

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 2		DOCKET NUMBER (2) 0 5 0 0 0 3 2 8	PAGE (3) 1 OF 0 3
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TITLE (4) Inoperable Containment Spray Pump	
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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	4	0	6	8	5	8	5	0	0	6	0	5	0	0	0		
0	4	0	6	8	5	8	5	0	0	6	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)		50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)				
	20.405(a)(1)(iii)	XXX	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)(vii)(B)						
20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)							

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME David P. Ormsby, Compliance Engineer		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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

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)

On April 6, 1985, the air control valve for the essential raw cooling water valve 2-FCV-67-186 was found in the closed position. This would have prevented the supply of cooling water to CS pump room cooler 2B-B and resulted in inoperability of the CS pump. The valve was immediately returned to its normal position. This event is reportable per 10 CFR 50.73 a.2.i.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Sequoyah, Unit 2	05000328	85	006	00	02	OF	03

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

This event was discovered while unit 2 was in mode 1 (100 percent power, 2250 psig and 573 degrees F).

While making a routine inspection on April 6, 1985, an Assistant Unit Operator (AUO) found the three-way air valve for the 2B-B CS pump room cooler essential raw cooling water (ERCW) valve 2-FCV-67-186 in the closed position. This would have blocked the supply of ERCW and would have prevented the pump room cooler from performing its intended function. If CS pump 2B-B was placed in operation, the room temperature would have exceeded the design limit of 110 degrees F for the pump. The air valve was immediately returned to its correct normal position.

A review of historical information related to this event shows that in early 1984 modifications were made to the ERCW valve controllers for engineered safety feature pump room coolers, to comply with equipment qualification as specified in NUREG-0588. Specifically, the Containment Spray System (CSS), Safety Injection System (SIS), Residual Heat Removal System (RHRS), and centrifugal charging pumps were involved. As a result, the existing backing plates for the selector switches for the three-way air valves provided incorrect indication of normal and closed positions. On May 25, 1984, the air valve for the 2B-B SIS pump room cooler ERCW valve 2-FCV-67-182 was found closed and immediately returned to normal. It was determined that the valve had been placed in the incorrect position following Surveillance Instruction (SI)-566. Since the valve had been in the incorrect position less than the 72 hours specified in the Limiting Condition for Operation (LCO) of Technical Specification 3.6.2.1, this event was not reportable to NRC in accordance with 10 CFR 50.73 or any other reporting requirement; however, it was recognized that improper valve alignment was due to the incorrect position indications on the valve back plate. To address this problem, the tips of the selector switches and the ends of the air lines for the normal position were painted orange to show the proper alignment. Operations employees were informed to disregard the positions indicated by the back plates and to align the valves in accordance with the orange paint.

As stated previously, the air valve for ERCW valve 2-FCV-67-186, was found in the closed position on April 6, 1985. The last activity associated with this valve was SI-566. A check of the data sheets completed during the walkdown to verify system alignment, following completion of SI-566 on March 24, 1985, indicated the valve was in the normal position. However, interviews with the AUO and test representative involved in the system walkdown disclosed that neither employee recalled the requirement for valve alignment in accordance with the orange markings. The mispositioning of the valve is therefore attributed to the improper back plate indications. To prevent recurrence, the back plates for the air controllers of the ERCW valves for the CSS, SIS, RHRS, and centrifugal charging pump room coolers will be modified to provide correct indication for valve position.

After the 2B-B valve was found and returned to normal, all other air control valves affected by the improper plates were verified to be in their normal position. With the 2B-B CS pump room cooler inoperable, the pump would have operated for approximately one hour before the pump room temperature exceeded 110 degrees F. The redundant train of CS (pump 2A-A) was operable and could have provided sufficient spray.

# LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
Sequoyah, Unit 2	0500032885	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	0003	OF	03
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

In view of the similar event on May 25, 1984, and the likelihood that for the second event the 2B-B CS pump was in an inoperable configuration for more than the 72 hours allowed by Technical Specification 3.6.2.1, this is reportable per 10 CFR 73 a.2.1. There was no effect on public health and safety.

TENNESSEE VALLEY AUTHORITY

Sequoyah Nuclear Plant  
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Soddy Daisy, Tennessee 37379

May 6, 1985

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

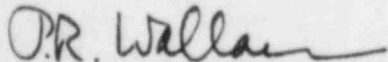
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 2 - DOCKET NO.  
50-328 - FACILITY OPERATING LICENSE DPR-79 - REPORTABLE OCCURRENCE REPORT  
SQRO-50-328/85006

The enclosed licensee event report provides details concerning an inoperable  
containment spray (CS) pump. 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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