NRC Form 366 (5-92) | U.S. NUCLEAR REGULATORY COMMISSION | Approved OMB No. 3150-0104 Expires 5/31/95

LICENSEE EVENT REPORT (LER)

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Sequoyah Nuclear Plant (SQN), Unit 1	0 5 0 0 0 3 2 7	1 OF 1 4

TITLE (4) Three Events that were Granted Enforcement Discretion: Problems Encountered During a Modification to the 2A-A Diesel Generator Speed Controller, Problems with Unit 1 Vital Inverter 2-I, Oil System Problems with the Unit 2 Turbine-Driven Auxiliary Feedwater Pump

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)
1 2	1 4	9 4	9 4	0 1 6	0 0	0 1	1 2	9 5	SQN, Unit 2	0 5 0 0 0 3 2 8
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following)(11)					
POWER LEVEL (10)	1 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)	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	TELEPHONE NUMBER (AREA CODE)
J. Bajraszewski, Compliance Licensing	6 1 5 8 4 3 - 7 7 4 9

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
X	E F	J S	G 0 8 0	Y					

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 December 14, 1994, with Units 1 and 2 in power operation (Mode 1) at approximately 100 percent, it was determined that TVA should provide NRC notification for three events in accordance with 10 CFR 50.73. These events were previously granted enforcement discretion by NRC; therefore, they were not previously considered 10 CFR 50.73 reportable by TVA. The events are being reported as conditions that resulted in operations prohibited by technical specifications (TSs). The first event occurred on July 8, 1994. In this event, the TS allowable outage time (AOT) was exceeded as a result of problems encountered during modification of the 2A-A diesel generator speed controller. The second event occurred on October 2, 1994, when the TS AOT was exceeded for Unit 1 Vital Inverter 2-I. The inverter was out-of-service because of problems encountered during the performance of maintenance activities. The third event occurred on November 7, 1994, when the TS AOT was exceeded for the Unit 2 turbine-driven auxiliary feedwater (TDAFW) pump. The TDAFW pump was out-of-service because of problems with its oil system. In each event, the specific problems were resolved, and the equipment was tested, found acceptable, and returned to service.

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I. PLANT CONDITIONS

Event Nos. 1 and 2:

Unit 1 was in power operation at approximately 100 percent (Mode 1), and Unit 2 was in cold shutdown (Mode 5) in a refueling outage.

Event No. 3:

Unit 1 was in power operation at approximately 100 percent (Mode 1), and Unit 2 was in hot standby (Mode 3) in preparation for power operation following a refueling outage.

II. DESCRIPTION OF EVENT

A. Event

On December 14, 1994, it was determined that TVA should provide NRC notification for three events in accordance with 10 CFR 50.73. These events were previously granted enforcement discretion by NRC; therefore, the events were not previously considered 10 CFR 50.73 reportable by TVA. The events are being reported as conditions that resulted in operations prohibited by technical specifications (TSs).

Event No. 1:

On July 8, 1994, at 1956 Eastern daylight time (EDT), the TS allowable outage time (AOT) was exceeded for Diesel Generator (D/G) 2A-A (EIIS Code EK). On June 15, 1994, Phase 1 of the modification to the electronic speed controller (EIIS Code SC) was started for installation of the magnetic pickup, engine frame mounting bracket, and shielded cable between the engine and the control panels. On July 5, 1994, the D/G was removed from service for the implementation of Phase 2 of the modification (installation of the replacement load control panel, wiring modification, and postmodification/postmaintenance testing [PMT]). TS Limiting Condition for Operation (LCO) 3.8.1.1 was entered at that time. The modification was split into two phases to limit risk and LCO entry time. The modification was planned and scheduled for completion well within the 72-hour TS LCO AOT. During Phase 2 implementation, emergent problems were identified (design output errors and configuration errors for a current transformer).

Prior to exceeding the TS AOT, enforcement discretion of TS LCO 3.8.1.1 Action (a) was requested. The request was initiated because several problems were encountered during implementation of the modification, which made meeting the TS LCO action statement requirements unattainable. The request for a period of 41 hours was granted.

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After resolution of the problems, D/G 2A-A successfully passed the PMT and was declared operable at 0049 EDT on July 10, 1994.

Event No. 2:

On October 2, 1994, at 0641 EDT, the TS AOT was exceeded for Vital Inverter 2-I (EIIS Code EF). On October 1, 1994, Vital Inverter 2-I was removed from service for planned maintenance activities, and TS LCO 3.8.2.1 was entered. At 1330 EDT, the maintenance activity was field complete and the foreman discovered that the rectifier output breaker (EIIS Code BKR) had been tested instead of the direct current (DC) input breaker. A management decision was made to replace the untested DC input breaker with a qualified spare rather than test the breaker and risk breaker failure and challenge of the AOT.

After the spare DC input breaker was installed, the clearance was released and the inverter was energized. The inverter was observed to have no output. Troubleshooting was performed, and it was determined that the replacement DC input breaker had two auxiliary contacts wired incorrectly at the factory. This problem was corrected, and the inverter was reenergized. The alternating current (AC) output switch (EIIS Code JS) was closed to perform the PMT, at which time the switch mechanically failed. A replacement AC output device was located. Engineering began gathering test data in order to test the replacement AC output switch prior to installation. The replacement AC output device had a paper nomenclature tag attached to it calling it a "switch"; however, the catalog cross-referenced test data curves were applicable to molded-case circuit breakers. Plant and vendor drawings depicted the AC output switch as a breaker. The AC output switch was bench-tested to molded-case circuit breaker criteria, and the switch was destroyed.

Prior to exceeding the TS AOT, enforcement discretion of TS LCO 3.8.2.1 Action (b) was requested because of the unavailability of a replacement AC output switch, which made meeting the LCO action statement requirements unattainable. The request for a period of 24 hours was granted.

A replacement AC output switch was located at Watts Bar Nuclear Plant and was shipped to SQN. The switch was tested and installed in Vital Inverter 2-I. Vital Inverter 2-I successfully passed the PMT and was declared operable on October 2, 1994, at 1534 EDT.

Event No. 3:

On November 7, 1994, at 1852 Eastern standard time (EST), the TS AOT was exceeded for the Unit 2 turbine-driven auxiliary feedwater (TDAFW) pump (EIIS Code BA). Unit 2 entered Mode 3 on November 3, 1994, at 1852 EST. On November 4, 1994, after adequate steam conditions existed to allow the start of confirmatory testing of the TDAFW pump, TS LCO 3.7.1.2 was entered. An oil system problem associated with the outboard bearing housing was observed on November 6, 1994. The repair of this problem was required in order to be able to declare the pump operable.

Prior to exceeding the TS AOT, enforcement discretion of TS LCO 3.7.1.2 Action (a) was requested because of the time required to troubleshoot and repair the oil system. The request for a period of 72 hours was granted.

The oil problem was corrected, and the TDAFW pump was tested and declared operable at 1757 EST on November 10, 1994.

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

Event Nos. 1, 2, and 3:

None.

C. Dates and Approximate Times of Major Occurrences

Event No. 1:

April 29, 1994	A design change package for the modification of the D/G electronic speed control was issued.
June 8, 1994	The design change package was revised to incorporate late information from the vendor. The modification was planned for implementation in two phases to reduce risk and LCO entry time.
June 15, 1994	Phase 1 of the modification was started. The magnetic pickup, engine frame mounting bracket, and shielded cable between the engine and the control panels were installed.
July 5, 1994 at 1956 EDT	The 2A-A D/G was removed from service for Phase 2 of the planned modification, and LCO 3.8.1.1 was entered. Several problems were identified during implementation.

July 8, 1994	Enforcement discretion of TS 3.8.1.1 Action (a) was requested because the resolution of the emergent problems would result in D/G 2A-A being out-of-service beyond the TS AOT.
July 10, 1994 at 0049 EDT	The installation problems were resolved, the PMT was completed, and D/G 2A-A was returned to service. TS LCO 3.8.1.1 was exited.

Event No. 2:

October 1, 1994 at 0641 EDT	Vital Inverter 2-I was removed from service for planned maintenance activities, and LCO 3.8.2.1 was entered.
October 1, 1994 at 1330 EDT	The maintenance activity was "field complete," and the foreman discovered that the rectifier output breaker had been tested instead of the DC input breaker.
October 1, 1994 at approximately 2000 EDT	The new DC input breaker was installed, and the inverter was energized. The inverter was observed to have no output. Troubleshooting was performed, and it was determined that the replacement DC input breaker had two auxiliary contacts wired incorrectly.
October 1, 1994 at approximately 2300 EDT	The DC input breaker wiring was corrected, and the inverter was reenergized.
October 1, 1994 at 2330 EDT	The AC output switch failed mechanically.
October 2, 1994 at approximately 0300 EDT	The replacement AC output switch was bench-tested to molded-case circuit breaker criteria, and the switch was destroyed.
October 2, 1994 at approximately 0645 EDT	Discretionary enforcement of TS LCO 3.8.2.1 was requested because of the unavailability of a replacement AC output switch, which made meeting the LCO action statement requirements unattainable. The request for a period of 24 hours was granted.
October 2, 1994 at 1534 EDT	A replacement AC output switch was located, tested, and installed in Vital Inverter 2-I. Vital Inverter 2-I was declared operable.

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Event No. 3:

November 3, 1994 at 1852 EST	Unit 2 entered Mode 3 following a refueling outage.
November 4, 1994 at approximately 1800 EST	Adequate steam conditions existed to begin the required confirmatory testing of the turbine-driven AFW pump.
November 4, 1994 at 1852 EST	Unit 2 entered TS LCO 3.7.1.2.
November 6, 1994 at approximately 1630 EST	A lubricating oil system problem was observed on the TDAFW pump during performance of the PMT for the pump's level-control valves.
November 7, 1994 at approximately 1200 EST	Following replacement of the lubricating oil and checking the oil system for blockages, additional tests were performed to check for oil leakage. No leakage was found, but the oil level in the sight glass dropped below the low-level mark.
November 7, 1994 at approximately 1700 EST	Enforcement discretion of TS LCO 3.7.1.2 Action (a) was requested because of the time required to troubleshoot, repair, and test the pump. The request for a period of 72 hours was granted.
November 7, 1994 at approximately 1900 EST	The oil system relief valve was replaced, oil piping was disassembled and inspected, and a tygon hose was installed to facilitate direct observation of the oil level. Drain line fittings were taped to preclude air induction, and system troubleshooting continued.
November 9, 1994 at approximately 0428 EST	The oil system equalizer pipe was reworked to add slope.
November 9, 1994 at approximately 1934 EST	The oil pressure relief valve setpoint was reduced from 15 pounds per square inch gauge (psig) to 10 psig.
November 10, 1994 at approximately 0230 EST	A larger (1 1/2-inch) oil drain pipe was installed on the governor end, and a vent was installed in the drain line.

November 10, 1994 at approximately 0355 EST	The TDAFW pump was operated for approximately 40 minutes with no oil level problems.
November 10, 1994 at approximately 0830 EST	American Society for Mechanical Engineers Section XI pump testing was started. The TDAFW pump operated for approximately two hours with no oil level fluctuations.
November 10, 1994 at approximately 1100 EST	A full flow test was performed. The test duration was approximately 15 minutes. No problems were observed.
November 10, 1994 at 1757 EST	The TDAFW pump was declared operable, and LCO 3.7.1.2 was exited.

D. Other Systems or Secondary Functions Affected

No other systems or secondary functions were affected by the three events.

E. Method of Discovery

Event No. 1:

During modification activities on D/G 2A-A, it was determined that the activity could not be completed within the TS AOT. Therefore, enforcement discretion was requested, and the LCO timeframe was exceeded.

Event No. 2:

During planned maintenance activities on Vital Inverter 2-I, it was determined that the activity could not be completed within the TS AOT. Therefore, enforcement discretion was requested, and the LCO timeframe was exceeded.

Event No. 3:

During PMT activities associated with TDAFW pump level control valves, a problem was discovered with the TDAFW pump lubricating oil system and it was determined that troubleshooting, repair, and testing could not be completed within the TS AOT. Therefore, enforcement discretion was requested, and the LCO timeframe was exceeded.

F. Operator Actions

No operator actions were required for the three events.

G. Safety System Responses

No safety system responses were required for the three events.

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III. CAUSE OF EVENT

A. Immediate Cause

Event No. 1:

The immediate cause of the condition was that D/G 2A-A could not be returned to service within the TS AOT because of the time required to resolve emergent modification implementation problems. An event review of the modification identified seven problems that contributed to the extension of the AOT.

Event No. 2:

The immediate cause of the event was the unavailability of a replacement AC output switch, which made meeting the LCO action statement requirements unattainable.

Event No. 3:

The immediate cause of the event was the unavailability of the TDAFW pump as a result of an oil system problem. The time necessary to conduct the troubleshooting, repair, and testing necessary to declare the pump operable resulted in the extension of the AOT.

B. Root Cause

Event No. 1:

The root cause of the condition was inadequate implementation of applicable existing procedures and processes with the major cause being inadequate recurrence control for a previous similar event.

Previous event problems with current transformer (CT) polarity in the load control circuit were identified. At that time, the deficiency was corrected by switching the CT leads, following discussion with the vendor. During a subsequent surveillance instruction performance, it was determined that the reverse-acting load sensor was defective and was replaced with a forward-acting sensor. The CT leads were reversed, restoring the wiring to the original configuration, and a condition adverse to quality (CAQ) document was initiated to address the condition on the other diesels. The associated drawings were revised based on closure of the CAQ action for replacement of the sensors in the action item tracking system. However, instead of replacing the sensors, the CAQ action had been revised to place tags on the components with a reference to the CAQ. As a result, a configuration error was unknowingly introduced.

Event No. 2:

The root cause of this event was unforeseen equipment failure of the AC output switch as a result of testing the switch as a breaker. The replacement AC output device had a paper nomenclature tag attached to it calling it a "switch"; however, the catalog cross-referenced to test data curves applicable to molded case circuit breakers. Plant and vendor drawings depicted the AC output switch as a breaker. The AC output switch was bench tested to molded-case circuit breaker criteria, and the switch was destroyed.

Event No. 3:

The root cause of this condition was an inherent design condition that resulted in air entrapment in the TDAFW pump lubrication oil. Air entrapment in the oil system was forcing oil out the outer bearing housing. This subsequent loss of oil resulted in the inoperability of the TDAFW pump.

C. Contributing Factors

Event No. 1:

The contributing factors to this event were design errors and the lack of a questioning attitude by the walkdown participants.

The design for the speed-control modification contained an inherent error because of the configuration error. However, the PMT identified other errors to the design. A review of these errors indicated that they were a result of inadequate error-detection practices.

During the premodification walkdown, participants should have seen the tag referencing the CAQ and evaluated the potential hardware impact to the modification. As a result of the lack of a questioning attitude by the walkdown participants, the reversed CT polarity was not identified until the performance of the PMT.

Event No. 2:

There were three contributing factors to this event. The first factor was the testing of the wrong breaker. This was determined to be personnel error resulting from inadequate management involvement. The prejob briefing performed by the foreman was lacking in sufficient detail for the complexity and urgency of this task. Field supervision of this task was also inadequate. The second factor was that the TVA drawing utilized did not provide sufficient detail to positively locate the input circuit breaker. Therefore, the rectifier output breaker was mistakenly tested as the input

breaker. The third factor was inadequate drawings and inadequate vendor information. The vendor failed to provide sufficient information to differentiate between the vendor's molded-case switches and their molded-case circuit breakers.

Event No. 3:

There were no contributing factors for this event.

IV. ANALYSIS OF EVENT

Event No. 1:

The operability of AC power sources during plant operation ensures power availability to safety-related equipment for (1) the safe shutdown of the facility and (2) the mitigation and control of accident conditions within the facility. Four separate and independent D/G sets are required to be operable. The removal of the 2A-A D/G from service affects the following common systems that are necessary to support Unit 1 operation in the event of a loss of offsite power: one essential raw cooling water (ERCW) pump on the "A" train header, one train of ventilation for the electric board areas and the auxiliary building motor-driven auxiliary feedwater area coolers, one train of the auxiliary building gas treatment system, and Vital Battery Exhaust Fan I.

In the unlikely event of a loss of offsite power, the redundant train capability was available for all of the affected functions. Additionally, emergency capability is provided in the design to cross-train the ERCW headers and the shutdown board electrical distribution centers. Since the affected functions are support functions, immediate availability is not necessary to mitigate design basis events. Sufficient time would have been available to establish and implement the appropriate controls to effectively utilize the available cross ties under extreme conditions (loss of offsite power, design basis events, and failure of the other emergency power trains or equipment).

Therefore, the condition did not adversely affect the health and safety of plant personnel or the general public.

Event No. 2:

The operability of AC and DC power sources and electrical distribution systems during plant operation ensures power availability to safety-related equipment for (1) the safe shutdown of the facility and (2) the mitigation and control of accident conditions within the facility.

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The 2-I vital inverter serves 120-volt (V) AC vital instrument power board (IPB) 2-I. The 2-I IPB was energized to the alternate feed when the inverter was removed from service. The alternate feed is not considered a qualified source only because power is interrupted while the electrical boards are being loaded on the D/Gs in the event of a loss of AC power.

The loads served by 120-V AC Vital IPB 2-I were reviewed, and no components were identified that could impact Unit 1 operation. Although initial reviews identified some components associated with systems common to both units (e.g., ERCW and component cooling system), further reviews showed that the specific components would have only affected Unit 2 operation, given the plant configuration.

In addition, a nonqualified output breaker was installed to allow the inverter to remain warm during the extended outage. Should a loss of AC event have occurred, Operations could close the AC output breaker for Vital Inverter 2-I.

Therefore, the condition did not adversely affect the health and safety of plant personnel or the general public.

Event No. 3:

The operability of the auxiliary feedwater (AFW) system ensures that the reactor coolant system can be cooled down to less than 350 degrees Fahrenheit from normal operating conditions in the event of a total loss of offsite power. The TDAFW pump provides an additional AFW source independent from the two motor-driven AFW pumps.

Since Unit 2 was returning from a refueling outage, the core decay heat at that time was low, approximately 1.26 megawatt thermal (MWT) or approximately 0.04 percent of the plant thermal rating. In the unlikely event of a main feedwater line break, it was determined that the existing steam generator inventories of the intact steam generators were adequate to maintain the reactor coolant system at or below normal operating temperature and pressure for Mode 3 operation for the first ten minutes of the accident. After that time, the analysis assumes that the faulted steam generator is isolated, and subsequently, only 20 gallons per minute of AFW flow is necessary to remove the decay heat. This flow rate is well within the capability of one motor-driven AFW pump. Both motor-driven AFW pumps were operable.

The station blackout (SBO) analysis was not affected by the inoperable TDAFW pump because sufficient decay heat removal was available during the 4-hour SBO period by the existing inventory in the steam generators. It was estimated that the steam generators would not boil dry for approximately 100 hours based on 1.26 MWT.

Therefore, the condition did not adversely affect the health and safety of plant personnel or the general public.

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V. CORRECTIVE ACTIONS

A. Immediate Corrective Actions

Event No. 1:

Immediate actions were taken to resolve the hardware problems that were identified during the modification.

Event No. 2:

A replacement AC output switch was located, tested, and installed in Vital Inverter 2-1. Vital Inverter 2-1 was declared operable and was returned to service.

Event No. 3:

The modification increasing the size of the governor end bearing housing drain line from 1 inch to 1 1/2 inches and the addition of the vent to this piping resolved the oil leak problem.

B. Corrective Action to Prevent Recurrence

Event No. 1:

An independent review of the modification package was performed to identify and correct any other potential design errors to minimize the diesel outage impact. As a result of the review, no additional problems impacting the modification were identified.

The modification of the 2B-B diesel for replacement of its speed-control module, which was scheduled to start after completion of the 2A-A diesel, was rescheduled to the end of the Unit 2 Cycle 6 outage so that lessons learned could be incorporated.

The drawings for the other diesels were revised to correct the configuration error. Also, an extent of condition review was performed to identify other corrective actions that may have been resolved by the use of a tag to identify the CAQ condition, and no other occurrences were identified.

A review of the Electrical Engineering checking and verification process was performed to determine if process changes were needed, and none were identified. Management expectations were communicated to Engineering personnel on the use of closures in the action item tracking system as input to changing design information. The lessons learned by this event regarding attention to detail in checking and the thoroughness of walkdowns were communicated to Electrical Engineering personnel.

Event No. 2:

Managerial requirements and supervisory techniques have been stressed to Maintenance supervision, including a review of this issue with the Maintenance department managers. Additionally, Maintenance employees have been cautioned regarding the potential problems associated with the acceptance of inadequate prejob briefings.

The appropriate plant drawings will be revised to identify the location of input and output circuit breakers. Also, applicable plant and vendor drawings will be revised, as appropriate, to differentiate the AC molded-case switch from a molded-case circuit breaker.

Event No. 3:

There are no corrective actions necessary to prevent recurrence on Unit 2 in addition to the actions already taken. The Unit 1 turbine-driven auxiliary feedwater pump was modified with the larger drain line and the addition of the vent. An industry nuclear network entry was made to alert other utilities of the potential condition.

VI. ADDITIONAL INFORMATION

A. Failed Components

Event Nos. 1 and 3:

None.

Event No. 2:

The AC output switch had an unforeseen equipment failure. The switch was a General Electric Model No. TQD22Y225.

B. Previous Similar Events

Event Nos. 1, 2, and 3:

No previous similar events were identified where enforcement discretion was granted and the event was reported as an LER.

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VII. COMMITMENTS

Event Nos. 1 and 3:

None.

Event No. 2:

Commitments associated with this event were provided as a response to Notice of Violation No. 50-327, 328/94-34-01, dated December 22, 1994. No additional commitments are required.