NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO 3150-0104
EXPIRES 8/31/85

LICENSEE EVENT REPORT (LER)

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

TITLE (4)

Breach of Auxiliary Building Secondary Containment Enclosure (ABSCE)

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 8	2 0	8 4	8 4	— 0 5 5	— 0 1	1 1	3 0	8 4	Sequoyah, Unit 2	0 5 0 0 0 3 2 8
										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)			
POWER LEVEL (10)	1 0 0	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)	X 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(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)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Michael R. Cooper, Compliance Engineer	6 1 5 8 7 0 1 - 1 6 6 4 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

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

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

This LER revision provides additional details on ABSCE breaches which occurred on 08/17/84 and 08/20/84 involving doors A208 and A209 (previously reported incorrectly as A206 and A207). Work was being performed on the auxiliary building roof, which required access through the two doors which are arranged in an airlock configuration. The outer door is a vital area boundary door and was unlocked using administrative controls. The personnel working at this location failed to realize the doors were an ABSCE boundary and opened both doors. The breaches can be attributed to (1) lack of knowledge of the personnel involved to realize the ABSCE boundary was located at these doors, (2) failure of procedures to adequately address ABSCE requirements, and (3) failure of communication between support groups and personnel within these groups.

This configuration would have prevented the auxiliary building gas treatment system (ABGTS) from maintaining a minus 1/4-inch water gauge pressure as required per Technical Specification 3.7.8, Surveillance 4.7.8.d.3.

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

The following report provides details on the breach of doors A208 and A209, which occurred on August 17 and August 20, 1984. It is the result of investigations which included conversations with Operations, maintenance personnel, and Public Safety officers involved or on shift when these breaches occurred. We believe that this report establishes the sequence of events and accurately describes the breaches as they occurred.

On August 16, 1984 work began on the auxiliary building roof, elevation 791, to build a storage facility for the plant maintenance insulators. The work performed on this day consisted of bringing up material to the roof that was required to build the storage facility. A simultaneous opening of doors A208 and A209 did not occur on this day. On the next day, August 17, the actual fabrication of the storage facility began. A Public Safety officer was stationed at the doors, since A209 was a vital area door which is normally locked closed. The work being performed at this time required 110 volt power for some power tools, but no source was available on the roof. The carpenters asked the guard if they could run an extension cord through the doors. The guard called his immediate supervisor at Post 1 and asked if this was acceptable. He was told that the doors were not fire barriers and that a breach of both doors was acceptable. The carpenters then ran an extension cord through and breached both doors open. This occurred at approximately 0700 CST. This breach continued until 0940 CST, at which time the maintenance personnel left for lunch. The officer then secured A209 and left the location. At 1045 CST the carpenters returned from lunch and a new Public Safety officer was stationed at the door. The carpenters worked for approximately one hour without a cord run through the doors and left for the day. Neither the carpenters, nor the Public Safety officers were aware of the ABSCE requirement for this door. Operations was not aware of the breach that had occurred, since breaching of a vital area door did not require their notification. If these doors had been fire barriers, a breach permit would have been required and Operations would have prevented the event.

At 0729 CST on the following Monday, August 20, work resumed on the roof. An extension cord was run through the doors and both doors were breached open. At 0830 CST a Field Services supervisor saw the condition, notified Operations, and told the carpenters to close the doors. An ASE was sent to the doors and verified that one of the two doors (A208) was closed. He found that the carpenters had taped the cord down and closed door A208 on it. He told them that this was acceptable and shortly thereafter called the carpenters' foreman and had the cord removed. The cord was then run up to the roof from a location outside the auxiliary building. The work on the roof continued until lunch. During lunch, door A209 was locked shut and all personnel left the area. At lunch the Public Safety officer who had been stationed at the doors became ill and left for the day. The officer who had been stationed at the doors on the previous Friday, August 17, was sent to monitor the doors. This Public Safety officer was not made aware of the breach problem which had occurred earlier in the day by either his management or by the carpenters performing the work. Due to the lack of ventilation in the area, he breached both doors to increase air circulation. This second breach occurred at approximately 1226 CST. At 1305 CST a third Public Safety officer assumed the post. He was advised by one of the carpenters at 1325 CST of the ABSCE problem and immediately closed door A208. The second door breach can be attributed to failure of communication between first line management and personnel performing the work.

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

The major contributing factor to these breaches was the failure of plant procedure TI-77, "Breaching of the Shield Building ABSCE," to list which doors were part of the ABSCE boundary. This, coupled with the lack of communication between the groups involved, caused the repeated events.

Corrective Action Taken

1. Plant Procedure TI-77 has been revised to list all doors which are part of the ABSCE boundary. A second revision to the procedure was also made to help clarify ABSCE requirements and has incorporated the ABSCE door breach permit form into the PHY-13 Fire Barrier Breach Permit. By combining the two forms, all Fire Breach Permits will be evaluated for TI-77 applicability.

2. All ABSCE doors have been labled as ABSCE boundary and require reference to TI-77 prior to breaching.

3. Personnel involved were instructed on the requirement of maintaining ABSCE.

4. Written guidance was sent to Plant Security to inform them which doors are ABSCE boundaries. This Night Order, issued by the Operations Supervisor, also required all auxiliary building door breaches to be evaluated by the Shift Engineer. It was implemented on October 9, 1984.

TENNESSEE VALLEY AUTHORITY
Sequoyah Nuclear Plant
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November 30, 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-50-327/84055, Revision 1

The enclosed licensee event report provides additional details concerning breaches of Auxiliary Building Secondary Containment Enclosure (ABSCE), which occurred on August 17, 1984 and August 20, 1984. This revision was made to meet commitments made in response to Violation 50-327/84-25-02 and 50-328/84-25-02. These events were reported in accordance with 10 CFR 50.73, paragraph (a)(2)(vii).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

O.R. Wallace

P. R. Wallace
Plant Manager

Enclosure
cc (Enclosure):

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