



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

Robert A. Fenech  
Vice President, Sequoyah Nuclear Plant

April 13, 1993

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

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET  
NO. 50-327 - FACILITY OPERATING LICENSE DPR-77 - LICENSEE EVENT REPORT  
(LER) 50-327/93005

The enclosed LER provides details concerning an inadvertent actuation of  
a containment isolation valve. This event is being reported in  
accordance with 10 CFR 50.73(a)(2)(iv) as a condition that resulted in  
the actuation of an engineered safety feature.

Sincerely,

Robert A. Fenech

Enclosure  
cc: See page 2

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cc (Enclosure):

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## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah Nuclear Plant, Unit 1										DOCKET NUMBER (2)   PAGE (3) 050003   2   7   1   OF   0   5									
TITLE (4) Inadvertent Actuation of a Containment Isolation Valve During Response-Time Testing Performance As a Result of Personnel Error																			
EVENT DAY (5)					LER NUMBER (6)					REPORT DATE (7)					OTHER FACILITIES INVOLVED (8)				
					SEQUENTIAL   REVISION					FACILITY NAMES					DOCKET NUMBER(S)				
MONTH   DAY   YEAR					NUMBER   NUMBER					MONTH   DAY   YEAR					050003   2   7   1   OF   0   5				
0   3   2   0   9   3   9   3					0   0   5   0   0   0   4   1   3   9   3					050003   2   7   1   OF   0   5									
OPERATING MODE (9)   THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following)(11)																			
(9)   5   20.402(b)   20.405(c)   XX   50.73(a)(2)(iv)   73.71(b)																			
POWER   20.405(a)(1)(i)   50.36(c)(1)   50.73(a)(2)(v)   73.71(c)																			
LEVEL   20.405(a)(1)(ii)   50.36(c)(2)   50.73(a)(2)(vii)   OTHER (Specify in																			
(10)   0   0   0   20.405(a)(1)(iii)   50.73(a)(2)(i)   50.73(a)(2)(viii)(A)   Abstract below and in																			
20.405(a)(1)(iv)   50.73(a)(2)(ii)   50.73(a)(2)(viii)(B)   Text, NRC Form 366A																			
20.405(a)(1)(v)   50.73(a)(2)(iii)   50.73(a)(2)(x)																			
LICENSEE CONTACT FOR THIS LER (12)																			
NAME										TELEPHONE NUMBER									
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   TO NPRDS					CAUSE   SYSTEM   COMPONENT   MANUFACTURER   TO NPRDS														
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED   MONTH   DAY   YEAR									
SUBMISSION										DATE (15)									
YES (If yes, complete EXPECTED SUBMISSION DATE)   X   NO										DATE (15)									
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																			

On March 20, 1993, at 1519 Eastern standard time, with Unit 1 in cold shutdown, a containment isolation valve was inadvertently actuated. The valve is the containment isolation valve for a lower compartment containment radiation monitor sample return line. An instrument mechanic (IM) inadvertently shorted test leads after verification of response time test equipment set-up. This caused a control circuit fuse to blow, resulting in the valve traveling to the closed position. The electrical short occurred when the IM was reinstalling the test leads to the back of a chart recorder after having completed chart scaling and labeling verification. The cause of the event was personnel error with a contributing factor involving access to the input terminals at the rear of the test equipment. The control power circuit fuse was replaced, and the valve was returned to the open position. The test equipment was properly connected and testing was completed without further incident. The event was discussed with the involved individual with emphasis on self-check techniques. Instrument Maintenance personnel were instructed to ensure that adequate access is provided to test equipment when setting up the equipment.

LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

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Sequoyah Nuclear Plant, Unit 1			SEQUENTIAL		REVISION						
		YEAR	NUMBER		NUMBER						
	050003 12 17 9 3	0	0	5	0	0	0	2	OF	0	5

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

I. PLANT CONDITIONS

Unit 1 was in Mode 5, cold shutdown, for a forced outage.

II. DESCRIPTION OF EVENT

A. Event

On March 20, 1993, at 1519 Eastern standard time (EST), a containment isolation valve was inadvertently actuated. The valve is the containment isolation valve (EIIIS Code JM) for a lower compartment containment radiation monitor (EIIIS Code IL) sample return line. An instrument mechanic (IM) inadvertently shorted test leads at the test equipment after verification of test equipment set-up (three chart recorders). The electrical short circuit caused a control circuit fuse to blow, resulting in the valve traveling to the closed position. The electrical short occurred while the IM was reinstalling the test leads to the back of one of the chart recorders after having completed chart scaling and labeling verification. The IM installed one lead into the recorder and then plugged the second lead into the first. The test equipment was set up on a work table against a wall by a different Instrument Maintenance crew. The size, weight, and sensitivity of the equipment did not allow for movement of the equipment or the table to provide better access to the input terminals at the rear after completion of equipment set-up.

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

None.

C. Dates and Approximate Times of Major Occurrences

March 20, 1993 at approximately 0730 EST	An Instrument Maintenance crew completed the test set-up portion of a surveillance instruction (SI) for valve response time testing.
March 20, 1993 at 1330 EST	Operations' review of the SI identified a need for a procedure change. The procedure change was initiated, and SI performance was placed on hold.
March 20, 1993 at approximately 1400 EST	The IM was instructed to verify the test hookup, chart scaling, and chart labeling.

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

March 20, 1993  
at 1519 EST

The IM shorted the test leads of one channel of the test recorder, resulting in a blown fuse on a control power circuit. The valve associated with the circuit traveled to the closed position.

March 20, 1993  
at approximately  
1522 EST

Operations evaluated plant response and took action to restore the affected equipment.

March 20, 1993  
at 1907 EST

Operations personnel reported the engineered safety feature component actuation to NRC in accordance with 10 CFR 50.72(b)(2)(ii).

March 21, 1993  
at 0005 EST

The SI testing was resumed.

March 21, 1993  
at 0530 EST

The SI was completed.

D. Other Systems or Secondary Functions Affected

The lower containment radiation monitor, associated with the actuated valve, alarmed because of the low flow condition induced by closure of the sample return line containment isolation valve. Also, the 125-volt direct-current vital battery board No. 1 abnormal alarm annunciated because of the blown fuse.

E. Method of Discovery

The IM observed a spark at the recorder while reconnecting the test leads to the recorder.

The radiation monitor instrument malfunction and 125-volt direct-current vital battery board alarms annunciated on the main control room panels. The main control room operators were notified of the event by the responsible IM.

F. Operator Actions

The operators verified equipment actuation, responded to the alarms, and recovered from the event.

G. Safety System Responses

No safety system responses were required. The only actuation was the closure of the single containment isolation valve.





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		YEAR	NUMBER
		NUMBER	

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

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

None.

VII. COMMITMENTS

None.