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Ken Powers  
Vice President, Sequoyah Nuclear Plant

May 20, 1994

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET  
NO. 50-327 - FACILITY OPERATING LICENSE DPR-77 - LICENSEE EVENT REPORT  
(LER) 50-327/94007

The enclosed LER provides details concerning a missed surveillance  
involving the monitoring of the reactor head flange leakoff system.

This event is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B)  
as an operation prohibited by plant technical specifications.

Sincerely,

Ken Powers

Enclosure

cc: See page 2

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cc (Enclosure):

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah Nuclear Plant (SQN), Unit 1 | DOCKET NUMBER (2) | PAGE (3) | 050003 | 27 | 10 | 05

TITLE (4) Missed Surveillance Associated With the Monitoring of the Reactor Head Flange Leakoff System

Table with columns: EVENT DAY (5), LER NUMBER (6), REPORT DATE (7), OTHER FACILITIES INVOLVED (8). Includes sub-headers for SEQUENTIAL, REVISION, FACILITY NAMES, and DOCKET NUMBER(S).

OPERATING MODE (9) | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following)(11) | 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) | XX 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: K. E. Meade, Compliance Licensing | TELEPHONE NUMBER: 615 843-7766 | AREA CODE: 615

Table for COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13). Columns: CAUSE, SYSTEM, COMPONENT, MANUFACTURER, TO NPRDS, REPORTABLE.

SUPPLEMENTAL REPORT EXPECTED (14) | EXPECTED MONTH | DAY | YEAR | SUBMISSION DATE (15) | YES (If yes, complete EXPECTED SUBMISSION DATE) | X | NO

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

On April 22, 1994, at 0043 Eastern daylight time, with Unit 1 in Mode 1 at approximately 30 percent rated thermal power, Operations personnel determined that Technical Specification (TS) Surveillance Requirement (SR) 4.4.6.2.1.e had not been met. This SR requires the reactor head flange leakoff system to be monitored at least once every 24 hours. On April 18, the reactor flange leakoff temperature indicator had drifted high. A main control room annunciator alarmed, alerting the operators of the high temperature condition. Operations personnel read the annunciator response procedure, verified that the indicated temperature increase was erroneous, and initiated a work request to repair the indicator. The annunciator response procedure also indicated that an evaluation of plant TS 3.4.6.2 and SR 4.4.6.2.1.e should be performed. The assistant shift operations supervisor inadvertently reviewed the wrong TS section and determined that the inoperable reactor flange leakoff temperature indicator had no impact on TSs. The cause of this event was personnel error. The Operations crew that declared the reactor head flange leakoff temperature indicator inoperable failed to perform an adequate review to determine the applicability of TSs. Personnel actions will be developed for the appropriate individuals involved in this event.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				PAGE (3)					
		YEAR	NUMBER	REVISION NUMBER	REVISION NUMBER						
Sequoyah Nuclear Plant (SQN), Unit 1	0500032794	0	0	7	0	0	0	2	OF	0	5

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

I. PLANT CONDITIONS

Unit 1 was in Mode 1 at approximately 30 percent rated thermal power.

II. DESCRIPTION OF EVENT

A. Event

On April 22, 1994, at 0043 Eastern daylight time (EDT), with Unit 1 in Mode 1 at approximately 30 percent rated thermal power, Operations personnel determined that Technical Specification (TS) Surveillance Requirement (SR) 4.4.6.2.1.e had not been met. This SR requires the reactor head flange leakoff system to be monitored at least once every 24 hours. This SR is routinely performed each midnight shift. Four days earlier, on April 18, the reactor flange leakoff temperature indicator had drifted high. A main control room annunciator alarmed, alerting the operators of the high temperature condition. Operations personnel read the annunciator response procedure, verified that the indicated temperature increase was erroneous, and initiated a work request to repair the indicator. The annunciator response procedure also indicated that an evaluation of plant TS 3.4.6.2 and SR 4.4.6.2.1.e should be performed. However, as a result of other control room activities, the assistant shift operations supervisor (ASOS) was detained from reviewing TSs for a short period of time. When the ASOS did review the TSs, the annunciator response procedure had been placed back in its storage location, and the ASOS reviewed the TSs from memory. The ASOS inadvertently reviewed the wrong TS section and determined that the inoperable reactor flange leakoff temperature indicator had no impact on TSs.

On April 22, a different ASOS assumed the midnight shift. In the process of reviewing a drawing deviation discovered during the repair of the subject temperature indicator, the ASOS determined that the SR for the reactor head flange leakoff system had not been met. The appropriate TS limiting conditions for operation were entered, and corrective actions were initiated. At 0203 EDT on April 22, the temperature indicator was declared operable, and the TSs were exited. This event is being reported in accordance with 10 CFR 50.73.a.2.i.B as an operation prohibited by plant TSs.

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

None.

C. Dates and Approximate Times of Major Occurrences

April 18, 1994 at 0150 EDT	The annunciator for the reactor flange leakoff temperature indicator alarmed, alerting Operations personnel of a high temperature indication. Operators reviewed the annunciator response procedure and determined that the high temperature reading was erroneous.
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Sequoyah Nuclear Plant (SQN), Unit 1	050032794	0	07	0	0	3	05

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

- April 18, 1994  
at 0155 EDT

The unit ASOS reviewed TSs to determine applicability. The ASOS inadvertently reviewed the wrong section of TSs and determined that TSs were not effected.
- April 21, 1994  
at 2300 EDT

A different ASOS assumed the midnight shift.
- April 22, 1994  
at 0030 EDT

After the review of a drawing deviation discovered during the repair of the subject temperature indicator, the ASOS determined that the SR associated with the reactor head flange leakoff system had not been met.
- April 22, 1994  
at 0043 EDT

The shift operations supervisor concurred that the missed surveillance had occurred. The appropriate TSs were entered.
- April 22, 1994  
at 0203 EDT

Maintenance personnel completed the repair of the subject temperature indicator. The appropriate TSs were exited.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

An ASOS discovered this condition upon the review of a drawing deviation associated with the repair of the subject temperature indicator.

F. Operator Actions

None.

G. Safety System Response

None.

III. CAUSE OF EVENT

A. Immediate Cause

The immediate cause of this event was the failure to perform local temperature readings associated with the reactor head flange leakoff system, once the subject temperature indicator was determined to be inoperable.



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											0	0
Sequoyah Nuclear Plant (SQN), Unit 1	050032734	0	0	7	0	0	0	0	0	4	0	5

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

B. Root Cause

The root cause of this event was personnel error. The Operations crew that declared the reactor head flange leakoff temperature indicator inoperable failed to perform an adequate review to determine the applicability of TSs.

IV. ANALYSIS OF EVENT

SR 4.4.6.2.1.e requires the reactor head flange leakoff system to be monitored at least once every 24 hours. The purpose of this surveillance is to ensure that the reactor coolant system (RCS) leakage limits specified in TS LCO 3.4.6.2 are within the allowable values.

Reactor head flange leakage drains into the reactor coolant drain tank (RCDT). Therefore, any leakage through this line would be evidenced by RCDT pressure, level, or temperature changes. Local annunciators at the auxiliary unit operator duty station provide an indication of the above RCDT parameters. The monitoring of the RCDT during the period that the subject temperature indicator was inoperable showed no abnormal changes in these parameters. Various other RCS leakage checks were being performed during this timeframe. These leakage checks would have also identified any leakage from the reactor head flange leakoff line. Therefore, there was no danger to the health and safety of the public as a result of this event.

V. CORRECTIVE ACTION

A. Immediate Corrective Action

Upon discovery of the missed surveillance, the appropriate TSs were entered. The repair of the subject temperature indicator was completed. The indicator was declared operable, and the appropriate TSs were exited.

B. Corrective Action to Prevent Recurrence

Personnel action will be developed for the appropriate individuals involved in this event.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

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TEXT CONTINUATION

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		YEAR	NUMBER	REVISION NUMBER	REVISION NUMBER	OF	PAGES						
Sequoyah Nuclear Plant (SQN), Unit 1	050003 27 9 4	--	0	0	7	--	0	0	0	5	OF	0	5

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

B. Previous Similar Events

A review of previous similar events identified 13 LERs that have been written since 1992 as a result of missed surveillances. None of the corrective actions associated with the previous events could have prevented this occurrence.

VII. COMMITMENT

Personnel actions will be developed by June 24, 1994, for the appropriate individuals involved in this event.