RAS 5930 50-390-CIVP, et. al. Joint Exhibit 2 - Rec'd 4/24/02

SEQUOYAH NUCLEAR SAFETY REVIEW BOARD (NSRE) MINUTES OF MEETING NO. 133 - AUGUST 21-22, 1991

EXECUTIVE_SUMMARY

Sequerah NSRB meeting No. 133 was held August 21-22, 1991. All members and advisors were present for both days except L. W. Myers.

The following subjects which were discussed may be of interest:

Radiological Controls Performance

In the August 1991 Systematic Assessment of Licensee Performance report, the Nuclear Regulatory Commission noted declining performance in radiological controls at Sequoyah and suggested management attention. Review by the NSRB identified that Sequoyah may not be adequately evaluating radiological control incidents and, therefore, not using lessons learned to improve the program. The threshold for identification of deficiencies and investigation of incidents appears to be too high. For example, an incident investigation was not performed when two individuals were contaminated as a result of violation of requirements for removal of material from the spent fuel pit. In addition, the number of radiological deficiency reports being issued, about one per week, seems low. The Site Vice President is taking action to review this area and will report back to the NSRB. In addition, Corporate Radiological Controls has initiated a review of the threshold for radiological deficiency reporting at Sequoyah.

Elimination of Radiological Assessment Review Committee (RARC-)

The RARC was established "to advise the Manager of Radiological Controls and the Plant Manager on all matters related to radiological assessments involving dose calculations and projections and environmental monitoring." Since RARC's establishment, other groups have taken on similar responsibilities. The NSRB believes RARC no longer fulfills a necessary role. Corporate Chemistry and Radiological Services was asked to consider elimination of RARC at both /Sequeyah and Browns Ferry.

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Site and Corporate response to NSRB recommended actions for proceduralizing preparation of Justifications for Continued Operation has been slow, but recent Sequoyah action indicates renewed progress.

QA had identified examples where technical specification changes were not correctly implemented into plant procedures. Site procedures have now been modified and constraints to implementation such as outages are identified to ensure timeliness of required actions.

Operations and Maintenance Subcommittee

The limited number of operators interviewed correctly stated their authority to manually trip the reactor if they believed they were losing control of the plant. Emphasis in this area was suggested for simulator training.

Plant personnel were sensitive to non-safety related equipment that was reaching the end of its service life and appropriate preventive measures were being taken. Although the component cooling system's plate heat exchangers were unique to TVA nuclear service when installed, they are performing satisfactorily. Care is needed, however, in selecting chemicals for in-place cleaning of these heat exchangers.

During discussion with the subcommittee, a reactor operator indicated that the Bypassed and Inoperable Status Indication (BISI) system appears to provide incorrect information. Action may be needed to bring BISI into conformance with the related NRC Regulatory Guide (A133-7).

Radiological Control/Chemistry Subcommittee

Incorrect contractor analysis of environmental samples has been identified by TVA's chemistry laboratory but the problem has not yet been resolved. Timely action to correct quality problems with the contract laboratory is needed (A133-8).

Site Chemistry was requested to review the impact of any unmonitored radioactive release paths. The subcommittee does not expect any major impact, but a formal review should be conducted (A133-9).

' The availability of the radiation exposure (REX) tracking system needs improvement to keep from impacting outage activities (A133-10).

Engineering, Construction, and Modification Subcommittee

Plans for testing critical motor operated valves and planned response to testing results are in place. Discussions are ongoing with the NRC regarding the acceptability of the proposed selective testing.

Good information sharing between Watts Bar and Sequoyah regarding containment corrosion control has occurred. If Sequoyah finds corrosion during outage inspections, adequate analysis and corrective measures are available.

Pipe stresses induced by thermal stratification are under study. Evaluation is planned to determine if additional inspections should be performed during the outage cool down.

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RADIOLOGICAL CONTROL/CHEMISTRY (RAD/CHEM) SUBCOMMITTEE REPORT

The subcommittee met on August 21-22, 1991, to review various aspects of Sequoyah's radiological and chemistry programs. Included in this review was discussion of the site's As Low As Reasonably Achievable program, outage preparation, actions on previous NSRB comments, high radiation area corrective actions, liquid radioactive waste, contractor laboratory analysis, and the functioning of the Radiological Assessment Review Committee (RARC). The following observations/recommendations are provided:

- In reviewing a recent event wherein three individual's shoes were contaminated while on tour in the vicinity of the fuel pool, the subcommittee learned that there was no intent to initiate an incident investigation. An investigation is required by site procedures. The contamination spread was apparently the result of the removal of a hose from the fuel pool without proper authorization or monitoring by radiological control. It should be noted that the fuel pool has been an industry source of "hot particles" and fairly significant overexposures. It is important that an incident investigation be completed that addresses, at a minimum, the cause of the event, procedural violations involved, why the significance was not recognized, and what corrective actions are required. It was confirmed during the NSRB meeting that an investigation has been initiated.
- On an average, there is only one radiological deficiency report generated per week. The subcommittee recommends that management review the threshold for these reports. Lowering the threshold at which events are reviewed should further improve the program (A133-1).
- In reviewing corrective actions being taken as a result of an audit of a vendor (SAIC) performing analysis of environmental samples, the subcommittee found the following:
 - No overall responsibility for resolving the problem has been established.
 - Although efforts are underway to qualify another laboratory, SAIC may be the only choice as of contract renewal in November. If this is the case, contract language should be reviewed relative to additional Quality Assurance (QA) requirements and/or penalties considered for failure to perform.
 - QA should formally establish an increased review frequency until laboratory performance improves.

It is recommended that actions be taken by Corporate Chemistry to resolve these issues (A133-8).

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ATTACHMENT D (Continued)

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The subcommittee requested that Site Chemistry investigate several suspected unmonitored radiation release liquid and gas pathways. It wasfound that such pathways existed. Additionally, the site discovered an inadequate answer was made on IN 80-10. The subcommittee recommends the site initiate a formal review of potential unmonitored pathways and resolve them as appropriate. The subcommittee believes these pathways will not significantly alter offsite doses (A133-9).

As requested by the NSRB Chairman, the subcommittee reviewed the functioning of RARC. It was learned organizational modifications and shifting of responsibilities to the site leaves the RARC with little purpose in support of TVA's environmental program. The subcommittee believes the line organization either has or can easily fulfill all needed responsibilities. The subcommittee recommends Corporate Chemistry and Radiological Services initiate actions to eliminate the requirement for RARC. Sequoyah, at a minimum, will require a technical specification change and Browns Ferry will require modification to procedures (A133-2).

Based on action item responses reviewed, the subcommittee recommends the following on action items:

- Close A132-3 as the site was responsive to suggestions to put a management representative at the radiation area control points.
- Close A132-4 on As Low As Reasonably Achievable suggestions.
- Close A132-7 as fuel pool foreign material exclusion warnings have been improved.
- Close A132-10 as better control of charcoal cartridges was evident.
- Close A128-4 es training on proper frisking has been improved.
- Close A132-5 as most exposure tracking concerns have been addressed.
 However, radiological exposure tracking system (REX) downtime still needs to be reduced to speed radiological control area work (A133-10).
- Fost-Accident Sampling System training concerns have not been addressed and this action item remains open (A132-6).

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