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J. L. Wilson
Vice President, Sequoyah Nuclear Plant

July 9, 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. 50-328 - FACILITY OPERATING LICENSE DPR-79 - LICENSEE EVENT REPORT (LER) 50-328/92006

The enclosed LER provides details concerning a failure to perform a surveillance instruction for verification of boron concentration in a cold leg accumulator within the required timeframe. This event is being reported in accordance with 10 CFR 50.73(a)(2)(i) as an operation prohibited by technical specifications.

Sincerely,

J. L. Wilson

Enclosure
cc: See page 2

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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)

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TITLE (4) Failure to Perform a Surveillance Instruction Within the Required Time Frame

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)
0 6	0 9	9 2	9 2	0 0 6	0 0	0 7	0 9	9 2		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)
Jan 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)

On June 9, 1992, at approximately 1750 Eastern daylight time, with Unit 2 in power operation at approximately 100 percent, the operator at the controls (OAC) determined that a surveillance instruction (SI) for verification of boron concentration in the cold leg accumulator had not been performed within the timeframe required by technical specifications. The missed SI was identified during routine performance of the control room shift log surveillance instruction when the OAC observed that a cold leg accumulator level increase had occurred during a previous shift, and boron concentration had not been verified. The SI was not performed within time limits because of inadequate communications and follow-up. Upon discovery of the missed SI, Operations immediately entered Limiting Condition for Operation (LCO) 3.5.1.1.a and notified the Radiochemistry Laboratory to verify boron concentration in the accumulator. The cold leg accumulator was sampled, boron concentration was found well within technical specification requirements, and the LCO was exited.

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

I. PLANT CONDITIONS

Unit 2 was in power operation at approximately 100 percent.

II. DESCRIPTION OF EVENT

A. Event

On June 9, 1992, at approximately 1750 Eastern daylight time (EDT), the operator at the controls (OAC) determined that a surveillance instruction (SI) for verification of boron concentration in the No. 4 cold leg accumulator (CLA) (EIIS Code BP) had not been performed within the timeframe required by technical specifications (TSs). The missed SI was discovered during routine performance of the control room shift log SI when the OAC observed that a cold leg accumulator level increase had occurred during a previous shift, and boron concentration had not been verified in accordance with Surveillance Requirement (SR) 4.5.1.1.1.b. This SR required verification of boron concentration within six hours of solution volume increase of greater or equal to one percent of the tank volume.

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

None.

C. Dates and Approximate Times of Major Occurrences

June 9, 1992 at 0230 EDT	During performance of the shift log SI, the OAC observed that the No. 4 CLA level had increased by 100 gallons. The OAC contacted the Radiochemistry Laboratory and requested performance of an SI to verify boron concentration.
June 9, 1992 at 0816 EDT	The day shift OAC assumed shift.
June 9, 1992 0816-1200 EDT	The day shift OAC performed the shift log SI, recording a level increase of greater than 100 gallons, and did not recognize additional action was required.
June 9, 1992 at 1636 EDT	The evening shift OAC assumed shift.
June 9, 1992 at 1750 EDT	During performance of the shift log, the OAC determined that the No. 4 CLA level increased by more than 100 gallons, performed further review, and determined that an SI had been missed. Limited Condition for Operation (LCO) 3.5.1.1.a was entered.

June 9, 1992 at 1840 EDT — Boron concentration for the No. 4 CLA was determined to be well within the TS limits (2,536 parts per million [ppm]), and LCO 3.5.1.1.a was exited.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

The missed SI was discovered during routine performance of the control room shift log SI when the OAC observed that a cold leg accumulator level increase had occurred during a previous shift, and boron concentration had not been verified.

F. Operator Actions

Upon discovery of the missed SI, LCO 3.5.1.1.a was entered, and the OAC requested the Radiochemical Laboratory to perform the SI.

G. Safety System Responses

Not applicable - no safety system responses were required.

III. CAUSE OF THE EVENT

A. Immediate Causes

The immediate cause of the event was a result of inadequate communications between Operations and Chemistry personnel. From the investigation, no record could be identified indicating Chemistry's receipt of the request to sample the CLA. The investigation identified that when Operations called the Radiochemistry Laboratory to request a CLA sample, key information such as the urgency of the sample was not communicated, and verbatim repeat-back was not used, as is required by site procedure.

B. Root Cause

The root cause of the event was determined to be of a lack of formality in oral and written communications. The OAC did not enter the level increase in the daily journal and did not follow-up the request to Chemistry to ensure performance of sampling and analysis by the Chemistry personnel.

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C. Contributing Factors

As a result of the lack of formality in communications, the need for action was not identified in the shift turnover for either the Operations or Chemistry organizations. The relief OAC did not properly review data and, therefore, did not recognize that additional action was required.

IV. ANALYSIS OF THE EVENT

The CLAs are designed to ensure that a sufficient volume of borated water will be forced into the core in the event of a large line break. Subsequent analysis determined that the boron concentration was 2,536 ppm, well above the TS limit of 2,400 ppm. Therefore, there was no impact as a result of the level increase. The missed SI did not have an adverse effect on the health and safety of plant personnel or the public.

V. CORRECTIVE ACTION

A. Immediate Corrective Actions

The immediate corrective action was to perform the SI to determine if the CLA boron concentration was acceptable.

B. Corrective Action to Prevent Recurrence

The importance and necessity for rigorous, consistent application of operational tools (communications, turnover, and journal-keeping) has been reemphasized.

Appropriate disciplinary action has been taken with the involved individuals.

Additionally, the Operations manager and Operations superintendent will monitor operator performance and determine effectiveness.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

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

B. Previous Similar Events

A review of previous events identified one LER (50-328/88011) associated with the failure to perform an SI within the applicable timeframe for verification of RA boron concentration. The cause of this event was a result of a misinterpretation of the TS requirements. The actions of training and procedure enhancement would not have prevented the current event.

Other SQN events involving operator performance have been reported (e.g., LER 50-327/91015, "Fire Watch Patrol was Not Performed Because of Inadequate Shift Turnover," LER 50-327/92006, "Failure to Properly Verify Reactor Coolant System Flow Above TS Limits," and LER 50-328/92007, "Entry into Mode 4 Operation Without Two Operable Containment Spray Systems Caused by Inadequate Configuration Control"). Corrective actions for these events, with the exception of LER 50-328/92007, involved correcting specific aspects of Operations' administrative processes without an integrated review of the process and implementation. Past corrective actions did not prevent the event discussed in this report because of the narrow scope of the actions. Collectively, the generic issue of inadequate communications, turnover, and journal-keeping by the Operations staff is being addressed by actions identified in LER 50-328/92007. The actions of LER 50-328/92007 have been initiated; however, insufficient time had passed at the time of this event to realize the full effects. Implementation of those actions should prevent recurrence of the current event.

VII. COMMITMENTS

None.