SEQUOYAH NUCLEAR SAFETY REVIEW BOARD (NSRB)
MINUTES OF MEETING NO. 132
MAY 22-23, 1991

EXECUTIVE SUMMARY

Sequoyah NSRB meeting No. 132 was held May 22-23, 1991. All members and advisors were present for both days except R. R. Calabro.

1. NSRB Recommendation

- Corrective Action Completion Timeliness, R115-1 (Closed)

  The implementation of the simplified Problem Evaluation Report has resulted in a short-term increase of new issues. The site vice president reported that the backlog of corrective actions has risen even though substantial resources are being expended on closure. Timeliness has improved even though the volume of reports has increased. The problem has substantial management attention and on this basis the NSRB closes the recommendation. The NSRB will continue to monitor progress in this area.

2. The following subjects were discussed.

- Fire Protection Responsibility

  Progress has been made in addressing fire protection concerns but additional problems have surfaced. Site and Corporate efforts are in progress to define and address all fire protection issues. The NSRB will hold this action item open until corrective actions are identified and scheduled.

- Actions to Improve Operations Performance

  The plant manager described his efforts to define and communicate management's expectations to operations personnel. The plant manager is giving regular and consistent direction to operations management for taking ownership of the plant during their shift. It was apparent, however, from plant incidents which have occurred this year and NSRB interviews with management and working level personnel that adherence to administrative procedures and communication of management expectations was often inadequate. The NSRB will monitor corrective actions necessary to ensure that management's expectations are clearly communicated to all levels of personnel.

CLEAR REGULATORY COMMISSION

Docket No 50-390 Official Exh. No. Joint-1

In the matter of TVA

Staff Joint	IDENTIFIED ✓
Applicant	RECEIVED ✓
Intervenor	REJECTED
Other	WITHDRAWN
DATE 4/24/02	Witness
Clerk BHM	

Cold Leg Accumulator Inleakage

Originally check valve seepage was thought to be the cause of the accumulator inleakage. Since valve manipulations have stopped the inleakage, it is now thought another path was more likely The site is requested to give a presentation at the August 1991 meeting covering the most likely inleakage path and the lessons learned from investigation of this event (A132-2).

Institute of Nuclear Power Operations (INPO) Evaluation

The site vice president reported that the recent INPO evaluation was generally successful with relatively few significant findings. Based on preliminary INPO conclusions, the most significant issue was a "global" concern regarding the ability of operators to take prompt effective action in dealing with plant events.

Subcommittee Activity Summary

Quality Assurance and Safety Oversight Subcommittee

The subcommittee concluded that while some improvements in trend report usefulness have been made since the NSRB made a recommendation in this area, there are still a variety of problems. The QA manager will discuss corrective plans with the subcommittee at the nexr NSRB meeting.

The subcommittee reviewed the status of the Corrective Action Program. Significant improvements have been made but opportunities remain for fine tuning the program to ease closure and raise the threshold for item inclusion. The subcommittee will reassess the program at the next meeting.

Operations, Maintenance, and Modifications Subcommittee

The subcommittee discussed methods to prevent the propagation of maintenance errors into redundant equipment with the outgoing and incoming maintenance managers. The methods in place appear adequate to prevent this low probability event.

The subcommittee met with modifications to discuss planning for a near term upgrade and a longer term overhaul of work control. The subcommittee cautioned that Quality Control inspectors should be trained along with modifications personnel on the changes.

Radiation and Chemistry Subcommittee

The subcommittee identified a number of areas where performance can be improved (1) in radiologically controlled area work through use of an outage management representative to help coordinate activities (A132-3), (2) in the As Low As Reasonably Achievable Program with more detailed radiation source definition (A132-4), (3) through more readily available radiation exposure tracking (A132-5), (4) by use of more realistic training for the Post-Accident Sampling System (A132-6), and (5) by improved spent fuel pool foreign material exclusion posting (A132-7).

- The Radiation Exposure Tracking System (REXS) has significantly contributed to the sites ability to manage its ALARA program. However, problems still exist:

  Recommendation

  System downtime is a hindrance and its impact could be greatly reduced, particularly during outages, through the use of personal computers. Implementation of an effective MPC-hour tracking change (keyed to area air samples) would save an estimated 2500 man-hours/year. Installation of a "clock" feature on radiation work permit (RWP) sign-in would enhance the ability to address changing radiological conditions. The addition of interactive questioning upon RWP sign-in would improve the confidence that workers had read and understand their RWP (A132-5).

  It is recognized that a tight schedule to complete phase 2 of REXS for Sequoyah may impact the addition of enhancements to the system. However, enhancements that will improve the plant's use of REXS should be prioritized for implementation.

- PASS training does not recognize time/exposure constraints on collecting and analyzing samples:

  Recommendation

  Include proficiency parameters in training to ensure original design criteria can be met in accordance with NUREG-0737. Ensure that the above is performed in the same anti-c's/respiratory protection anticipated for post-accident sampling conditions (A132-6).

- During a tour of the RCA, the following was observed:

  Radiological postings and material condition generally appeared good. Housekeeping in the Radwaste truck bay was very poor, however, and general housekeeping would be enhanced by picking up "clean" anti-c's.

  Recommendation

  Posting of foreign material exclusion warnings around the spent fuel pool could be improved. Currently there are two signs for the entire area and one was partially covered (A132-7).

- Discussions were held with chemistry on effluent analysis and pathway monitoring. Two known unmonitored pathways were discussed, and it was reported that they had been analysed and were "trivial." This subject will be reviewed further by the subcommittee.

- Progress on the previously established action item (A128-4) regarding the corporate requirement for frisking when leaving a radiation area is ongoing but incomplete.