective actions that could have or should have prevented this event.

VII. COMMITMENTS

None.