NRC Form 366 (9-83)  LICENSEE EVENT REPORT (LER)										US NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104 EXPIRES 8/31/85										
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On November 14, 1985, at 1305 CST, a high pressure fire protection (HPFP) valve, 1-FCV-26-231, inadvertently opened and charged fire hose stations in unit 1 containment. A determination was made that the opening of the deluge valve was not necessary, and the header was manually isolated. A review of drawings to determine what equipment was protected by this header was made by the unit operator (UO), and he determined that only hose stations around the reactor coolant pumps (RCPs) were involved. (This was incorrect since the header supplied fire hose stations in the annulus.) Since the unit was in mode 6 and the RCPs were not required, an entry in action (a) of Technical Specification Limiting Condition of Operation (LCO) 3.7.11.4 was not made. On November 18, 1985, at 1330 CST, a Surveillance Instruction (SI)-654 was performed which identified the annulus fire hose stations as being isolated. At 1345 CST, the header was returned to service. A personnel error made by the UO on November 14, 1985, when reviewing flow diagrams, was the root cause of this event.

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ABSTRACT (Limit to 1400 spaces i.e. approximately fifteen single space typewritten is

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSIO

APPROVED OMR NO 3150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)		LI	ER NUMBER (6)		PAGE (3)		
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TEXT Iff more space is required, use additional NRC Form 366A's) (17) This revision corrects information on the original LER as to which headers were charged. On November 14, 1985, at 1305 CST while in refueling, a deluge valve, 1-FCV-26-231, on high pressure fire protection (HPFP) inadvertently opened and charged the fire hose stations in unit 1 containment annulus. Revision 0 stated that the reactor coolant pump (RCP) area was charged, but the RCPs were on a separate header and were not charged. An alarm on the pyrotronics panel in the main control room indicated the opening of the valve but gave no indication of fire by cross zone fire detectors for that area. An assistant unit operator (AUO) was dispatched to investigate the problem and found the discharge drain valve on the deluge valve leaking. The valve was manually isolated by the AUO, and draining of the header was initiated. The unit operator (UO) in the main control room reviewed HPFP drawings and made a determination that only the hose station around the RCPs was being isolated. Since Technical Specification Limiting Condition for Operation (LCO) 3.7.11.4 requires backup hoses run only for areas that contain equipment which is required to be operable, the UO thought he was in compliance with the plant technical specification. In actuality, the annulus hose stations were supplied by that header. Since the annulus contains equipment that is required operable, a failure to comply with action (a) of Technical Specification LCO 3.7.11.4 occurred. That condition remained until its discovery on November 18, 1985, during the performance of a HPFP surveillance on valve positions. At that time, approximately 1345 CST, the header and associated hose stations were returned to service.

### Cause of the Event

The primary cause of this failure to comply with the technical specification was a personnel error made by the control room UO in determining what area was protected by the subject header. The drawing used by the UO has "Reactor Coolant Pump" labeled at the top of the page between two header systems. This labeling is intended for the header system to the left of the labeling (reactor coolant pump hose stations). The header system to the right is labeled underneath the drawing of the header in smaller lettering as being for the "Annulus" hose station(s) supply header.

#### Analysis of Event

This event was considered reportable per 10 CFR 50.73, paragraph a.2.1 since the plant was not in compliance with action (a) of Technical Specification LCO 3.7.11.4. Action (a) requires areas using hose stations for backup fire suppression to have temporary hoses routed within 24 hours. There were no temporary hoses routed during the four days that the annulus hose stations were out of service. In view of the fact that no fire occurred in the subject area during that time, there was no effect on public health or safety due to this event.

#### Corrective Actions

The header and hose stations were returned to service as soon as it was discovered that they were isolated. On November 18, 1985, the UO who failed to identify the annulus as an isolated area was involved in the discovery of his mistake. TVA considered this to be an isolated occurrence, and no additional action was required to preclude future occurrences.

# TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant Post Office Box 2000 Soddy Daisy, Tennessee 37379

February 21, 1986

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 SQR0-50-327/85046 REVISION 1

The enclosed revised licensee event report provides details concerning inoperable fire hose stations. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.i.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

O.R. Wallaur

P. R. Wallace Plant Manager

Enclosure cc (Enclosure):

J. Nelson Grace, Regional Administrator U.S. Nuclear Regulatory Commission Suite 2900 101 Marietta Street, NW Atlanta, Georgia 30323

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

NRC Inspector, NUC PR, Sequoyah