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Ken Powers
Vice President, Sequoyah Nuclear Plant

July 1, 1994

U.S. Nuclear Regulatory Commission
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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) 50-327/94009

The enclosed LER provides details concerning an inadequate surveillance
instruction that resulted in a failure to comply with technical
specifications.

This event is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B)
as an event that resulted in an operation or condition prohibited by
technical specifications.

Sincerely,

Ken Powers

Enclosure
cc: See page 2

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U.S. Nuclear Regulatory Commission

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July 1, 1994

cc (Enclosure):

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah Nuclear Plant (SQN), Unit 1										DOCKET NUMBER (2) PAGE (3) 050003 12 17 1107 01 5														
TITLE (4) Missed Surveillance Associated With the Monitoring of Postaccident Monitoring Instrumentation on the Neutron Flux and Auxiliary Feedwater Systems																								
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					Sequoyah, Unit 2					050003 12 18				
0 6 0 2 9 4 9 4					0 0 9 0 0 0 7 0 1 9 4										050003 11									
OPERATING MODE (9)					THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 51: (Check one or more of the following)(11)																			
1					20.402(b)					20.405(c)					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) 1 0 0					20.405(a)(1)(iii) XX					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 NPDs					REPORTABLE					CAUSE SYSTEM COMPONENT MANUFACTURER TO NPDs					REPORTABLE									
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED MONTH DAY YEAR														
YES (If yes, complete EXPECTED SUBMISSION DATE)										SUBMISSION DATE (15)														
X NO																								
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																								

On June 2, 1994, at 1330 Eastern daylight time, with Units 1 and 2 in power operation at approximately 100 percent, it was determined that Technical Specification (TS) Surveillance Requirement (SR) 3.3.3.7 had not been met for the source and intermediate range neutron flux accident-monitoring instruments because nonqualified indicators were being used in the surveillances for both Units 1 and 2. On June 21, 1994, during review of the condition, it was determined that the same TS SR had also not been met for auxiliary feedwater valve position indication. The SR requires accident monitoring instrumentation to be demonstrated operable by performance of a channel check at least every 31 days. The first failure to meet the SR was identified during resolution of a work document associated with instrument labeling. The cause of the events was an inadequate procedure. The procedure revision issued in December 1990 incorrectly incorporated a design change associated with postaccident monitoring instruments. Upon identification of the condition, Operations personnel verified equipment operability by using the qualified accident-monitoring indicators and found them to be operable. The procedure errors were corrected. Additional procedure reviews will be performed to ensure that the procedures performing channel checks associated with accident-monitoring instrumentation SRs implemented by the previous design change contain correct technical details.

LICENSEE EVENT REPORT (LER,
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	SR NUMBER (1)	PAGE (3)
Sequoyah Nuclear Plant (SQN), Unit 1	YEAR	SEQUENTIAL	REVISION
	NUMBER	NUMBER	NUMBER
050003 12 17 19 14		0 0	0 0 0 2 OF 0 5

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

I. PLANT CONDITIONS

Units 1 and 2 were in power operation, Mode 1, at approximately 100 percent.

II. DESCRIPTION OF EVENT

A. Event

On June 2, 1994, at 1330 Eastern daylight time (EDT), it was determined that Technical Specification (TS) Surveillance Requirement (SR) 3.3.3.7 had not been met for the source and intermediate range neutron flux (EIS Code 1G) accident-monitoring instruments (EIS Code 1P) because nonqualified indicators were being used in the surveillances for both Units 1 and 2. Two indicators are available for each neutron flux instrument, one of which is fully qualified for postaccident-monitoring (PAM) use. On June 21, 1994, during review of the condition it was determined that the same TS SR had also not been met for auxiliary feedwater valve (EIS Code BA) position indication. The SR requires accident-monitoring instrumentation to be demonstrated operable by performance of a channel check at least every 31 days. As a result of the operators checking nonqualified indicators, this SR was not being met. The first failure to meet the SR was identified during resolution of a work document associated with instrument labeling. A procedure revision issued in December 1990, incorrectly incorporated a design change associated with postaccident-monitoring instruments. Upon identification of the condition, Operations personnel verified the indication operability by using qualified accident-monitoring indicators and found the indicators to be operable.

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

None.

C. Dates and Approximate Times of Major Occurrences:

July 1990	Design change documents were issued to identify PAM instrumentation.
December 7, 1990	A TS change was issued revising the PAM instrument listing.
December 28, 1990	The Operations surveillance instructions for each unit were revised to incorporate the design change document and an associated TS change.
May 10, 1994	During the performance of a surveillance instruction (SI), a work document was initiated for correction of a perceived instrument labeling problem on the "A" channel of the source and intermediate-range neutron flux instruments.

LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)
Sequoyah Nuclear Plant (SQN), Unit 1		SEQUENTIAL	REVISION
		YEAR	NUMBER

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

June 2, 1994
at 1330 EDT

The work document was determined to be invalid; the indicator labeling was found to be correct. The indicators being used in the performance of the SI were not qualified for PAM use, and the SI was found to be in error. As a result, TS Limiting Condition for Operation (LCO) 3.3.3.7 was entered.

June 2, 1994

The PAM qualified indicators were channel-checked and found to be operable. LCO 3.3.3.7 was exited.

June 21, 1994
at 1428 EDT

During review of the June 2, 1994, event, it was determined that the SI for indicators being used for PAM operability verification of auxiliary feedwater valve position indication were nonqualified. LCO 3.3.3.7 was entered. The PAM qualified indications were channel-checked and found to be operable. LCO 3.3.3.7 was exited.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

The condition was discovered during resolution of a work document. The work document was initiated to correct a perceived labeling error on the indicators that were being used to comply with the TS SR. During a detailed review of the labeling requirements, it was determined that the indicators were correctly labeled as non-PAM indicators and that the procedure was in error.

F. Operator Actions

Operations personnel immediately entered the appropriate TS LCO and verified equipment operability by using the PAM-qualified indicators.

G. Safety System Response

No safety system response was required for these conditions.

III. CAUSE OF EVENT

A. Immediate Cause:

The immediate cause of the event was the failure to use PAM qualified indicators during the performance of the SI to satisfy the TS SR.

LICENSEE EVENT REPORT (LER)

TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				PAGE (3)			
		YEAR	NUMBER	REVISION					
Sequoyah Nuclear Plant, Unit 1	05000327	94	009	00	00	04	OF	05	

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

B. Root Cause:

The root cause of the event was an inadequate procedure. The procedure identified nonqualified neutron flux indicators and auxiliary feedwater valve indicators to be used for satisfying the TS SR. The procedure deficiency occurred when the procedure was revised to incorporate 1990 design change documents and the associated TS change identifying PAM instrumentation. The procedure reflected the general requirements of the TS change but did not incorporate the specific technical details identified in the design document for either the neutron flux indicators or the auxiliary feedwater valve position indication.

C. Contributing Factors:

A contributing factor to the event is that assistant unit operators (AUOs) performing the surveillance were not trained in PAM equipment labeling designation. Therefore, during performance of the surveillance, the individuals did not recognize that the procedure identified instruments that were not PAM qualified. Although the individuals performing the surveillance could not have prevented the procedure error, the condition could have been identified earlier.

IV. ANALYSIS OF EVENT

The operability of the accident-monitoring instrumentation ensures that sufficient information is available on selected plant parameters to monitor and assess these variables following an accident. SQN has redundant and diverse instrumentation and indication exists with selected channels fully qualified for accident monitoring. The neutron flux and auxiliary feedwater valve position indicators are a part of this redundant and diverse system. During the timeframe when the SR was not being satisfied for monthly operability verification, the equipment was being properly calibrated and functionally checked on the longer 18-month frequency and was found to be in an operable condition. Although the indicators that were being used to satisfy the SR were non-PAM qualified, they did reflect the status of the qualified accident-monitoring instrumentation. Therefore, the event did not adversely affect the health and safety of plant personnel of the general public.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)
Sequoyah Nuclear Plant, Unit 1		SEQUENTIAL	REVISION
		YEAR NUMBER	NUMBER
	10501013 12 17 19 4	0 0 9	0 0 0 5 of 0 5

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

V. CORRECTIVE ACTIONS

A. Immediate Corrective Actions

Upon discovery of the missed surveillance, the appropriate TS LCOs were entered, and operability of the correct indicator was verified on each unit. Additionally, each unit's applicable procedure was corrected.

B. Corrective Action to Prevent Recurrence

A detailed technical review will be performed to ensure that surveillance instructions performing channel checks that incorporated the 1990 PAM design change contain the correct technical details to satisfy accident-monitoring instrumentation SRs.

Operations AUO personnel will be instructed in PAM labeling designation.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

A review of previous similar events identified 14 LERs that have been written since 1992 as a result of missed surveillances. Of these LERs, three LERs (50-327/93006, 93030, and 94003) were the result of an inadequate procedure. Actions performed for LER 50-327/94003 included a review of the Operations procedures to ensure that the proper surveillances were listed and that the steps performed met the intent of the TS SRs. The corrective actions associated with the previous events would not have prevented this occurrence nor would previous actions have identified the condition earlier.

VII. COMMITMENTS

1. A detailed technical review will be performed by November 30, 1994, to ensure that surveillance instructions performing channel checks that incorporated the 1990 PAM design change contain the correct technical details to satisfy accident-monitoring instrumentation SRs.
2. Operations AUO personnel will be instructed in PAM labeling designation by September 2, 1994.