

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 2 7	PAGE (3) 1 OF 0 4
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Personnel Not Properly Implementing Approved Administrative Procedure Resulting In Inappropriately Exiting A Technical Specification Action Statement on Radiation Monitor

EVENT DATE (5) MONTH: 01, DAY: 16, YEAR: 88	LER NUMBER (6) SEQUENTIAL NUMBER: 005, REVISION NUMBER: 00	REPORT DATE (7) MONTH: 02, DAY: 12, YEAR: 88	OTHER FACILITIES INVOLVED (8) Sequoyah, Unit 2	DOCKET NUMBER (5) 0 5 0 0 0 3 2 8
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OPERATING MODE (9) 5	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	20.405(a)(1)(i) <input type="checkbox"/>	20.405(c) <input type="checkbox"/>	50.73(a)(2)(i) <input type="checkbox"/>
	20.405(a)(1)(ii) <input type="checkbox"/>	50.36(a)(1) <input type="checkbox"/>	50.73(a)(2)(iv) <input type="checkbox"/>
	20.405(a)(1)(iii) <input type="checkbox"/>	50.36(a)(2) <input type="checkbox"/>	50.73(a)(2)(vii) <input type="checkbox"/>
	20.405(a)(1)(iv) <input type="checkbox"/>	XX 50.73(a)(2)(i) <input checked="" type="checkbox"/>	50.73(a)(2)(viii)(A) <input type="checkbox"/>
	20.405(a)(1)(v) <input type="checkbox"/>	50.73(a)(2)(ii) <input type="checkbox"/>	50.73(a)(2)(viii)(B) <input type="checkbox"/>
	20.405(a)(1)(vi) <input type="checkbox"/>	50.73(a)(2)(iii) <input type="checkbox"/>	50.73(a)(2)(ix) <input type="checkbox"/>

LICENSEE CONTACT FOR THIS LER (12) NAME: R. E. Kilgore, Plant Operations Review Staff	TELEPHONE NUMBER AREA CODE: 615, NUMBER: 871 0171
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CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14) <input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15) MONTH: , DAY: , YEAR:
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On January 16, 1988, at approximately 1700 EST, it was discovered that the Turbine Building sump release line radiation monitor (RM) was inappropriately declared operable on January 15, 1988, at 1400 EST, and the technical specification (TS) action statement was exited. At the time of the discovery, units 1 and 2 were in mode 5 (0 percent power, 4 psig, 124 degrees F and 0 percent power, 90 psig, 123 degrees F, respectively).

The Turbine Building sump release line RM was declared inoperable on January 5, 1988, to clean the sample line. The applicable TS action statement was entered, at that time, which required grab samples to be taken for total gamma analysis at least once every 12 hours.

On January 11, a second job was started to repair the RM after failing its surveillance test. The RM job was completed and functionally tested satisfactory on January 15. The control room operators (CRO) subsequently declared the RM operable and exited the TS action statement.

On January 16, an assistant unit operator (AUO) was dispatched to investigate the cause of a instrument malfunction alarm on the RM. The AUO reported the RM valves were tagged shut. The tags were installed for the hold order (HO) to support the sample line cleaning job. The CROs realized at that time that the RM was inoperable with this HO in effect. The TS action statement was reentered at that time.

Incorrectly declaring this RM operable resulted in a failure to take grab samples for 25.5 hours.

The cause of this event is attributed to a cognizant operator error not properly returning the RM to service in accordance with approved procedures.

As corrective action, the procedure used to maintain cognizance of operation status will be covered in week one of the 1988 Operator Requalification Training.

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		YEAR 88	SEQUENTIAL NUMBER 005	REVISION NUMBER 002	OF	04

TEXT (if more space is required, use a optional NRC Form 305A (1) (17))

DESCRIPTION OF EVENT

On January 16, 1988, at approximately 1700 EST, units 1 and 2 were in mode 5 (0 percent power, 4 psig, 124 degrees F and 0 percent power, 90 psig, 123 degrees F, respectively) when it was discovered that the Turbine Building sump release line radiation monitor (EIS Code IL) was inappropriately declared operable on January 15, 1988, at 1400 EST, and the Technical Specification (TS) action statement was exited while the radiation monitor still had a hold order (HO) in effect.

The Turbine Building sump release line Radiation Monitor (O-RM-90-212) was declared inoperable on January 5, 1988, at 0105 EST to clean the sample line in accordance with Work Request (WR) B296305 upon the issuance of HO 0-88-037 by the assistant shift engineer. The TS Limiting Condition for Operation (LCO) 3.3.3.9 action statements were entered and complied with at that time. TS LCO 3.3.3.9 action statements provide the appropriate compensatory measures when both channels of the Turbine Building sump effluent line radiation monitor are inoperable. These measures require collecting grab samples from the Turbine Building sump effluent and analyzing them using the gamma spectroscopy method, at least once every 12 hours. Chemistry laboratory personnel were notified that the action statements of TS LCO 3.3.3.9 were entered, and they began sampling every eight hours, in accordance with Surveillance Instruction (SI)-414, "Turbine Building Sump or ERCW Discharge Radioactivity."

On January 11, 1988, WR B257462 was submitted on O-RM-90-212 channel B because the associated annunciator cleared with a trip alarm actuated during the performance of SI-204, "Functional Test for the Radiation Monitoring System." No clearance was required to be issued for the work down by WR B257462. The O-RM-90-212B circuit was repaired and SI-204 was completed with satisfactory results on January 15, 1988. The test director informed the unit operator and the senior reactor operator of the test results, and they declared O-RM-90-212 operable at 1400 EST. Upon declaring the radiation monitor operable, the TS LCO 3.3.3.9 action statements were exited while the sample line cleaning job continued. Chemistry laboratory personnel were notified by Operations that they exited the action statements, and Chemistry subsequently suspended taking 8-hour grab samples. The last sample taken was at 1200 EST on January 15, 1988.

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TEXT (if more space is required, use additional NRC Form 266A (9-83))

On January 16, 1988, at approximately 1700 EST, the control room operator dispatched an assistant unit operator (AUO) to investigate the cause of a 0-RM-90-212 instrument malfunction alarm. The AUO discovered that the 0-RM-90-212 root isolation valves (FCV-0-90-271 and FCV-0-90-272) were tagged in the closed position by HO 0-88-037. This HO was in place to support the sample line cleaning job being done under WR B296305. FCV-0-90-271 and FCV-0-90-272 prevented flow through 0-RM-90-212, and thus the cause for the alarm. The HO also prevented Turbine Building sump releases from being processed through 0-RM-90-212. The control room operators realized that 0-RM-90-212 was inoperable with this HO in effect, and they reentered TS LCO 3.3.3.9 action statements. Chemistry laboratory personnel were notified of this condition, and they resumed taking 8-hour grab samples for radioactivity analysis.

A routine daily sample had been taken by Chemistry at 1330 EST on January 16, 1988, before being notified by Operations to resume 8 hour samples, as required by SI-421, "Turbine Building Sump Discharge Radioactivity Determination." No radioactivity was detected in the last sample taken on January 15, 1988, nor was radioactivity detected in the sample taken at 1330 EST on January 16, 1988. The first sample taken, following reentry into SI-414, was completed at 2000 EST on January 16, 1988, and it too had no detectable amounts of radioactivity in it.

CAUSE OF EVENT

The cause of this event is attributed to licensed Operations personnel not properly returning 0-RM-90-212 to service in accordance with approved procedures. This event was determined to be a result of a cognizant personnel error since the task is correctly covered by an approved procedure. No unusual working conditions was determined to have contributed to this error.

The administrative instruction (AI) governing the return to service of equipment when a clearance is not involved is AI-58, "Maintaining Cognizance of Operation Status-Configuration Status Control." AI-58 specifies the systems required to be under configuration control for each operational mode. For mode 5, all radiation monitoring systems are required to be under configuration control. This is implemented via a configuration log in the control room, organized by systems, and a system status file maintained in the control room to provide the system status. AI-58 also provides the reference to the system operating instructions (SOIs) for the normal system configuration. For 0-RM-90-212, SOI 90.1A, "Liquid Process Radiation Monitors," is applicable and requires an independent verification of valves FCV-0-90-271 and FCV-0-90-272 to be opened in order to return it to service. The configuration log and the status file did contain an entry for the sample line cleaning job which required postmaintenance testing and proper valve alignment to be complete in order to return 0-RM-90-212 to an operable status. HO 0-88-37 is referenced by the status file. A review of the configuration log or system status file before declaring RM-0-90-212 operable would have prevented the inappropriate exit of the TS action statements.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (if more space is required, use additional NRC Form 366A (9-83))

ANALYSIS OF EVENT

This event is being reported under 10 CFR 50.73, paragraph a.2.i.B, as a condition prohibited by the plant's TSS.

TS LCO 3.3.3.9 action statement b, requires grab samples of the effluent to be taken and analyzed for radioactivity at least once every 12 hours when 0-RM-90-212 is inoperable. A period of 25.5 hours, from January 15 at 1200 EST to January 16 at 1330 EST, transpired without taking a grab sample for analysis. Since the Turbine Building sump pump operates automatically by a sump level controller, there is no assurance that no release was made during this period. However, based on the fact that the samples taken on January 15 and 16 did not have radioactivity detected in them and since the Turbine Building sump is not normally found to have detectable amounts of radioactivity in it, there is reasonable assurance that a radioactive release was not made. In addition, the Turbine Building sump effluent is released to either the low-volume waste pond or the yard pond at Sequoyah before being released to waters beyond the site boundary. In light of these conditions, it is concluded that no significant safety consequences resulted from this occurrence.

CORRECTIVE ACTION

As immediate corrective actions, TS LCO 3.3.3.9 action statements were entered, and Chemistry personnel resumed taking grab samples for analysis accordingly.

Operators involved in this occurrence have been counseled by their managers and appropriate disciplinary action has been taken.

To address the root cause of this event, AI-58, "Maintaining Cognizance of Operation Status - Configuration Status Control," will be a training topic in week one of the 1988 Operator Regualification training. Week one will be complete on March 11, 1988.

ADDITIONAL INFORMATION

There have been two occurrences previously reported concerning personnel error resulting in a condition outside of TS - SQRO-50-327/84024, and 86058.

0860Q

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant
Post Office Box 2000
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February 12, 1988

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/88005

The enclosed licensee event report provides details concerning personnel not properly implementing approved administrative procedures resulting in inappropriately exiting a technical specification action statement while the Turbine Building sump radiation monitor was inoperable. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.i.B.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

S. J. Smith
Plant Manager

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