



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

J. L. Wilson
Vice President, Sequoyah Nuclear Plant

June 26, 1992

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

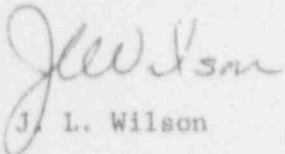
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET
NO. 50-... - FACILITY OPERATING LICENSE DPR-79 - LICENSEE EVENT REPORT
(LER) 50-328/92003, REVISION 1

The enclosed LER is being revised to provide details concerning the cause of an inoperable mechanical snubber. This LER was reported on April 27, 1992, in accordance with 10 CFR 50.73(a)(2)(i) as a condition that resulted in an operation prohibited by plant technical specifications.

Revisions to the LER are annotated by vertical bars in the right-hand margin.

Sincerely,


J. L. Wilson

Enclosure
cc: See page 2

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U.S. Nuclear Regulatory Commission
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cc (Enclosure):

INPO Records Center
Institute of Nuclear Power Operations
1100 Circle 75 Parkway, Suite 1500
Atlanta, Georgia 30339

Mr. D. E. LaBarge, Project Manager
U.S. Nuclear Regulatory Commission
One White Flint, North
11555 Rockville Pike
Rockville, Maryland 20852

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

Mr. B. A. Wilson, Project Chief
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah Nuclear Plant, Unit 2 DOCKET NUMBER (2) PAGE (3)
050003 12 18 110 4

TITLE (4)
Inoperable Mechanical Snubber

EVENT DAY (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)																
MONTH	DAY	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES			DOCKET NUMBER (5)														
0	3	2	7	9	2	9	2	0	0	3	0	1	0	6	2	6	9	2	0	5	0	0	0	1	1

OPERATING MODE (9) THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following)(11)

16	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
10	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)
10	20.405(a)(1)(iii)	XX 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
10	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
10	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
Jar. 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

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)

This LER is being revised to provide details concerning the cause of an inoperable mechanical snubber. On March 27, 1992, at approximately 0750 Eastern standard time, with Unit 2 in a refueling outage (Cycle 5), a snubber was observed to be disconnected from the pipe clamp, and various support attachment bolts were found loose or missing. This condition was detected during performance of a surveillance instruction on an adjacent snubber. Investigation has concluded that the snubber was in the inoperable condition since the previous Unit 2 refueling outage (Cycle 4), at which time the snubber was disconnected to facilitate reactor coolant pump No. 3 main flange retensioning. This event was the result of a temporary employee failing to follow procedure requirements by inadequately documenting work configuration during performance of a work request. An engineering analysis was performed demonstrating that plant safety and operability were not adversely affected by the condition. A work request was initiated and completed, correcting the condition. Prior to discovery of this event, work processes and controls were strengthened for staff augmentation (temporary) personnel. The event in this LER occurred prior to implementation of these actions.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	NUMBER	NUMBER			
Sequoyah Nuclear Plant Unit 1		1992	03	03	01	02	04

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

I. PLANT CONDITIONS

Unit 2 was in Mode 6, in the process of refueling.

II. DESCRIPTION OF EVENT

A. Event

At approximately 0750 Eastern standard time (EST) on March 27, 1992, with Unit 2 in a refueling outage (Cycle 5), a snubber (EIIIS Code SNB) was observed to be disconnected from the pipe clamp, and various support attachment bolts were loose or missing. Through investigation of Cycle 5 and Cycle 4 work activities, it was determined that the snubber had been in the inoperable condition since the previous Unit 2 refueling outage (Cycle 4), at which time the snubber was disconnected to facilitate reactor coolant pump No. 3 main flange retensioning.

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

None.

C. Dates and Approximate Times of Major Occurrences

September 19, 1990	The snubber was disassembled to facilitate reactor coolant pump (RCP) main flange retensioning.
October 14, 1990	A work document indicates that the snubber was reinstalled.
March 13, 1992	Unit 2 Cycle 5 refueling outage began.
March 27, 1992 at 0750 EST	Snubber mark No. 2-CVCH-931 was observed to be disconnected from the pipe clamp, and various pipe support attachment bolts were loose or missing.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

The condition of snubber mark No. 2-CVCH-931 was discovered during performance of a surveillance instruction on an adjacent snubber.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	NUMBER	NUMBER			
Sequoyah Nuclear Plant Unit 1	05000328	92	03	01	01	01	4

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

F. Operator Actions

No operator action was required; the unit was in Mode 6 (in process of refueling), and operability of the RCP seal leakoff piping was not required.

G. Safety System Responses

Not applicable - no safety system responses were required.

II.. CAUSE OF THE EVENT

A. Immediate Causes

The immediate cause of this event was that the snubber was removed in accordance with a work request and was not reinstalled following maintenance activities.

B. Root Cause

This event was the result of a temporary employee failing to follow procedure requirements by inadequately documenting work configuration during performance of a work request.

C. Contributing Factors

None could be identified.

IV. ANALYSIS OF THE EVENT

The potential consequence of an inoperable snubber is an increase in the probability of structural damage to piping or components, as a result of a seismic or other event initiating dynamic loads. An engineering analysis was performed, demonstrating that the piping system (including pipe stresses, loads on other pipe supports, nozzle loads on the RCP, and valve accelerations) remained within allowable limits for this specific condition. Therefore, plant safety and operability were not adversely affected by the condition.

V. CORRECTIVE ACTIONS

A. Immediate Corrective Actions

The pipe snubber and associated support were restored to an operable condition.

A field walkdown of 16 other snubbers installed on the No. 1 seal leakoff and the No. 1 seal bypass piping at all four reactor coolant pumps was performed. The other snubbers were found properly installed.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)			
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER				
Sequoyah Nuclear Plant Unit 1	0150100328	1982	003	0	1	0	4	0

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

B. Corrective Action to Prevent Recurrence

Prior to discovery of this event, the following actions were taken:

1. Maintenance personnel have been briefed on the importance of following work instructions, of maintaining the configuration change log, and of accuracy of verification.
2. Additionally, controls and work processes have been strengthened for staff augmentation (temporary) personnel by assessment of personnel that will be temporarily set up to supervisory levels and issuance of a site maintenance management directive that addresses control of temporary work forces.

The event in this LER occurred prior to implementation of the above actions.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

A review of previous events identified one LER associated with snubber operability. LER 327/88040 addressed the failure to ensure operability of a safety-related snubber during unit Modes 1 through 4. This condition was found during closure review of a work document and was attributed to scheduling inadequacies. The corrective action of LER 327/88040 would not have prevented the event described in this LER since scheduling of the work document was not a problem.

A previous reportable event, LER 50-327/91025, concerning the inoperability of the Unit 1 main steam isolation valves, contained causes or contributing factors similar to those noted in the investigation of this event, i.e., proper configuration control and control of temporary workers. The actions of LER 50-327/91025 directly address the root cause of this event and should prevent recurrence. The event in this LER occurred prior to implementation of the actions described by LER 50-327/91025.

VII. COMMITMENTS

None.