

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401  
400 Chestnut Street Tower II

REGION II  
ATLANTA, GEORGIA

May 11, 1983

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U.S. Nuclear Regulatory Commission  
Region II  
Attn: Mr. James P. O'Reilly, Regional Administrator  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC-OIE REGION II INSPECTION REPORT  
50-327/83-05 AND 50-328/83-05 - RESPONSE TO VIOLATIONS

The subject OIE inspection report dated April 14, 1983 from R. C. Lewis to  
H. G. Parris cited TVA with one Severity Level IV Violation and one  
Severity Level V 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

  
L. M. Mills, Manager  
Nuclear Licensing

Enclosure

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

ENCLOSURE

RESPONSE - NRC INSPECTION REPORT NOS.  
50-327/83-05 AND 50-328/83-05  
R. C. LEWIS' LETTER TO H. G. PARRIS  
DATED APRIL 14, 1983

Item 327, 328/83-05-01

Technical Specification 6.8.1.a requires that written procedures shall be implemented covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, 2/78, including discharging liquid radioactive waste as effluents. System Operating Instruction SOI-77.1C1 "Cask Decontamination Tank Release" provides requirements, conditions, precautions and instructions for releasing the cask decontamination tank (CDCT).

Contrary to the above, procedure SOI-77.1C1 was not implemented in that on February 10, 1983, during a planned release from the CDCT, valve 0-77-573 was open causing the inadvertent release of approximately 5300 gallons from the Monitor Tank. SOI-77.1C1 requires that valve 0-77-573 be shut before commencing the release. The SOI valve check list had been completed by two auxiliary operators. The open valve was identified by the licensee and immediately shut. Calculations performed by the licensee demonstrated that the concentrations of radioactive material inadvertently released did not exceed 10 CFR 20 Appendix B, Table II limits.

This is a Severity Level IV Violation (Supplement IV). This violation applies to both Units.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

As stated above, the SOI-77.1 valve checklist had been completed. The primary reason for this event was personnel error in that the SOI valve checklist showed double assistant unit operator (AUO) verification that valve 0-77-573 was closed before the start of the release when it was actually open. The AUOs involved stated that they could not specifically remember checking the valve for position. The primary AUO assumed that the valve was shut from a previous shift when he had closed it. The configuration log and the radwaste log book indicated the valve as being open, and the AUOs should have noticed this. If applicable instructions had been followed properly, the event would not have occurred. As requested in your report, a comparison has been made between this event and the February 11, 1981 inadvertent containment spray event. Communication breakdowns, inadequate procedures, clear authorities and responsibilities of AUOs, and inadequate on-the-job

training were contributing causes for the 1981 event. There are no root cause similarities between this event and the previous occurrence.

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

The unplanned release was started at 0225 CST on February 10, 1983. At 0335 CST the radwaste operator discovered the open valve and immediately shut it, thereby terminating the release. The shift engineer was then notified. An investigation was begun to gather data and assess consequences, and an investigation was also performed by the Independent Safety Engineering Group. NRC was notified and the resident inspectors provided with appropriate information. This event resulted in a total of approximately 5,300 gallons unplanned release from the monitor tank. The tank contents were sampled, and an event analysis determined that no 10 CFR Part 20 limits or technical specification limits were exceeded for activity levels.

4. Corrective Steps Which Have Been Taken to Avoid Further Violations

- A. Appropriate disciplinary actions were taken with regard to the personnel responsible for this occurrence.
- B. Training meetings were held with each operations shift group from February 17, 1983, to March 10, 1983, with the Operations Supervisor presiding. The title of the meetings was "Attention to Detail," and the importance of proper system alignment, the purpose and responsibility of double verification signoffs, and the consequences of signing checklists without full knowledge of the status were stressed.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on February 10, 1983, when valve 0-77-573 was closed terminating the unplanned release.

Item 327, 328/83-05-02

10 CFR 50.72(a)(8) requires each licensee of a nuclear power reactor to notify the NRC Operations Center as soon as possible, and in any event, within one hour by telephone of any accidental, unplanned or uncontrolled radioactive release.

Contrary to the above, the licensee did not notify the NRC Operations Center within one hour of an unplanned release in that on February 10, 1983 the licensee discovered that they had inadvertently released approximately 5,300 gallons of radioactive waste water from the monitor tank at 0335 CST and the NRC Operations Center was not notified until 0703 CST.

This is a Severity Level V Violation (Supplement I). This violation applies to both Units.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

The cause of this violation has been attributed to personnel error. 10 CFR 50.72 requires a one-hour immediate notification to NRC as indicated in Administrative Instruction (AI) 18. The shift engineer and shift technical advisor immediately reviewed technical specifications which did not address this situation and did not look at AI-18 until necessary information about the event was assembled. Operations personnel were gathering data and requiring samples to be taken for analysis before reportability requirements were recognized.

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

The NRC Operations Center was notified at 0703 CST.

4. Corrective Steps Which Have Been Taken to Avoid Further Violations

A. All shift engineers have been cautioned to make immediate phone calls as needed in accordance with AI-18. They were also cautioned to look closely at each event to determine the type of reporting required.

B. Shift technical advisors (STAs) have been given primary responsibility for advising the shift engineer on reporting requirements. A memorandum was sent to all STAs on this subject on March 24, 1983, with renewed emphasis on AI-18 (10 CFR 50.72) requirements.

C. Appropriate disciplinary action was taken.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on February 10, 1983.