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August 15, 1994

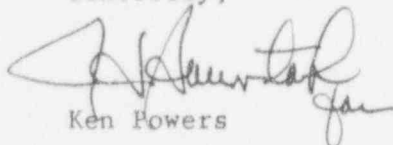
U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - DOCKET
NOS. 50-327 AND 50-328 - FACILITY OPERATING LICENSES DPR-77 AND DPR-79 -
LICENSEE EVENT REPORT (LER) 50-327/94012

The enclosed LER provides details concerning the discovery that the containment building penetration surveillance was not being performed as required by Technical Specification Surveillance Requirement 4.9.4. The procedure implementing the required surveillance was incorrect in that it did not specify that the penetrations were required to be verified once every seven days during core alterations or during the movement of irradiated fuel in containment. This report is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B) as an operation prohibited by the plant's technical specifications.

Sincerely,



Ken Powers

Enclosure
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U.S. Nuclear Regulatory Commission

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cc (Enclosure):

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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 (SQN), Unit 1	0500032794	--	0	1	2	--	0	0	0	2	OF 06

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

I. PLANT CONDITIONS

Unit 1 was in Mode 3 and Unit 2 was in Mode 6.

II. DESCRIPTION OF EVENT

A. Event

On July 15, 1994, it was discovered that the containment building penetration verification surveillance was not implemented in instructions as required by Technical Specification (TS) Surveillance Requirement (SR) 4.9.4. The procedure implementing the required surveillance was incorrect in that it did not specify that all containment penetrations were required to be verified once every seven days during core alterations or during the movement of irradiated fuel in containment. Subsequently, it was determined that the surveillance had not been implemented during the Unit 1 Cycle 6 refueling outage as required by TSs. In September 1991, the procedure implementing the SR was revised, separating the procedure into two separate procedures, one for each unit. The new procedures did not require the complete performance of the procedure once every seven days as specified in SR 4.9.4. The surveillance only required verification of the penetrations associated with containment ventilation isolation valves and not all containment penetrations. This condition had existed since that time.

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

None.

C. Dates and Approximate Times of Major Occurrences

August 21, 1991	The previous surveillance instruction was deleted and replaced with two new instructions, one for each unit. The new instruction did not completely implement TS requirements.
October 14, 1991	The new surveillance was used for the first time on Unit 1 during the Unit 1 Cycle 5 refueling outage. Deficiencies with the procedure were not identified. The verification of containment penetrations once every seven days was not required during this outage.
March 26, 1992	The new surveillance was used for the first time on Unit 2 during the Unit 2 Cycle 5 refueling outage. Deficiencies with the procedure were not identified. The verification of containment penetrations once each seven days was not required during this outage.

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Sequoyah Nuclear Plant (SQN), Unit 1		<div> <div>YEAR</div> <div>NUMBER</div> </div>	<div> <div>NUMBER</div> </div>
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

April 18, 1994 The new surveillance was used on Unit 1 during the Unit 1 Cycle 6 refueling outage. The verification of containment penetrations once every seven days should have been performed from June 19, 1993, through July 12, 1993.

July 15, 1994 In preparation for the core off-load for the Unit 2 Cycle 6 refueling outage, a shift operations supervisor identified the procedure deficiency during a review of the procedure. Subsequently, it was determined that the surveillance had not been implemented during the Unit 1 Cycle 6 refueling outage as required by TSs.

July 15, 1994 The Units 1 and 2 surveillances were revised to properly implement TS requirements.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

In preparation for the core off-load for the Unit 2 Cycle 6 refueling outage, a shift operations supervisor identified the procedure deficiency during a review of the procedure.

F. Operator Actions

Upon discovery of the condition, the appropriate Operations personnel were notified of the condition.

G. Safety System Responses

Not applicable - No safety system responses were required.

III. CAUSE OF EVENT

A. Immediate Cause

The immediate cause of this condition was the failure to properly implement the surveillance as required by TSs.

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

B. Root Cause

The root cause of this event was an improper procedure revision and inadequate procedure reviews that were performed during a procedure enhancement project in 1991. The individuals involved either did not understand or did not properly review the TS SRs associated with the procedure.

IV. ANALYSIS OF EVENT

TS SR 4.9.4 requires the verification of containment penetrations once each seven days during core alterations or movement of irradiated fuel within containment. Before fuel movement or core reload was initiated, the verification of containment penetrations was performed as required by SR 4.9.4.

During the Unit 1 Cycle 6 refueling outage core reload activities, a fuel assembly became tilted on June 18, 1993. At this time, core reload was suspended until the fuel assembly could be erected and removed from the core. To ensure that containment integrity was maintained, a manual Phase A isolation and a containment ventilation isolation (CVI) were initiated. On July 5, 1993, the tilted fuel assembly was removed from the core. On July 12, 1993, fuel reload was completed.

During the period of June 18, 1993, to July 12, 1993, the CVI verification was performed once every seven days as required by TSs. Verification of the other penetrations, the equipment hatch, and the personnel airlock doors was not performed as required. A review of operator logs and breaching permit logs was performed to determine if any containment penetrations were degraded during this time. There was no evidence indicating that containment integrity was degraded during this time. Based on the above information, it is concluded that there was no danger to the health and safety of plant personnel or the public.

V. CORRECTIVE ACTIONS

A. Immediate Corrective Actions

Upon discovery of the condition, the Units 1 and 2 surveillances were revised to properly implement TS requirements.

B. Corrective Action to Prevent Recurrence

A review of Operations' surveillances is being performed to ensure that TS required surveillances are properly implemented in instructions.

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

Operations' management will counsel any remaining employees involved in the deficient procedure revisions as to their responsibility for ensuring complete and accurate procedure revisions.

A review will be performed to identify the population of suspect procedure revisions based on the time period of the revision and the personnel involved with the revision.

A complete technical review of the procedures identified as suspect will be performed to ensure total compliance with the SRs referenced by the procedures.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

A review of previously-reported occurrences was conducted to identify similar events. There were 36 previously-reported events associated with missed surveillances since 1989. From the events identified, the corrective actions associated with LER 50-327/94003 were inadequate to have identified this condition. Previous corrective actions included training of personnel and should have minimized the chance for this condition. The current process and qualification of the appropriate personnel should reduce the chances for future procedural errors.

C. Extent of Condition

As a result of the review of Operations' surveillances to date, no additional examples of surveillances not properly implementing TSs have been identified.

VII. COMMITMENTS

1. A review of Operations surveillances is being performed to ensure that TS required surveillances are properly implemented in instructions. This action will be completed by September 30, 1994.
2. Operations' management will counsel any remaining employees involved in the deficient procedure revisions as to their responsibility for ensuring complete and accurate procedure revisions. This action will be completed by September 9, 1994.

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3. A review will be performed to identify the population of suspect procedure revisions based on the time period of the revision and the personnel involved with the revision. This action will be completed by August 26, 1994.
4. A complete technical review of the procedures identified as suspect will be performed to ensure total compliance with all SRs referenced by the procedures. This action will be completed by October 28, 1994.