

TENNESSEE VALLEY AUTHORITY REGION II

CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

January 4, 1983

U.S. Nuclear Regulatory Commission  
Region II  
Attn: Mr. James P. O'Reilly, Regional Administrator  
101 Marietta Street, Suite 3100  
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC-OIE REGION II INSPECTION REPORT  
50-327/82-28 AND 50-328/82-28 - RESPONSE TO VIOLATION

The subject OIE inspection report dated December 6, 1982 from D. M. Verrelli to H. G. Parris cited TVA with two Severity Level V Violations and one Severity Level IV Violation. Enclosed is our response to the subject inspection report.

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

*D S Kammer*

D. S. Kammer  
Nuclear Engineer

Enclosure

cc: Mr. Richard C. DeYoung, Director (Enclosure)  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

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ENCLOSURE

RESPONSE - NRC INSPECTION REPORT NOS.  
50-327/82-28 AND 50-328/82-28  
D. M. VERRELLI'S LETTER TO H. G. PARRIS  
DATED DECEMBER 6, 1982

Item A (327/82-28-01)

Technical Specification 6.8.1.a requires that written procedures be established and implemented covering authorities and responsibilities for safe operation and shutdown. Administrative Instruction AI-2, section 11, requires that critical systems shall be aligned according to applicable check lists and deviations shall be handled according to Operational Section Instruction Letter OSLA-58 "Maintaining Cognizance of Operational Station."

Contrary to the above, critical system alignment was not maintained according to AI-2 or OSLA-58 in that on November 1, 1982 valve 1-FCV-74-524 was found locked shut instead of locked open as indicated by the Unit 1 configuration log and a System Operating Instruction valve check performed on October 31, 1982. Valve 1-FCV-74-524 (inlet to "A" train Residual Heat Removal (RHR) heat exchanger) was found shut while the operator was attempting to align RHR for shutdown cooling.

This is a Severity Level V Violation (Supplement I). This violation applies to Unit 1 only.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

The valve checklist, SOI-74.1A-1, required the valve 1-74-524 to be in the locked open position but evidently was left closed during the performance of the valve checklist. The assistant unit operator and auxiliary operator failed to follow the instructions by signing off the valve as being open when it was not open.

3. Corrective Steps Which Have Been Taken and the Results Achieved

The RHR pump 1A-A was immediately stopped and valve 1-74-524 opened. Surveillance Instruction (SI) 128 was performed to verify that the pump was not damaged and was operable. There was no damage to the pump.

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

Disciplinary action was taken with the involved operations personnel. A memorandum was sent to all operations personnel concerning the event.

to emphasize their responsibility in adhering to and performing instructions correctly.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on December 1, 1982.

Item B (327/82-28-02)

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

Contrary to the above, written procedures for surveillance of safety-related equipment were not properly implemented in that on November 2, 1982 while performing a functional test on Unit 1 source range neutron instrument N-31 in accordance with IMI-92-SRM-FT, the instrument mechanic did not record data that the procedure called for. While testing the "Loss of Detector Voltage" bistable, instead of recording the "as found" detector voltage that the procedure called for, the mechanic recorded the desired voltage 2000 VDC. The licensee had previously determined that the desired voltage needed to be recorded to check the bistable but never changed the procedure.

This is a Severity Level V Violation (Supplement I). This violation applies to Unit 1 only.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred but not as stated. This was a procedural inadequacy and not a personnel error.

2. Reasons for the Violation if Admitted

A review of 22 previous performances of IMI-92-SRM-FT indicates that 19 had recorded voltages of 2000 VDC. These were performed by 18 different instrument mechanics which indicates that the procedure as written was being interpreted and implemented in a common method. Procedures were being properly implemented in that the instrument mechanic was following a common interpretation in performance of this functional test.

However, a close review of the procedure indicates that the procedure was unclear and did not properly specify what voltage to record. This is a procedural deficiency.

3. Corrective Steps Which Have Been Taken and the Results Achieved

The instrument mechanics were recording "as found" readings for the trip and reset voltages. These voltages were within setpoint tolerances and the test was satisfactorily completed. No immediate corrective actions were appropriate. See below for long term corrective actions.

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

A change was made to the procedure to clarify voltages to be recorded. The instrument mechanics have been instructed on using the revised procedure.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on November 16, 1982, when the procedure was revised.

Item C (328/82-28-01)

10 CFR 50, Appendix B Criterion XVI and Section 17.2.16 of the accepted QA Program requires that measures shall assure that the cause of significant conditions adverse to quality are determined and corrective action taken to preclude repetition. The TVA Operational QA Manual, Part III, Section 7.2 and Sequoyah Administrative Instruction AI-12 "Adverse Conditions and Corrective Actions", paragraph 1.0 both state their purpose is to provide measures which assure that conditions adverse to quality are identified and corrected and that actions are taken to preclude their recurrence.

Contrary to the above, corrective actions taken to preclude recurrence were inadequate in that the upper containment personnel airlock door operating linkage adjustment was not properly maintained to prevent both air lock doors from being opened simultaneously on October 2, 1982. Similar events occurred on Unit 1 on July 19, 1981, September 26, 1980 and July 11, 1980.

This is a Severity Level IV Violation (Supplment I). This violation applies to Unit 2 only.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

Corrective actions had been taken due to similar problems with the airlock door linkage in that a preventive maintenance program was established to verify proper adjustment of the linkage at least every

six months. The surveillance interval evidently was not selected to be performed on a frequent enough basis to prevent recurrence.

3. Corrective Steps Which Have Been Taken and the Results Achieved

For the occurrence on October 2, 1982, the inner airlock door was closed within 15 seconds of opening. The outer door swing operating chain was adjusted and the doors satisfactorily tested at 0015 CST on October 3, 1982.

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

To prevent recurrence, the frequency for verifying proper adjustment of the operating chain will be changed from at least every six months to at least every three months. Also, during periods of high usage of the airlocks, a person trained in proper operation of the doors will be stationed at the airlock to operate the doors for all entries and exits.

5. Date When Full Compliance Will Be Achieved

Full compliance will be achieved by January 15, 1983.