



Tennessee Valley Authority, Post Office Box 2000, Soddy-Daisy, Tennessee 37379-2000

Ken Powers  
Vice President, Sequoyah Nuclear Plant

June 20, 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, 328/94-13 -  
REPLY TO NOTICE OF VIOLATIONS (NOVs) 50-327, 328/94-13-01 AND 94-13-02

Enclosure 1 contains TVA's response to Jon R. Johnson's letter to Oliver D. Kingsley dated May 23, 1994, which transmitted the subject NOVs. The first violation involves the failure to follow procedures (noncompliance with Technical Specification 6.8.1), resulting in the misconfiguration of three valves in the component cooling system. The second violation involves inadequate corrective action (a violation of 10 CFR 50, Appendix B, Criteria XVI) associated with the failure to perform preventive maintenance on electrical panels. Commitments are listed in Enclosure 2.

If you have any questions concerning this submittal, please telephone C. H. Whittemore at (615) 843-7210.

Sincerely,

Ken Powers

Enclosures

cc: See page 2

9406270312 940620  
PDR ADDCK 05000327  
PDR

JED

U.S. Nuclear Regulatory Commission

Page 2

June 20, 1994

cc (Enclosures):

Mr. D. E. LaBarge, Project Manager  
U.S. Nuclear Regulatory Commission  
One White Flint, North  
11555 Rockville Pike  
Rockville, Maryland 20852-2739

NRC Resident Inspector  
Sequoyah Nuclear Plant  
2600 Igou Ferry Road  
Soddy-Daisy, Tennessee 37379-3624

Regional Administrator  
U.S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30323-2711

ENCLOSURE 1

RESPONSE TO NRC INSPECTION REPORT  
NOS. 50-327, 328/94-13  
JON R. JOHNSON'S LETTER TO OLIVER D. KINGSLEY  
DATED MAY 23, 1994

Violation 50-327, 328/94-13-01

"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 operations procedures to maintain required configuration control for safety-related components and systems.

"Procedure 1-SI-OPS-070-032.A, COMPONENT COOLING WATER VALVES POSITION VERIFICATION TRAIN A, Revision 5, specifies the required throttle position for Component Cooling Water System (CCS) Valve 1-VLV-70-702 as being 20.25 turns from the open position.

"Procedure 1-SO-70-1, COMPONENT COOLING WATER SYSTEM "A" TRAIN, HP Revision 5, specifies the required position for CCS Valve 1-VLV-70-705 as being open.

"Attachment 6 of procedure 0-SO-70-1.06, CCS "A" TRAIN VALVE CHECKLIST 0-70-1.06, Revision 3, specifies the required position for CCS Valve HCV-0-70-532 as being open.

"Contrary to the above, the licensee failed to follow the above procedures such that, between the period of April 9 and 11, 1994, CCS Valves 1-VLV-70-702, 1-VLV-70-705, and HCV-0-70-532 were found out of their required positions.

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

Reason for the Violation

The reason for this violation is personnel error. The root cause for the personnel error is indeterminate.

The personnel responsible for positioning the 1-VLV-70-702 and 1-VLV-70-705 valves had been trained, qualified, and experienced and were confident that the valves had been left in their proper position. In addition, personnel used the concurrent verification process during the positioning of the throttle valve. Mechanical problems, e.g., sludge build-up, inoperable valve position indicators, etc., were investigated and found not to be a factor in the mispositioning of the valves. Therefore, it can be concluded that the cause for these valves being out of position was personnel error.

The HCV-0-70-532 valve is a vent valve and is manipulated during chemical additions and venting and filling operations by the Operations group. The manipulation is always controlled by approved procedures, and the position is always required to be verified. Therefore, it can be concluded that the cause for this valve being mispositioned was personnel error.

Corrective Steps That Have Been Taken and the Results Achieved

In the initial walkdown of the CCS, a valve (1-VLV-70-705) in series with the throttle valve was repositioned to its correct configuration after it was discovered slightly less than full open, i.e., not significantly out of position. Immediate corrective action upon discovery of the mispositioned throttle valve (1-VLV-70-702) was to correctly position the valve and then to verify the position of other throttle valves in the CCS and ERCW systems (no other throttle valves were found out of position). A problem evaluation report (PER) was initiated to document the issue and investigate the problem of the two valves that were found to be out of configuration. Later, a third valve (a vent valve) was also found to be out of its correct configuration. This vent valve was correctly repositioned. Another PER was initiated to document the issue, investigate the problem, and formulate the corrective action.

A training letter describing this event and management's expectations concerning correctly positioning valves, especially throttle valves, has been issued to Operations personnel.

The appropriate personnel actions have been developed and implemented for each individual associated with this event.

Corrective Steps That Will be Taken to Avoid Future Violations

No additional corrective action is warranted.

Date When Full Compliance Will be Achieved

TVA SQN is in full compliance with respect to the violation (failing to follow procedure) and mispositioning valves in the component cooling system. The corrective actions described above will serve to prevent recurrence.

Violation 50-327, 328/94-13-02

"10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, requires, in part, that measures be established to assure that conditions adverse to quality such as failures, malfunctions, and nonconformances, are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall ensure that the cause of the condition is determined and corrective action taken to preclude repetition.

"Contrary to the above, corrective action for Condition Adverse To Quality Report (CAQR) SQP890626, which on November 22, 1989, identified dust and dirt within relays located inside relay cabinets 1-R-70 through 1-R-79 and 2-R-70 through 2-R-79, was inadequate. The CAQR stated that dust and dirt on and in the relays could be detrimental to relay operation and was identified as a condition adverse to quality. The root cause was identified as a lack of preventive maintenance for cleaning equipment within the auxiliary instrument room relay cabinets. Corrective action consisted of developing an annual Preventive Maintenance Instruction to clean equipment in the relay cabinets periodically. However, as of April 11, 1994 relays within cabinets 1-R-70 through 1-R-79 had not been cleaned. Dirt and debris were identified on and inside relays located within relay cabinets 1-R-48, 1-R-51, 1-R-55, 1-R-58, 1-R-70, 1-R-71, 1-R-72, and 1-R-73.

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

#### Reason for the Violation

The reason for the violation was the lack of good housekeeping practices during the performance of work inside relay panels in that tape, screws, and other debris were not removed after the completion of activities.

The NRC inspection report cited SQN with a violation of 10 CFR 50, Appendix B, Criteria XVI for inadequate corrective action. The NRC report references the failure to complete the corrective actions associated with a 1989 corrective action document. The corrective action document was written primarily as a result of a cable-pulling lubricant that was found in several relay racks. The document also noted that the relays had dust and dirt accumulation in the racks. The corrective action to the dust and dirt problem was to initiate preventive maintenance (PM) instructions to periodically clean the dust and dirt from the relays. The scope of the PMs was limited to only 10 panels containing both open- and closed-type relays on each unit. However, because of a scheduling error the PMs were never performed. Since the PMs were written primarily for the prevention of the build-up of dust and dirt on panel faces and not for the inspection of individual relays or relay contacts, the performance of the PMs would not necessarily have identified and removed any debris on the relay contacts. Therefore, it can be concluded that the performance of these PMs would not have prevented this event.

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

The immediate corrective action was to remove the debris inside the relay panel and determine the extent of the problem.

An inspection for dust, dirt, and debris in and around Unit 1 relay panels was conducted. The inspection was subsequently followed by a cleaning and vacuuming of relay panels.

In addition, a training letter describing this event and management's expectations concerning housekeeping during work activities has been issued.

Corrective Steps That Will be Taken to Avoid Further Violations

Modifications and Maintenance management directives will be revised to increase the sensitivity and identify the potentially adverse effect of debris in open electrical equipment. The directives will also clearly define housekeeping monitoring efforts.

PM procedures providing instructions for performing the inspection and subsequent cleaning of relays will be developed and then scheduled with a definite periodicity. Unit 2 relays will be inspected and cleaned during the Unit 2 Cycle 6 refueling outage.

Date When Full Compliance Will be Achieved

SQN will be in full compliance when the relays are inspected and cleaned during the Unit 2 Cycle 6 refueling outage.

ENCLOSURE 2

Commitments

Violation 50-327, 328/94-13-02

1. Maintenance management directives will be revised to increase the sensitivity and identify the potentially adverse effect of debris in open electrical equipment. The directives will also clearly define housekeeping monitoring efforts. This will be accomplished by August 5, 1994.
2. Modifications' management directives will be revised to increase the sensitivity and identify the potentially adverse effect of debris in open electrical equipment. The directives will also clearly define housekeeping monitoring efforts. This will be accomplished by August 5, 1994.
3. Preventive maintenance procedures providing instructions for performing the inspection and subsequent cleaning of relays will be developed and then scheduled with a definite periodicity. This will be accomplished by August 5, 1994.
4. Unit 2 relays will be inspected and cleaned during the Unit 2 Cycle 6 refueling outage.