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R.J. Adney
Site Vice President
Sequoyah Nuclear Plant

April 24, 1996

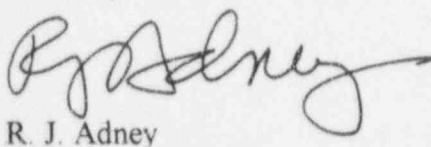
U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT (SQN)
UNITS 1 AND 2 - DOCKET NOS. 50-327 AND 50-328 - FACILITY OPERATING
LICENSES DPR-77 AND DPR-79 - LICENSEE EVENT REPORT (LER) 50-327/96003

The enclosed report provides details concerning the failure to perform surveillance requirements associated with fire barrier penetrations inside the auxiliary building as required by technical specifications (TSs). This condition is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B) as an operation prohibited by the plant TSs. This report also satisfies the reporting requirements for TS Limiting Condition for Operation 3.7.12 Action (a).

Sincerely,



R. J. Adney

Enclosure
cc: See page 2

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Enclosure

cc (Enclosure):

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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)
Sequoyah Nuclear Plant (SQN), Units 1 and 2DOCKET NUMBER (2)
05000327PAGE (3)
1 of 5

TITLE (4) Failure to Perform Surveillance Requirements for Penetration Fire Barrier Inspections as Required by Technical Specifications

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 NAME SQN Unit 2	DOCKET NUMBER
03	25	96	96	003	00	04	24	96	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)				
POWER LEVEL (10)	100	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)(vii)	OTHER	
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)	
		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
J. Bajraszewski, Compliance Licensing EngineerTELEPHONE NUMBER (Include Area Code)
(423) 843-7749

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

CAUSE	SYS TEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES
(If yes, complete EXPECTED SUBMISSION DATE).

X NO

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On March 25, 1996, with Units 1 and 2 in power operation at approximately 100 percent, it was discovered that surveillance requirements (SRs) associated with the inspection of penetration fire barriers in the auxiliary building were not performed as required by technical specifications (TSs). TSs require that at least once every 18 months fire barrier penetrations shall be verified to be functional by a visual inspection. A fire protection audit discovered that the August 1995 performance of the penetration visual inspection surveillance instruction (SI) did not inspect the penetrations in five areas of the auxiliary building. The cause of this condition was personnel error in that the SI performer and reviewer incorrectly believed that visual inspection was not required if access to an area was restricted by radiological conditions (high radiation, dose rate greater than 1 rem/hour). This belief was the result of a misunderstanding of the SI requirements. Based on this belief, the performer anoted the SI for areas not accessed, and the reviewer marked the SI as acceptance criteria met. A review of previously-performed SIs identified that one of the same areas was not accessed in the March 1994 performance by the same individuals. Upon identification of the condition, Operations entered the appropriate limiting condition for operation (LCO), and the areas not accessed were inspected. The inspection did not identify any deficiencies, and the LCO was exited. This report also satisfies the reporting requirements for TS LCO 3.7.12 Action (a). The appropriate disciplinary action was taken with the involved individuals, and they were counseled on the event to understand lessons learned.

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

I. PLANT CONDITIONS

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

II. DESCRIPTION OF EVENT**A. Event**

On March 25, 1996, it was discovered that surveillance requirements (SRs) associated with the inspection of penetration fire barriers [EIIS Code SEAI.] in the auxiliary building [EIIS Code NF] were not performed as required by technical specifications (TSs). TSs require that at least once every 18 months fire barrier penetrations shall be verified to be functional by a visual inspection. A fire protection audit discovered that the August 1995 performance of the surveillance instruction (SI) for penetration visual inspections did not access and inspect the penetrations in five areas of the auxiliary building. A review of previous SI performances identified that one of the same areas was not accessed in the March 1994 performance by the same individuals. Subsequent inspections did not identify any deficiencies. This report also satisfies the reporting requirements for TS Limiting Condition for Operation (LCO) 3.7.12 Action (a).

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

None.

C. Dates and Approximate Times of Major Occurrences

August 24, 1995	An SI for the visual inspection of penetration fire barriers was performed. The individuals involved did not inspect fire barriers that were restricted by radiological conditions (high radiation, dose rate greater than 1 rem/hour).
March 25, 1996	It was discovered that the SI was incorrectly performed.
March 27, 1996 at 0930 Eastern standard time (EST)	The action for LCO 3.7.12.a was entered as a result of the failure to visually inspect fire barrier penetrations.
March 28, 1996 at 0922 EST	LCO 3.7.12.a was exited. A visual inspection found the fire barrier penetrations that were not inspected on the previous performance of the SI to be functional.

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D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

During the performance of a fire protection audit, it was discovered that the August 1995 SI performance of penetration fire barriers in the auxiliary building visual inspection of barriers associated with five rooms was not performed. Extent of condition reviews identified that one of the same areas was not inspected in the March 1994 SI performance.

F. Operator Actions

After the main control room operators were notified of the condition, the action of LCO 3.7.12.a was entered.

G. Safety System Responses

No safety system response was required.

III. CAUSE OF EVENT

A. Immediate Cause

The immediate cause of this condition was the failure to properly perform the TS SR.

B. Root Cause

The root cause of the condition was personnel error in that the SI performer and reviewer incorrectly believed that visual inspection was not required if access to an area was restricted by radiological conditions (high radiation, dose rate greater than 1 rem/hr). This belief was the result of a misunderstanding of the SR requirements. The SI required the inspection of both sides of a barrier. If access was restricted because of radiological conditions or immovable obstructions, then at least one side required visual inspection along with a written justification. The involved individuals incorrectly thought that noting access restrictions was appropriate justification for not performing the inspection. The

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review of previously performed SIs found that in the March 1994 SI performance one of the same areas in the auxiliary building was not inspected based on access restrictions. That SI was performed by the same individuals. A review of other fire barrier inspection SIs performed by different individuals did not identify performance discrepancies.

C. Contributing Factors

None.

IV. ANALYSIS OF EVENT

The functional integrity of the fire barrier penetrations ensures that fires will be confined or adequately retarded from spreading to adjacent portions of the plant. The visual inspection of penetration fire barriers in accordance with TS SR 4.7.12 ensures functional integrity. Subsequent to the SI performance, a visual inspection found the missed fire barriers to be functional. Therefore, in the unlikely event of a fire, the penetration fire barriers would have confined or retarded the spread of fire. Based on these facts, the condition would not have resulted in adverse consequences to plant personnel or to the general public.

V. CORRECTIVE ACTIONS

A. Immediate Corrective Action

The control room staff promptly entered the appropriate LCO action, and the missed areas were visually inspected. The inspection determined that the penetration fire barriers were functional.

The appropriate disciplinary action was taken with the involved individuals, and they were counseled on the event to understand lessons learned. After the condition was identified, additional records were reviewed to identify other missed performances. The inspection of one area in the auxiliary building was found missed in the March 1994 SI performance. This area was inspected and was found to be acceptable.

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B. Corrective Action to Prevent Recurrence

Management has reinforced expectations for proper procedure adherence, proper completion of documentation, and accountability (including potential disciplinary actions) with site employees.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

A review of previous reportable events identified two LERs (50-327/92-03 and 92-21) associated with missed SIs as a result of access restrictions and two LERs (50-327/91-08 and 92-13) associated with the failure to visually inspect fire barrier penetration seals. The cause of these events was deficient procedures and was corrected by the revision of the associated procedures. Actions taken for these previous events would not have prevented the condition described by the current LER.

C. Additional Information

SIs associated with fire barriers are being reviewed to determine if improvements in implementation performance could be made through SI consolidation and/or a change of the implementing organization.

VII. COMMITMENTS

None.