

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant
Post Office Box 2000
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U.S. Nuclear Regulatory Commission
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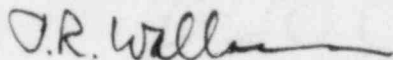
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.
50-327 - FACILITY OPERATING LICENSE DPR-77 - SPECIAL REPORT 85-02

The enclosed special report provides details concerning the inoperability of two fire barriers in excess of seven days. This event is reported in accordance with Sequoyah Unit 1 Technical Specifications 3.7.12 and 6.9.2.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



P. R. Wallace
Plant Manager

Enclosure
cc (Enclosure):

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SEQUOYAH NUCLEAR PLANT
SPECIAL REPORT 85-02
UNIT 1

Event Description and Probable Cause

Two separate events are described in this report. The first event occurred on February 7, 1985, when Operations personnel were notified by the Industrial Safety Staff of a failure to close a fire penetration breach within the allotted seven days in accordance with technical specification limiting condition for operation (LCO) 3.7.12, action (a). The penetration was found breached on January 28, 1985. The penetration was breached by a not completely sealed cable tray. A gap was detected between the penetration frame, the cerafiber board, and the ceiling by air blowing through the penetration. The gap may have existed since the construction of the plant. Upon discovery of the gap, a maintenance request (MR) was issued to repair the gap within seven days, and a breaching permit (PhySI-13, Attachment F) was issued to administratively control the breach. The planner failed to assign the MR to be worked within seven days of January 28, 1985. On February 7, 1985, the Industrial Safety Staff notified the planner that the breaching permit had expired. The planner then immediately assigned the MR to be worked. Actual work began on February 9, and the gap was sealed on February 11, 1985.

The MR did have a statement on it that the work should be completed within seven days. The planner did notice the seven-day statement, but failed to assign the MR accordingly. PhySI-13 requires a breaching permit to be issued, but it does not provide a means of tracking the breaching permit. This gap in the fire barrier penetration could not be seen visibly; therefore, it was not detected during previously run surveillances.

The second event occurred on February 17, 1985, when a fire door was found by Operations personnel to be breached for greater than seven days. The door was breached at 0800C on February 9, 1985, in accordance with procedure PhySI-13, Attachment F, and closed at 1200C on February 17, 1985. Upon event discovery, Operations personnel immediately verified that the door was functional by visual inspection and closed the breaching permit at 1200C on February 17, 1985.

The cause of the failure to close the fire door within the required time frame was due to an oversight of the expiration date on the breaching permit.

Corrective Action

As stated in previous special reports, Operations personnel were to review the breaching permit log on a daily basis to provide early warning of expiration dates; however, this corrective action failed to prevent this incident. Due to evidence of this corrective action not helping, the Sequoyah ISEG recommended the following corrective actions to plant management for implementation.

1. Prepare a new or revise an existing plant instruction to limit the number of people who can obtain a breaching permit by using an authorized list in the procedure and make these people responsible for ensuring breaches are closed in a timely manner.
2. Track all breaching permits that are active as part of the plant's daily planning and scheduling computer program. Provide a list of the active (open) permits to each supervisor on a daily basis showing the door breached, the applicable section, and the due date.