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MEDFORD,M.O. Tennessee Valley Authority
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SUBJECT: Response to NRC 890522 ltr re violations noted in Insp Repts 50-259/89-11,50-269/89-11,& 50-296/89-11.Tech Specs.....

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JUL 10 1989

U.S. Nuclear Regulatory Commission
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Washington, D.C. 20555

Gentlemen:

In the Matter of	)	Docket Nos. 50-259
Tennessee Valley Authority	)	50-260
		50-296

BROWNS FERRY NUCLEAR PLANT (BFN) UNITS 1, 2, AND 3 - NRC INSPECTION REPORT NOS. 259/89-11, 50-260/89-11, AND 50-296/89-11 - RESPONSE TO NOTICE OF VIOLATION - TECHNICAL SPECIFICATIONS 3.2.A AND 4.6.B.1.c

This letter provides TVA's response to the notice of violation transmitted in the subject report. The report was sent from Bruce A. Wilson to Oliver D. Kingsley, Jr. dated May 22, 1989, and cited TVA with two violations involving two instances of failure to satisfy compensatory actions required by technical specifications when equipment was not operable.

The enclosed information responds to NRC concerns regarding deficiencies in the planning, review, and implementation of maintenance activities, and in evaluating the impact of those activities on operability requirements. On June 21, 1989, a telephone call was made to William S. Little of your staff to extend the due date of this response from June 21, 1989 to July 5, 1989. Enclosure 1 provides TVA's violation response.

A list of commitments is provided in enclosure 2.

If you have any questions, please telephone Patrick P. Carier, BFN, at (205) 729-3570.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

Mark O. Medford

Mark O. Medford
Vice President and Nuclear
Technical Director

Enclosures
cc: See page 2

IE01

U.S. Nuclear Regulatory Commission

JUL 10 1989

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Enclosure 1

RESPONSE
NRC INSPECTION REPORT
NOS. 50-259/89-11, 50-260/89-11, AND 50-296/89-11
LETTER FROM B. A. WILSON TO O. D. KINGSLEY, JR.
DATED MAY 22, 1989

Violation A

Technical Specification 3.2.A, Table 3.2.A, note G requires that the Reactor Building be isolated and the Standby Gas Treatment system be started when the Instrument Channel which provides the "Reactor Building Ventilation High Radiation-Reactor Zone" function is inoperable.

Contrary to the above, for the periods of February 25, 1989, at 6:05 p.m., to February 26, 1989, at 8:17 a.m., and February 26, 1989, at 8:50 a.m., to February 28, 1989, at 10:20 a.m., the Unit 1 Reactor Zone Exhaust Radiation Monitor (channel A) was inoperable and the required compensatory actions were not in place.

TVA's Response

Admission or Denial of the Alleged Violation

TVA admits the violation.

Reason for the Violation

The violation occurred as a result of a failure to identify and track technical specification (TS) required equipment that would be made inoperable during the performance of maintenance or modification. Consequently, the compensatory actions which had been in effect were not maintained as required. Had the radiation monitor been properly identified as inoperable, compensatory actions would have been initiated and continued until postmaintenance testing was completed, and the equipment was declared operable.

The cause of the failure is personnel error. Instrument maintenance personnel failed to follow the procedure in that the the troubleshooting Maintenance Request (MR) was not revised or returned for further review before repair work was performed on the monitor. Other contributing factors included inadequate communications between the Senior Reactor Operator (SRO) and the instrument maintenance personnel performing the troubleshooting activity. From these communications, the SRO believed that the troubleshooting work would not make the monitor inoperable.

Corrective Steps Which Have Been Taken and Results Achieved

Upon discovery by a utility maintenance engineer that postmaintenance testing of the unit 1 reactor zone exhaust radiation monitor had not been completed, the compensatory actions required by the TS were taken. These actions included isolation of the reactor building and actuation of the standby gas treatment and control room emergency ventilation systems. Postmaintenance testing on the radiation monitor was completed on March 1, 1989 at 1:50 p.m., and the monitor was declared operable.

Instrument maintenance and operations personnel have been provided a description of this event to emphasize the need for thorough and precise communication. The instrument maintenance personnel involved were counseled on the importance of adherence to procedures. Appropriate plant procedures have been revised to clarify requirements on troubleshooting MRs to require revision before repair on all safety-related equipment.

This was a licensee identified violation. It was reported to NRC on March 30, 1989, by Licensee Event Report (LER) 259/89006. In addition to the corrective action in the LER, BFN has reviewed the activities required to be performed before maintenance is allowed on TS required equipment. TS equipment undergoing maintenance or modifications is brought to the attention of the Shift Operations Supervisor (SOS) or his representative on shift for review of impact on operations. The SOS personally decides on equipment operability/inoperability. The SOS also ensures that the Shift Technical Advisor (STA) tracks all inoperable equipment/systems which result in a limiting condition for operation (LCO) on the LCO tracking list.

Corrective Steps Which Will Be Taken to Avoid Further Violations

After reviewing this and other related events, BFN upper management has determined that more comprehensive pre-analysis of maintenance activities involving TS required equipment is needed. Site Director Standard Practice (SDSP)-7.9, "Integrated Schedule and Work Control," will be revised to ensure positive communication and acknowledgement for required compensatory actions and LCO tracking.

SDSP-7.9 currently requires an impact evaluation sheet for any maintenance or modification on TS required equipment. However, BFN will upgrade the impact evaluation sheet to require the SOS or his designee to specifically determine the effect of the work on operability of TS required equipment and sign this determination. If TS equipment operability is affected, the impact evaluation sheet will further require STA verification that the item has been added to LCO tracking, as appropriate. In addition, the SOS will acknowledge on the impact evaluation sheet that post maintenance/modification testing is adequate to exit the LCO and has been completed before cessation of any compensatory actions. The LCO tracking procedure will be revised to require acknowledgment for each shift by the responsible individual for the completion or continuation of compensatory actions, attesting that these actions are satisfactory.

Date When Full Compliance Will Be Achieved

SDSP-7.9 will be revised by August 1, 1989, to provide for appropriate STA and SOS signature acknowledgment on the impact evaluation sheet for any maintenance or modification on TS equipment. The LCO tracking procedure will also be revised by August 1, 1989, to require acknowledgment for each shift by the individual responsible for the completion or continuation of appropriate compensatory actions.

Violation B

Technical Specification 4.6.B.1.c, requires that a sample of reactor coolant be analyzed at least every 8 hours when the continuous conductivity monitor is inoperable.

Contrary to the above, on March 6, 1989, the continuous conductivity monitor was made inoperable at 9:15 a.m., and a reactor coolant sample was not taken and analyzed until March 7, 1989, at 6:15 a.m.

Admission or Denial of the Alleged Violation

TVA admits the violation.

Reason for the Violation

This violation occurred as a result of procedural deficiencies in SDSP-7.9. This SDSP states that an impact evaluation sheet is not required for chemical instrument work that has no control function on the equipment that it is monitoring or any other equipment other than alarm function only. Since the continuous conductivity monitor had no control function, an impact evaluation sheet was not completed.

Other contributing factors included inadequate communications between the Assistant Shift Operations Supervisor (ASOS) and instrument technicians performing the MR on the monitor. The ASOS did not have full knowledge of the actions that were going to be taken by the instrument technicians during the calibration. Even though attachments from Instrument Maintenance Special Instruction (IMSI)-3014 were part of the MR package allowing the instrument maintenance technicians to remove the monitor, the ASOS did not recognize this. In addition, attachment 1 of IMSI-3014 requires the use of stickers or markings in the control room when instrument accuracy is questionable or removed from service, but the instrument maintenance technicians did not utilize this portion of the IMSI-3014 in the performance of their work.

Corrective Steps Which Have Been Taken and Results Achieved

An analysis on the reactor coolant water was performed on March 7, 1989 at 6:15 a.m. The results were 0.32 micromhos/centimeter, which is well within the TS requirements of <10 micromhos/centimeter.

The ASOS has been counseled on attention to detail in the performance of his duties. The instrument technicians have been instructed to follow the work control form, Attachment 1 of IMSI-3014, as written, especially in notifying the SOS when equipment is being made inoperable.

This was a licensee identified violation. It was reported to NRC on April 5, 1989, by LER 296/89002. In addition to the corrective action in the LER, BFN has reviewed the activities required to be performed before maintenance is allowed on TS required equipment. TS equipment undergoing maintenance or modifications is brought to the attention of the SOS or his representative

on shift for review of impact on operations. The SOS personally decides on equipment operability/inoperability. The SOS also ensures that the STA tracks all inoperable equipment/systems which result in a LCO on the LCO tracking list.

Corrective Steps Which Will Be Taken to Avoid Further Violations

Same as Violation A

Date When Full Compliance Will Be Achieved

Same as Violation A

ENCLOSURE 2

RESPONSE
NRC INSPECTION REPORT
NOS. 50-259/89-11, 50-260/89-11, AND 50-296/89-11
LETTER FROM B. A. WILSON TO O. D. KINGSLEY, JR.
DATED MAY 22, 1988

LIST OF COMMITMENTS

1. Site Director Standard Practice 7.9 will be revised by August 1, 1989, to provide for appropriate Shift Technical Advisor and Shift Operations Supervisor signature acknowledgment on the impact evaluation sheet for any maintenance or modification on TS equipment.

2. The limiting condition for operation tracking procedure will be revised by August 1, 1989, to require acknowledgment for each shift by the individual responsible for the completion or continuation of appropriate compensatory actions.