

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 2 7	PAGE (3)
		1 OF 0 2

TITLE (4)

Pressurizer Pressure Indicator Inoperable

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 6	1 0	8 4	8 4	0 4 1	0 0	0 7	0 9	8 4			0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
	20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)			
	20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)			
	20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
	20.405(a)(1)(iii)		XX 50.73(a)(2)(i)		50.73(a)(2)(vii)(A)					
20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)						
20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)						

LICENSEE CONTACT FOR THIS LER (12)									
NAME Glenn Duggin, Compliance Section Engineer									
TELEPHONE NUMBER AREA CODE 6 1 5 8 7 0 - 6 1 4 6									

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs		

SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE) XX NO														

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

The pressurizer pressure indicator in the auxiliary control room (ACR) was discovered inoperable by the performance of a monthly surveillance instruction (SI). Upon investigation, it was discovered that a wire had been reterminated incorrectly the last time this indicator was calibrated. The wire was lifted, reterminated in the correct position, and the loop was returned to service. Since the ACR was not required to be in use during this time, the indicator was not relied upon by personnel for the operation of the plant.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1) Sequoyah, Unit 1	DOCKET NUMBER (2) 05000327	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		84	041	00	02	OF	02

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

The pressurizer pressure indicator channel, PI-68-342C, was discovered to be inoperable at 2157C on 06/10/84 while unit 1 was in mode 1 (100% power, 2235 psig, 578 degrees F), and it was returned to service at 1108C on 06/13/84. The time frame involved above is well within the seven days allowed by technical specifications.

During the performance of surveillance instruction (SI) 3, "Daily, Weekly, and Monthly Logs," pressure indicator 342C was found downscale and declared inoperable. Maintenance personnel measured the loop current and found it to be zero. Plant conditions did not allow maintenance personnel to get to the transmitter for the next two days. When maintenance personnel were able to investigate, they determined that the positive lead on the transmitter was terminated on the wrong part of the terminal block. The wire was returned to its proper terminal, and the pressure channel was checked and returned to service.

Investigation into this termination error revealed that the error occurred on 04/27/84 when it was last calibrated. The error was not discovered immediately by SI-3 because the unit reactor coolant system (RCS) pressure was lower than the indicator range at that time.

When the indicator was last calibrated, the wire was lifted, but before it could be reterminated, the person that was doing the work became contaminated and had to leave the area. The wire was reterminated by another person and verified by a third person who had not seen the wire being lifted. The terminal block is difficult to get to, and it is hard to see the markings on the face of the block. Also, there were several unused termination points on the block.

Several factors contributing to this error are: (1) The person who lifted the wire did not record descriptively enough where the wire was supposed to go; (2) The person who lifted the wire was not the one who reterminated the wire; (3) The dressout conditions required and time allowed for the work did not allow personnel to be as careful as they could have; (4) The verifier did not get in a position so that he could see the markings on the face of the terminal block. He considered watching the wire being reterminated as sufficient.

Corrective action taken includes: (1) Personnel were warned about attention to detail and the importance of positive second person verification; (2) The SI package will be revised to (a) include the lifted wire as a part of the instruction, (b) include a channel check after the wire is reconnected, and (c) verify proper indication when a calibration sticker is removed; (3) Personnel will be scheduled for training on independent verification.

There was no effect on public health or safety, and no plant safety margins were exceeded. This indicator would not have been used unless the main control room had been abandoned.

Previous occurrences - none.

TENNESSEE VALLEY AUTHORITY

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

July 9, 1984

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

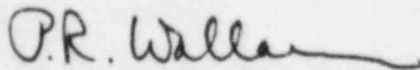
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT
SQRO-50-327/84041

The enclosed licensee event report provides details concerning the
pressurizer pressure indicator in the auxiliary control room being inoperable.
This event is reported in accordance with 10 CFR 50.73, paragraph a.2.i.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



P. R. Wallace
Plant Manager

Enclosure
cc (Enclosure):

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NRC Inspector, NUC PR, Sequoyah

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