

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONT

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REPORT SOURCE

L	6	0	5	1	0	0	3	2	8	7	1	1	0	7	8	3	8	1	2	0	6	8	3	9
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60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 8		7 8 9		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE	
0 9		S F 11		A 12		A 13		Z Z Z Z Z Z 14				Z 15		Z 16			
7 8		9 10		11		12		13				18		19		20	
17		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.							
LER/RO REPORT NUMBER		8 3 21 22		1 5 1 24 26		0 3 28 29		L 30		0 32							
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURE	
X 18		X 19		Z 20		Z 21		0 0 0 0 37 40		Y 23		N 24		Z 25		Z 9 9 44	
33		34		35		36		41		42		43		44			

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 5 C 28 0 0 0 29 NA 30
 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35
 1 6 Z 33 Z 34 NA 35
 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
 DISCOVERY DESCRIPTION 32
 B 31 Operator observation
 LOCATION OF RELEASE 36
 NA

PERSONNEL EXPOSURES									
NUMBER			TYPE		DESCRIPTION (39)				
1	7	0	0	0	17	Z	18	NA	

PERSONNEL INJURIES					
NUMBER		DESCRIPTION			
1	8	0	0	0	(40) NA

LOSS OF OR DAMAGE TO FACILITY		(43)
TYPE	DESCRIPTION	
1	2	

7 8 9 10 NA

FURCILITY

ISSUED DESCRIPTION (45)

8312160229 831206
PDR ADOCK 05000328

NRC USE ONLY

8312160229 831206
PDR ADDCK 05000328
S PDR

NRC USE ONLY ▼

Sequoyah Nuclear Plant

LER SUPPLEMENTAL INFORMATION

SQRO-50-328/83151

Technical Specification Involved: 3.5.1.2

Reported Under Technical Specification: 6.9.1.13.c

Date of Occurrence: 11/07/83

Time of Occurrence: 1730 CST

Identification and Description of Occurrence:

During startup of unit 2, while the reactor coolant system (RCS) was being heated and pressurized, it was noted that the RCS pressure had exceeded 1900 psig without the upper head injection (UHI) isolation valves being opened. Investigation into this event revealed that two of the four isolation valves would not operate correctly. Upon event discovery, the unit complied with the action requirements of LCO 3.5.1.2.

Conditions Prior to Occurrence:

Unit 2 in mode 3 (0% Rx power, 450 degrees F, 2100 psig).

Apparent Cause of Occurrence:

The event of 11/07/83 was caused by a personnel error in that the operator inadvertently failed to follow procedures. During the startup phase, the operator had become involved in several other jobs at the same time and failed to notice the RCS pressure increase and to open the UHI isolation valves. Immediately upon event discovery, the operator decreased RCS pressure to less than 1900 psig by opening the pressurizer sprays and turning off the pressurizer heaters. After decreasing the RCS pressure, an attempt was made to open the four UHI isolation valves. However, valves 2-FCV-87-23 and -24 were found to operate incorrectly due to improperly terminated wiring in the associated level switches. The wiring errors were caused by personnel errors during recent level switch calibrations.

Analysis of Occurrence:

On 11/01/83 while the unit was in mode 1 at 100% power, the instrumentation mechanics calibrated UHI level switches 2-LS-87-23 and -24. These level switches contain a microswitch which has two sets of contacts, one for closing the associated valve using the control room handswitch and the other for actuating the dump solenoid to fast close the isolation valve on an accumulator low level. The internal wiring to the level switches was lifted to better facilitate the test equipment setup; however, the calibration procedure (SI-196.2) did not contain steps to lift wiring. Following calibration, the wiring was incorrectly reterminated and the unit condition did not allow for post-maintenance testing of the valves. Therefore, the error was not noted at this time.

On 11/02/83, with unit 2 shut down for a scheduled outage and while trying to close the UHI isolation valves in mode 3 before going below 1200 psig, valve 2-FCV-87-23 would not close by the control room handswitch. Initial troubleshooting did not reveal the problem and the valve was fast closed by jumpering the dump solenoid at the level switch. The problem was thought to be in the control room handswitch, and troubleshooting between 11/03/83 and 11/07/83 did not reveal the problem.

After the incident of 11/07/83, the plant management initiated an investigation into all problems associated with the UHI system. At this time, the wiring errors were noted. Valve 2-FCV-87-23 was found such that it would have closed on a low level signal if required, but not from the control room handswitch. Valve 2-FCV-87-24 would not have closed on a low-level signal and therefore did not comply with LCO 3.5.1.2 requirements. However, the valve would operate from the control room handswitch.

Corrective Action:

The operator was counseled and disciplinary action initiated to reinforce the importance of following procedures and observation of plant parameters. Maintenance personnel will be given training on the use of configuration control forms. This will be reinforced periodically on an informal basis. The SI-196.2 UHI level switch procedure is being revised to add the necessary steps to use configuration control forms if leads are lifted.

Failure Data:

None.

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

1750 Chestnut Street Tower II

03 DEC 12 A 9:37

December 6, 1983

Mr. James P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Suite 2900
101 Marietta Street, NW.
Atlanta, Georgia 30303

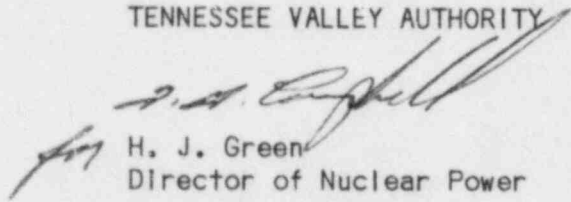
Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET
NO. 50-328 - FACILITY OPERATING LICENSE DPR-79 - REPORTABLE OCCURRENCE
REPORT SQRO-50-328/83151

The enclosed report provides details concerning the UHI Isolation valves
which were not opened before exceeding 1900 psig. This report is submitted
in accordance with Sequoyah unit 2 Technical Specification 6.9.1.13.c.

Very truly yours,

TENNESSEE VALLEY AUTHORITY


H. J. Green
Director of Nuclear Power

Enclosure

cc (Enclosure):

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NRC Inspector, NUC PR, Sequoyah

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