TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401
400 Chestnut Street Tower II

March 22, 1985

U.S. Nuclear Regulatory Commission
Region II
ATTN: Dr. J. Nelson Grace, Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Dear Dr. Grace:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC-OIE REGION II INSPECTION REPORT 50-327/85-06 AND 50-328/85-06 - RESPONSE TO VIOLATION

Enclosed is our response to D. M Verrelli's March 1, 1985 letter to to H. G. Parris transmitting IE Inspection Report Nos. 50-327/85-06 and 50-328/85-06 for our Sequoyah Nuclear Plant which cited TVA with one Severity Level V Violation.

If you have any questions, please get in touch with R. E. Alsup at FTS 858-2725.

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

Very truly yours,

TENNESSEE VALLEY AUTHORITY

J. A. Domer

J. A. Domer
Nuclear Engineer

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

Records Center
Institute of Nuclear Power Operations
1100 Circle 75 Parkway, Suite 1500
Atlanta, Georgia 30339

ENCLOSURE

RESPONSE - NRC-OIE INSPECTION REPORT NOS.
50-327/85-06 AND 50-328/85-06
D. M. VERRELLI'S LETTER TO H. G. PARRIS
DATED MARCH 1, 1985

Item 328/85-06-01

10 CFR 50.72(b)(2)(ii) requires the licensee to notify the NRC operations center as soon as practicable and in all cases, within four hours of any event or condition that results in manual or automatic actuation of the Reactor Protection System (RPS). 10 CFR 50.72(c) "Followup Notification" requires that the results of ensuing evaluations or assessments of plant conditions and information related to plant behavior that is not understood be immediately reported.

Contrary to the above, on January 12, 1985, notification of the NRC operations center of an RPS actuation within the four hour requirement was made, however the licensee failed to report that the RPS train A trip breaker had failed to automatically open and was manually tripped. No follow-up notification to the operations center was made when licensee personnel determined that the initial report was incomplete.

This is a Severity Level V violation (Supplement I).

1. Admission or Denial of the Alleged Violation

   TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

   The NRC notification required by 10 CFR 50.72 was made by the onshift shift technical advisor (STA) who, at the time of the phone call, was unaware of the failure of the 'A' train reactor trip breaker to open automatically. At the time of the trip, the reactor operator (RO) immediately noted that the breaker did not open automatically and, within five seconds of the trip, manually opened the breaker using a handswitch on the main control board. However, this information was not known to the STA at the time of the phone call.

   Later, on the day of the trip, the malfunction was learned by the STAs on shift; however, following some time of discussion and evaluation on the need for further reporting to the NRC operations center, it was concluded that it was not necessary. This decision was based on the fact that a licensee event report (LER) would be written on the event and would describe fully the malfunction, and that the NRC Resident Inspector had been notified of the event. The cause of the failure to provide followup notification to the NRC operations center on this event was a misinterpretation of the reporting criteria. This is the first event of this nature and is considered an isolated case and not a generic problem of reporting events at Sequoyah.

3. Corrective Steps Which Have Been Taken and Results Achieved

Several discussions were held between Sequoyah management and NRC personnel concerning this event, including the reporting aspect. It was agreed that events of this nature which were not included as part of the initial phone call would be included in a followup call as the information is known. This clarification of policy was verbally transmitted to onshift personnel who would be responsible for 10 CFR 50.72 notifications, including the STA. Further, a memorandum from the Operations Section manager to all licensed personnel and STAs is being sent to provide written clarification on NRC phone calls. These actions will preclude similar misunderstandings in the future.

4. Corrective Steps Taken To Avoid Further Violations

See item 3.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on January 14, 1985.