TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

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October 30, 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:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC-OIE INSPECTION REPORT 50-327/81-30, 50-328/81-38 - RESPONSE TO VIOLATIONS

The subject inspection report dated September 29, 1981 cited TVA with four Severity Level V Violations and one Severity Level VI Violation in accordance with 10 CFR 2.201. Enclosed is our response.

If you have any questions, please get in touch with R. H. Shell at FTS 858-2688.

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

Very truly yours,

TENNESSEE VALLEY AUTHORITY

M. R. Wisenburg
Nuclear Engineer

Enclosure
cc: Mr. Victor Stello, Director (Enclosure)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

ENCLOSURE
SEQUOYAH NUCLEAR PLANT UNIT 2
RESPONSE TO VIOLATIONS

VIOLATION 50-328/81-38-01

Technical Specification 6.8.1.b requires that written procedures shall be established, implemented, and maintained for refueling operations.

Contrary to the above, on July 14, 1981, written procedures for unit 2 fuel load were not properly implemented in that Maintenance Instruction MI-1.2, 'Removal and Replacement of Reactor Pressure Vessel Head,' was not being properly signed off as work was being performed and Appendix B to MI-1.2, 'Clearance Requirements,' was not properly in force during the reassembly of the reactor vessel following initial fuel load.

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

Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

Reasons for the Violation if Admitted

All steps of Maintenance Instruction (MI) 1.2 were performed under the direct supervision of the outage refueling supervisor. He had personal knowledge of all work being done but due to the workload failed to sign off this section of the MI before proceeding with the next section as instructed in the MI.

Requirements of Appendix B of the instruction were established after hot functional testing before vessel disassembly. The requirements were temporarily removed to support Preoperational Test W-6.1F, 'Integrated Engineered Safety Features Test.' After the test, all equipment necessary to support vessel reassembly was tagged by operations personnel but portions of the requirements of Appendix B were inadvertently not reinitiated before proceeding with vessel reassembly.

Corrective Steps Which Have Been Taken and the Results Achieved

The unsigned completed steps of the maintenance instruction were signed by the outage refueling supervisor and the Appendix B clearance was immediately reestablished. No work was performed without the cognizant supervisor's knowledge of the completion of all necessary prerequisites and his approval.

Corrective Steps Which Will Be Taken To Avoid Further Violations

The requirements of MI-1.2 were discussed with the onsite field services director, the outage refueling supervisor, and the operations supervisor. Emphasis was placed on following these requirements.

Date When Full Compliance Will Be Achieved

Full compliance was achieved October 20, 1981.

VIOLATION 50-328/81-38-02

Technical Specification 6.8.1.c requires that written procedures shall be established, implemented, and maintained for surveillance and test activities of safety-related equipment.

Contrary to the above, on July 15, 1981, written procedures for testing safety-related equipment were not established and implemented in that the 12-inch upper head injection system check valves were being leak tested without properly reviewed or approved written procedures.

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

Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

Reasons for the Violation if Admitted

The leak checking of the 12-inch upper head injection valves was performed on maintenance requests initiated as emergency requests because the testing of these valves was considered by the cognizant engineer to be "critical path" to the startup of unit 2. Although a maintenance request does constitute a written procedure, the cognizant engineer misused the intent of an "emergency" maintenance request while planning work for critical path as defined in the Operational Quality Assurance Manual (OQAM).

TVA disagrees with the statements made in item 6 of the Details to the inspection report which states that TVA failed to maintain system cleanliness during the testing. The cognizant engineer maintained system cleanliness as stated in the instructions on the maintenance request. Also, as stated in the instructions on the maintenance request, the system was verified to be clean (in accordance with MI-1.2) during vessel reassembly.

Corrective Steps Which Have Been Taken and the Results Achieved

Upon completion of the leak test, the work performed was reviewed by the plant quality assurance staff and found to be adequate.

Corrective Steps Which Will Be Taken To Avoid Further Violations

Responsible personnel were cautioned by plant management concerning the interpretation of the use of "emergency maintenance request," and better planning of "critical path" work was stressed.

Date When Full Compliance Will Be Achieved

Full compliance was achieved October 20, 1981.

VIOLATION 50-328/81-38-03

Technical Specification 6.8.1.b requires that written procedures shall be established, implemented, and maintained for refueling operations.

Contrary to the above, on July 4 and July 8, 1981, written procedures for unit 2 fuel loading were not properly implemented in that Fuel Handling Instruction FHI-4B, 'Movement of Fuel Assemblies with the Manipulator Crane,' was being conducted by personnel engaged in the fueling activities without benefit of safety lines as required by paragraph IV.A of the instruction.

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

It is TVA's understanding that item 328/81-38-03 is being withdrawn in that no violation of NRC regulations occurred. This item was discussed with Inspector R. V. Crlenjak on October 29, 1981.

VIOLATION 50-328/81-38-04

10 CFR 50, Appendix B, Criterion XVII, and section 17.2.17 of TVA-TR75-1, the licensee's accepted QA Program require that sufficient records be maintained to furnish evidence of activities affecting quality and that these records be retrievable.

Contrary to the above, as of June 13, 1981, the licensee was unable to locate and retrieve the reactor coolant system hydrostatic pressure tracing which was recorded in the control room during the test conducted on November 4, 1980.

This is a Severity Level VI Violation (Supplement I.F.).

Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

Reasons for the Violation if Admitted

Upon completion of the hydrostatic test performed on November 4, 1980, the chart recording of the system pressure during the test was misplaced. The plant has made several investigations to locate this document and has been unsuccessful. The plant has concluded that the document is lost.

Corrective Steps Which Have Been Taken and the Results Achieved

The pressure during the hydrostatic test was continuously monitored by personnel using the designated test gauges. The pressure was hand recorded every 15 minutes. These records are being maintained and are retrievable.

Corrective Steps Which Have Been Taken To Avoid Further Violations

Responsible plant personnel have been instructed to the importance of maintaining documentation of plant activities affecting quality.

Date When Full Compliance Will Be Achieved

Full compliance was achieved October 20, 1981.

VIOLATION 50-328/81-38-05

10 CFR 50, Appendix B, Criterion II, and section 17.2.2 of TVA-TR75-1, the licensee's accepted QA Program, require that activities affecting quality shall be accomplished under suitably controlled conditions. Controlled conditions include adequate cleanliness.

Contrary to the above, cleanliness of the upper internals as required by Maintenance Instruction MI-1.2, 'Removal and Replacement of RPV Head and Attachments,' paragraph 9.5, was not implemented in that the upper internals contained pine straw and organic debris between the time the refueling canal was flooded on June 26, 1981, and the date the material was discovered on July 9, 1981.

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

Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

Reasons for the Violation if Admitted

During storage of the upper internals setdown stand (while the unit was under construction), it appeared that birds had built nests in the circular I-beam ring of the stand. This was not discovered until after flooding of the refueling cavity.

Corrective Steps Which Have Been Taken and the Results Achieved

All visible foreign organic material was retrieved and subsequent inspections were made of the refueling cavities and the refueling water storage tank (RWST). Water samples were also taken of the reactor coolant system (RCS) and no further deposits were found. The circular I-beam was flushed with demineralized water.

Corrective Steps Which Will Be Taken To Avoid Further Violations

No further action is required at Sequoyah Nuclear Plant since the upper internals setdown stand will be permanently stored in the refueling cavity. In order to prevent recurrence at future plants, Operational Quality Assurance Manual (OQAM), Part II, Section 5.3, will be revised to clarify that before initially placing internals in the reactor vessel, a quality control holdpoint will be used to verify cleanliness and foreign material exclusion.

Date When Full Compliance Will Be Achieved

Full compliance was achieved October 20, 1981.