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Ken Powers  
Vice President, Sequoyah Nuclear Plant

May 31, 1994

U.S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, D.C. 20555

Gentlemen:

In the Matter of ) Docket Nos. 50-327  
Tennessee Valley Authority ) 50-328

SEQUOYAH NUCLEAR PLANT (SQN) - INSPECTION REPORT NOS. 50-327, 328/94-09 -  
REPLY TO NOTICE OF VIOLATION (NOV) 50-327, 328/94-09-01

The enclosure contains TVA's response to Mark S. Lesser's letter to Oliver D. Kingsley dated May 2, 1994, which transmitted the subject NOV. The violation is associated with clearance forms that were not completed as required by site procedures. One handswitch was discovered to be in a position different from that specified on the clearance sheet and the hold order tag. One handswitch was discovered with no position specified on the hold order tag. Another handswitch was discovered with no position specified on either the clearance sheet or the hold order tag.

There are no commitments associated with this submittal.

If you have any questions concerning this submittal, please telephone K. E. Meade at (615) 843-7766.

Sincerely,

Ken Powers

Enclosure  
cc: See page 2

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U.S. Nuclear Regulatory Commission

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cc (Enclosure):

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ENCLOSURE

RESPONSE TO NRC INSPECTION REPORT  
NOS. 50-327, 328/94-09  
MARK S. LESSER'S LETTER TO OLIVER D. KINGSLEY  
DATED MAY 2, 1994

VIOLATION 94-09-01

"Technical Specification Section 6.8.1 requires, in part, that procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A of Regulatory Guide 1.33 includes administrative procedures for conduct of operations and testing of the facility.

"The requirements of Technical Specification 6.8.1 are implemented, in part, in the Operations area by Site Standard Practice (SSP)-12.3, Equipment Clearance Procedure, Revision 6. Paragraph 3.2.2.A.4 of SSP-12.3 states, in part, that clearance forms shall be completed in accordance with the SSP, and that the clearance tag shall be hung as specified on the clearance forms. Appendix P of SSP-12.3 requires that the clearance sheet specify the position or condition that the device is to be placed in and tagged. Appendix P also requires that the individual placing the equipment/device in the specified position initial the clearance sheet verifying that the tag was hung and equipment properly placed. In addition, a second individual is required to independently verify that the device is tagged and in the position indicated.

"Contrary to the above, SSP 12.3 was not followed on or before April 2, 1994 in that:

- Handswitch 1-HS-30-159A was tagged by hold order 1-HO-94-1017. No switch position was specified on the hold order tag. The switch was in the pull-to-lock (PTL) position.
- Handswitch 1-HS-46-27A was tagged by hold order 1-HO-94-1165. The tag and clearance sheet specified the switch position required as P-Auto. The switch was found to be in the PTL position.
- Handswitch 1-HS-6-117A was tagged by hold order 1-HO-94-1133. No switch position was designated on the tag or clearance sheet. The switch was in the PTL position.

"This is a Severity Level IV violation (Supplement I)."

#### Reason for the Violation

This violation was caused by a lack of attention to detail on the part of the personnel involved with completing the clearance sheets. The individuals involved failed to verify that the handswitch position was specified on the clearance sheet and the hold order tags and that the switch was in the specified position. In addition, an independent verification that the handswitch is tagged in the position specified on the hold order tag and clearance sheet is required for the subject switches. This independent verification also lacked the necessary attention to detail.

A new computerized clearance program had recently been implemented. All of the subject clearance discrepancies involved the new computerized clearances. No training was provided with respect to this change. The lack of the formal introduction of requirements associated with the computerized clearance process was a contributing factor in this violation.

#### Corrective Actions That Have Been Taken and the Results Achieved

A standing order was written to Operations personnel that explained the subject discrepancies and detailed expectations regarding the clearance program.

A 100 percent audit of all Unit 1 clearances was performed before restart of the unit from the extended outage. One additional example of a handswitch without the position specified on the hold order tag was identified.

A 100 percent audit of all additional clearances was also performed. Several other administrative-type discrepancies were identified. All of the identified discrepancies have been corrected.

The appropriate action was taken with respect to both the individuals that lacked attention to detail and the individuals that failed to provide training before implementing the new computerized clearance process.

A review of the clearance procedure was performed. This review resulted in a procedure revision designed to clarify the requirements of the computerized clearance process.

#### Corrective Steps That Will be Taken to Avoid Future Violations

As part of the Operations Improvement Plan, Operations management continues to stress attention to detail to all Operations personnel.

#### Date When Full Compliance Will be Achieved

Sequoyah Nuclear Plant is in full compliance.