

USNRC TENNESSEE VALLEY AUTHORITY
ATLANTA, GEORGIA CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

81 AUG 13 AIO: 1'

August 7, 1981

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Region II - Suite 3100
101 Marietta Street
Atlanta, Georgia 30303

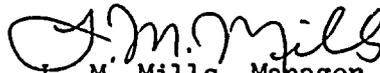
Dear Mr. O'Reilly:

This is in response to R. C. Lewis' July 8, 1981 letter to H. G. Parris, Report Nos. 50-259/81-14, -260/81-14, and -296/81-14, concerning activities at the Browns Ferry Nuclear Plant which appeared to violate NRC requirements. Enclosed is our response to Appendix A, Notice of Violation. If you have any questions, please call Jim Domer at FTS 857-2014.

To the best of my knowledge, I declare the statements contained herein are complete and true.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



L. M. Mills, Manager
Nuclear Regulation and Safety

Enclosure

8109010499 810818
PDR ADOCK 05000259
Q PDR

1954

1954

NOTICE OF THE DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315
1954

THE DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315
1954

1954

1954

1954

1954

1954

ENCLOSURE
RESPONSE TO R. C. LEWIS' LETTER
DATED JULY 8, 1981 TO H. G. PARRIS
INSPECTION REPORT NOS.
50-259/81-14, 50-260/81-14, AND 50-296/81-14

Violation A

Technical Specification 3.5.E.1 requires that the high pressure coolant injection system shall be operable whenever there is irradiated fuel in the reactor vessel and the reactor vessel pressure is greater than 122 psig. Operating Instruction 57 requires the HPCI injection valve (73-44) to be open for the HPCI system to be considered operable when a unit battery is out of service.

Contrary to the above, the HPCI system was inoperable in that the HPCI injection valve (73-44) was not opened when a unit battery was removed from service at 1:16 p.m. on May 5, 1981, nor was the system declared inoperable until 27 hours after unit battery was removed from service for a load test. This violation continued for about 26 hours after our inspector informed plant supervision of the violation.

This is a Severity Level IV Violation (Supplement I.D.3) applicable to unit 3.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

Due to a leaking downstream check valve causing excessive suction pressure on the HPCI pump, the unit 3 HPCI discharge valve (FCV 73-44) could not be opened as required by SI 4.9.A.2.c. Operations personnel were not aware of Step 10 of the GE design criteria on figures 8.6-4b and 8.6-4c of the FSAR. The requirements of operational instruction (OI) 57 to declare the HPCI system inoperable were inadequate because there was no control in effect to flag the use of this procedure during the performance of SI 4.9.A.2.c or during the sequence of events associated with the HPCI pump suction pressure problems.

3. Corrective Steps Which Have Been Taken and Results Achieved

When supervisors were made aware of the requirements in OI-57, the HPCI system was declared inoperable and appropriate surveillance tests were performed. The HPCI system remained inoperable until 4.9.A.2.c was completed.

4. Corrective Steps Which Will Be Taken to Avoid Further Violations

- A. SI 4.9.A.2.c has been revised to state the reason for HPCI valve FCV 73-44 abnormal lineup and to add a prerequisite signoff to ensure that all prerequisites have been met.
- B. This event will be covered in licensed operator retraining along with the findings of the inspection report.



5. Date When Full Compliance Will Be Achieved

- A. SI 4.9.A.2.c has been revised and was PORC approved on July 21, 1981.
- B. Retraining on the event will be complete by January 1, 1982.

Violation B

Technical Specification 3.11.A.1.b requires that the high pressure fire protection system shall have automatic initiation logic operable.

Contrary to the above, the requirement for automatic initiation logic to be operable was not met in that on May 1, 1981 it was determined by the licensee that the automatic start feature for the fire pumps was inoperable and had been in this condition since sometime after April 17, 1981. This condition was caused by leads being lifted in the automatic start circuit during plant modifications.

This is a Severity Level V Violation (Supplement I.E.).

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

A modification in the fire protection logic system panel was being performed when leads were apparently inadvertently lifted. Lifting these leads removed power for the automatic start logic for the fire protection system.

The engineer in charge of the job had previously taped the terminal block in question and instructed the craftsmen not to work behind the tape. We have concluded that the craftsmen involved were responsible for the violation.

3. Corrective Steps Which Have Been Taken and Results Achieved

The leads that were lifted for the automatic start feature of the fire pumps were reconnected immediately upon discovery and the auto start feature of the fire pumps was restored.

4. Corrective Steps Which Will Be Taken to Avoid Further Violations

The craft foremen and general foremen have been made aware of the necessity to follow verbal instruction from the cognizant engineers and to follow the workplan.

5. Date When Full Compliance Will Be Achieved

We were in full compliance on May 2, 1981 when discussions were held as described in item 4 above.



Violation C

Technical Specification 6.3.A.6 requires detailed written procedures be prepared, approved and adhered to for surveillance and operations of systems and components involving nuclear safety.

1. Contrary to the above, written procedures were not adhered to in that the HPCI discharge valve (73-44) was not opened for unit 3 as required by the prerequisite section of Surveillance Instruction 4.9.A.2.c during a battery discharge test on May 5-6, 1981.
2. Contrary to the above, a written procedure, which specified switch position (Operating Instruction 31) was not followed for the operation of the control room emergency pressurization unit (CREU) in that on May 20, 1981 at 8:45 a.m., the "B" CREU unit would not start automatically on an accident signal because of an improper switch lineup.

This is a Severity Level V Violation (Supplement I.E.).

Violation C.1

1. Admission or Denial of the Alleged Violation

- . TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

The senior reactor operator (SRO) assigned to perform SI 4.9.A.2.c misinterpreted the requirements to open HPCI discharge valve FCV 73-44 to apply only to the unit 2 HPCI which was the unit battery under test. After this misinterpretation of the procedure, further action was not considered by the operators.

3. Corrective Steps Which Have Been Taken and Results Achieved

- A. The HPCI system was declared inoperable on May 6, 1981. It was not possible to open FCV 73-44 due to the probability that the pump would be damaged by the high suction pressure. (See response to Violation A.)
- B. The event was discussed with the SRO assigned to SI 4.9.A.2.c and the SRO was given a verbal reprimand.

4. Corrective Steps Which Will Be Taken to Avoid Further Violations

- A. SI 4.9.A.2.c has been revised to clearly state that the requirement to open FCV 73-44 applies to all units.
- B. This event and the findings of the inspection report will be covered in licensed operator retraining.

5. Date When Full Compliance Will Be Achieved

- A. SI 4.9.A.2.c has been revised and was PORC approved on July 21, 1981.
- B. Licensed operator retraining will be completed by January 1, 1982.



Violation C.2

1. Admission or Denial of the Alleged Violation

TYA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

Determination has not been made as to what events lead to the specific violation. The most probable cause was the switches being realigned in the incorrect position following testing of the control room emergency pressurization unit system. Surveillance instruction 4.7.E.6 for the control room emergency pressurization system operability was found to be inadequate to ensure proper switch alignment following completion of the operability test.

3. Corrective Steps Which Have Been Taken and Results Achieved

The "B" control room emergency pressurization unit switches were immediately realigned in the proper position and surveillance tests were performed on the "A" and "B" control room emergency pressurization units to prove operability.

4. Corrective Steps Which Will Be Taken to Avoid Further Violations

SI 4.7.E.6 for testing the control room emergency pressurization systems has been revised to ensure proper lineup of control switches upon completion of testing.

5. Date When Full Compliance Will Be Achieved

SI 4.7.E.6 has been revised and was PORC approved on July 14, 1981.

