



UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W.
 ATLANTA, GEORGIA 30323

Report Nos.: 50-327/85-23 and 50-328/85-23

Licensee: Tennessee Valley Authority
 500A Chestnut Street
 Chattanooga, TN 37401

Docket Nos.: 50-327 and 50-328

License Nos.: DPR-77 and DPR-79

Facility Name: Sequoyah 1 and 2

Inspection Conducted: June 6 - July 5, 1985

Inspectors: *A. J. Agnatoris*
 for K. M. Jenison, Senior Resident Inspector

8/01/85
 Date Signed

A. J. Agnatoris
 for L. J. Watson, Resident Inspector

8/01/85
 Date Signed

Approved by: *S. P. Weise*
 S. P. Weise, Section Chief
 Division of Reactor Projects

8/1/85
 Date Signed

SUMMARY

Scope: This routine, announced inspection involved 349 resident inspector-hours onsite in the areas of operational safety verification including operations performance, system lineups, radiation protection, security and housekeeping inspections; surveillance and maintenance observations; review of previous inspection findings; followup of events; review of inspector followup items; and review of licensee identified items.

Results: In the areas inspected, three violations were identified:

1. Failure to properly store stainless steel piping (paragraph 3).
2. Failure to follow a site security procedure (paragraph 5).
3. Failure to take corrective actions in response to a previous violation (paragraph 3).

REPORT DETAILS

1. Licensee Employees Contacted

- H. L. Abercrombie, Site Director
- *P. R. Wallace, Plant Manager
- *L. M. Nobles, Operations and Engineering Superintendent
- *B. M. Patterson, Maintenance Supervisor
- M. R. Harding, Engineering Group Supervisor
- J. M. Anthony, Operations Group Supervisor
- D. C. Craven, Quality Assurance Supervisor
- *D. E. Crawley, Health Physics Supervisor
- *J. L. Hamilton, Quality Engineering Supervisor
- *G. B. Kirk, Compliance Supervisor
- *D. L. Cowart, Quality Section Supervisor

Other licensee employees contacted included technicians, operators, shift engineers, security force members, engineers and maintenance personnel.

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized with the Plant Manager and members of his staff on July 8, 1985. Violations described in paragraphs 3 and 5 were discussed. The licensee acknowledged the inspection findings. In addition, the licensee committed to frisk Beta-contaminated smears as discussed in paragraph 5 of this report. The licensee did not identify as proprietary any material reviewed by the inspectors during this inspection. During the reporting period, frequent discussions were held with the Site Director, Plant Manager and his assistants concerning inspection findings. At no time during the inspection was written material provided to the licensee by the inspector.

3. Licensee Action on Previous Inspection Findings (92702, 61726, 62703)

(Closed) Violation (327/83-16-01). The licensee's response of October 7, 1983, was reviewed and the indicated corrective action was audited. The corrective action stipulated was to revise instruction SOI 30.5D, Auxiliary Building Heating and Ventilating Systems and Room Coolers, to include all operations necessary to recover from auxiliary building isolations including the placement of Auxiliary Building Gas Treatment System (ABGTS) fan control switches back to the "A-Auto" position after shutting down the fans. The current revision of SOI 30.5D was verified to return the ABGTS to normal ("A-Auto") after shutting down the fans. The licensee's actions are considered complete.

(Closed) Violation (327,328/83-18-01). The licensee's response of November 1, 1983, was reviewed and the corrective action was audited. The corrective action stipulated was to revise instruction IMI-3, Main and Auxiliary Feedwater System, to include independent verification of lifting and terminating electrical leads. The current revision of IMI-3 was verified to require that lifted and terminated leads be independently verified. The licensee's actions are considered complete.

(Closed) Violation (327,328/83-01-01). The licensee's response of February 25, 1983, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated were to adjust the alarm setpoint of the Essential Raw Cooling Water (ERCW) system effluent monitors to account for the background radiation resulting from a nearby Refueling Water Storage Tank pipe, and to amend instruction SI-3, Daily, Weekly, and Monthly Logs, to require that monitor alarms be promptly cleared or the monitor be declared inoperable and the action statement implemented. The current revision of SI-3 has been revised to include the clearance of monitor alarms and the ERCW effluent monitors were observed to be operable and not in the alarm state. The licensee's corrective actions are considered complete.

(Closed) Violation (327,328/83-12-01). The licensee's response of September 23, 1983, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated were to insure that all stainless steel pipe was stored in accordance with ANSI-45.2.2, Packaging, Shipping, Receiving, Storage, and Handling of Items for Nuclear Power Plants, and to write a section instruction letter to Power Stores personnel in order to reinforce instruction AI-11. This corrective action appeared to have been adequate within the Power Stores and the Shop Stores areas of responsibility. However, a similar situation was identified in a stainless steel storage area on the 690 level within the Auxiliary Building. TI-70, Cleaning and Decontamination of Plant Equipment, implements in part the licensee's commitments to the aforementioned ANSI standard. TI-70 requires stainless steel material to be stored with the ends capped or taped. Contrary the above, the licensee failed to store several lengths of stainless steel pipe, including elbows and flanges, in the proper manner. The section responsible for this storage area reports to the Office of Engineering. Violation (327,328/83-12-01) is considered closed; however, the failure to properly store stainless steel pipe on the 690 level of the Auxiliary Building is a violation (327,328/85-23-01).

(Open) Violation (328/83-26-01). The licensee's responses of December 21, 1983, July 20, 1984, and September 21, 1984, were reviewed and the indicated corrective actions were audited. The corrective actions stipulated were to submit a Technical Specification (TS) change to TS 3.3.3.7 and to issue formal interpretations to the Operations Department staff concerning the requirement for acoustic monitor operability. The formal interpretation issued to the Operations Department staff was added to the TS interpretations manual, which identified the acoustic monitors as one of two required indications of flow from the power operated relief valves. The TS amendment is still under review by the NRC.

(Closed) Violation (327/83-26-01). The licensee's response of December 21, 1983, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated in the response were to change a computer program which incorrectly calculated Overtemperature Delta Temperature (OTDT) and to revise Technical Instruction TI-36, Incore-Excore Calibration, to include TS values. These items are considered to be complete.

(Closed) Violation (327, 328/83-26-02). The licensee's response of December 21, 1983, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated in the response were to complete an engineering evaluation comparing the as-built plant, Surveillance Instruction SI-162.1, and TS to determine if required snubbers appeared in all three documents. A TS change was submitted to account for design changes in snubber location and number. Additionally, Surveillance Instruction 162.1 was revised. A TS amendment has been issued by the NRC to delete tables related to hydraulic snubbers from the TS. A list of snubbers will be maintained by the licensee and revisions to the list will be made in accordance with 10 CFR 50.59. The licensee's actions are considered to be complete.

(Closed) Violation (327, 328/83-29-01). The licensee's response of January 10, 1984, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated in the response were to discipline and retrain the involved personnel that failed to follow an established radioactive waste effluent discharge procedure. In addition, procedure SOI-14.3, Condensate Demineralizer Waste Disposal, was revised to include independent verification of valve alignment. These actions are considered to be complete.

(Closed) Violation (327, 328/83-29-02). The licensee's response of January 10, 1984, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated in the response were to reemphasize to the engineering staff that identification of Critical Systems, Structures and Components (CSSC) is required prior to the execution of a work plan. In addition, the subject work plan (WP10260) was reworked as a CSSC job. These actions are considered to be complete.

(Closed) Violation (328/83-29-03). The licensee's response of January 10, 1984, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated in the response were to reemphasize to the Operations Department staff that procedures were to be followed and that plant parameters were to be observed. These actions are considered to be complete.

(Closed) Violation (327,328/83-31-01). The licensee's response of March 15, 1984, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated in the response were to reemphasize to all personnel the importance of following radiation work permit (RWP) requirements, to review RWP postings for accuracy and to compare key card

entry data with RWP data on a periodic basis. The corrective actions involved with a periodic RWP/key card comparison were not completed as committed to in the licensee's response. This failure to conduct the periodic RWP/key card comparisons is an instance of not taking prompt corrective actions to insure quality operations and is a violation (327,328/85-23-02).

(Closed) Violation (328/83-31-02). The licensee's response of March 15, 1984, was reviewed and the indicated corrective actions were audited. The corrective actions stipulated in the response were to revise procedure SOI-63.1 and complete and document training in the areas of following procedures, reduction of personnel errors and several other areas. The revision to SOI 67.1 was reviewed and initial and scheduled retraining in the Operations Department was verified.

(Closed) Violation (327/84-11-01). The licensee's response of July 16, 1984, was reviewed and the indicated corrective actions were audited. The corrective action included revision of a procedure for mode change and modification of an RCS sample line. The inspector reviewed: Technical Instruction, TI-59, Listing of Technical Specification Instruments; Surveillance Instruction SI-90.6, Reactor Trip Instrumentation Quarterly Functional Tests; and General Operating Instruction GOI-1, Plant Startup from Cold Shutdown to Hot Standby. The inspector verified that the procedures required operability of steam generator level transmitter 1-LT-3-38 prior to entry into Mode 3. The inspector also audited Workplan 10721, Rev. 1, which implemented a modification to assure operability of a pressurizer level transmitter. The licensee actions in this area are considered to be complete.

4. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

One unresolved item was identified during this inspection regarding performance of maintenance on a safety-related transducer is discussed in paragraph 7.

5. Operational Safety Verification (71707)

a. Plant Tours

The inspectors observed control room operations, reviewed applicable logs, conducted discussions with control room operators, observed shift turnovers, and confirmed operability of instrumentation. The inspectors verified the operability of selected emergency systems, reviewed tagout records, verified compliance with Technical Specification (TS) Limiting Conditions for Operation (LCO) and verified return to service of affected components. The inspector verified that maintenance work orders had been submitted as required and that followup activities and prioritization of work was accomplished by the licensee.

Tours of the Diesel Generator, Auxiliary, Control, Turbine Buildings, and Reactor Containment were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and plant housekeeping/cleanliness conditions. During one routine tour of the Auxiliary building, door A-57 was identified to have what appeared to be cracks in its vertical and horizontal ribs, and in its hinges. This door is an auxiliary building secondary containment isolation door and is required to be shut and capable of withstanding a force of one-half psid pressure. The licensee evaluated these apparent cracks by removing the existing paint and visually examining the welds. All apparent cracks were determined to be the result of cracked paint material. The inspector had no further questions.

The inspectors walked down accessible portions of the following safety-related systems on Unit 1 and Unit 2 to verify operability and proper valve alignment:

- Safety Injection System (Units 1 and 2)
- Turbine Driven Auxiliary Feedwater System (Units 1 and 2)
- Motor Driven Auxiliary Feedwater System (Units 1 and 2)
- Upper Head Injection System (Units 1 and 2)
- 125V DC Vital Batteries
- Diesel Generators (Units 1 and 2)
- Ice Condenser (Unit 1)

b. Security

During the course of the inspection, observations relative to protected and vital area security were made, including access controls, boundary integrity, search, escort, and badging. During a routine tour on June 12, 1985, in an assembled group of approximately twelve workmen, the inspector observed one permanently badged individual who did not have his badge in his possession and one temporarily badged individual who was not displaying his badge correctly. These workers were inside the protected area. This constitutes a violation (327,328/85-23-03) of licensee procedures for display of security identification badges.

c. Radiation Protection

(1) The inspectors observed Health Physics (HP) practices and verified implementation of radiation protection control. On a regular basis, radiation work permits (RWPs) were reviewed and specific work activities were monitored to assure the activities were being conducted in accordance with applicable RWPs. Selected radiation

protection instruments were verified operable and calibration frequencies were reviewed. A review of RWP data indicated minor clerical errors in the protective dress requirements of five RWPs:

02-085867
02-085902
02-085611
02-085638
02-085732

The resolution of the above errors and the nonrecurrence of this type of minor inadequacy will be reviewed as Inspector Followup Item (327, 328/85-23-04).

- (2) The inspectors routinely evaluated the transfer of material out of and into the regulated area. Health Physics (HP) technicians routinely smear materials leaving the regulated area at a stand situated at one of the regulated area boundaries. In addition, some general area smears are also evaluated by HP technicians at this same stand. During the monitoring of contaminated smears, taken from an area with a relatively high level of Beta contamination, an HP technician was observed covering the smears with a tissue prior to the frisking process. The technician then placed the frisker probe in contact with the tissue paper and read the smear.

The HP supervisor was asked to determine if the shielding provided by the paper was significant and to account for this shielding in the Radiation Work Permit (RWP) process. The HP supervisor provided the inspector with an evaluation of the frisking process which indicated that, when the probe was held one-quarter inch above a series of control smear samples, the tissue reduced the Beta reading by approximately twelve percent. When the probe was placed in contact with the tissue, however, the reading that resulted was approximately eight percent higher than the reading taken at one-quarter inch above the same smear sample when not covered. Therefore, the frisking method observed was conservative. The licensee committed to use the contact method of frisking of covered smears.

- (3) A review of TVA Health Physics form 17195 (DOH&S1-80), Request For Estimate of Current Radiation Dose Total, was conducted. 10 CFR 19.13(e) requires that licensees, if requested, provide workers terminating employment or ending temporary work assignments involving radiation dose in the licensee's facility with a written report or estimate of the radiation dose received by that worker from operations of the licensee.

The inspector determined that on two separate occasions, individuals who requested dose records upon terminating assignments involving radiation dose at the licensee's facility were given incorrect written estimates in that the estimates did not represent the radiation dose received by the worker from operations of the licensee during the specifically identified time period. One individual had dose from another facility included in the Sequoyah Nuclear Facility dose estimate and one individual had the dose estimate calculated incorrectly. In both cases, the estimates indicated a dose higher than that received and were therefore conservative. This is identified as an Inspector Followup Item pending NRC Region II review of additional licensee dose records (327, 328/85-23-05).

- (4) During a tour of the Auxiliary Building on June 11, 1985, the inspector observed a worker placing tools inside a yellow bag. The worker subsequently placed the bag inside a desk door on Elevation 690 of the Auxiliary Building. The inspector interviewed the worker concerning the control of contaminated tools. The worker stated that the tools were not contaminated; however, the worker stored the material in the yellow wrapping without a survey or marking of the material as required by RCI-1, "Radiological Control Instruction." The worker stated that he was aware he had not followed the procedure.

The licensee was cited in IE Inspection Report 327,328/85-20 for several examples of failure to survey and mark contaminated items. Improper use of yellow wrappings can contribute to this problem. The licensee has a program in progress, as part of the corrective action to the violation, to monitor the controlled area and worker activities in the controlled area to assure the proper use of yellow wrappings and appropriate labeling and storage of contaminated materials. The licensee is taking disciplinary action against employees who fail to adhere to radiological control procedures. The inspector will continue to monitor corrective action in response to the violation to assure that the program is effective. This is identified as Inspector Followup Item (327, 328/85-23-06).

d. Operational Verification of Ice Condenser Doors

In conjunction with the operational verification of the ice condenser on Unit 1, an evaluation of the licensee's control of ice condenser parameters, ice condenser doors and associated appurtenances was conducted by the inspectors. It was determined that Technical Specification 4.6.5.3.2 may be routinely violated by the licensee and that there is a chronic ice buildup problem on the intermediate doors. This ice buildup has resulted in almost daily entries into the Unit 1 containment building in order to remove ice from the intermediate door surfaces (between 40 and 60 pounds of ice a day). This issue will be discussed in inspection report (327,328/85-24).

In addition to the review of ice buildup on certain ice condenser doors, a review of the use of lower inlet door blocking devices was conducted. The licensee presently uses a blocking device which is pressed between the lower inlet doors and the downward air flow vanes. Proper administrative control of blocking devices is mandatory since the blocking devices, if not removed prior to plant operation, could make the ice condenser inoperable. The blocking devices are normally used during ice weighing outages and other sufficiently long outages. The devices are installed and removed using the routine maintenance request (MR) process. The unused blocking devices are stored in a shop area when not in use, and there is no numerical accountability for the devices. During ice weighing and/or servicing, Maintenance Instruction (MI) 5.3, Ice Servicing, is used in conjunction with the MR process to install and remove the devices.

Several existing procedures control observations of the intermediate and/or the lower ice condenser doors to assure operability of the doors. These procedures are:

Maintenance Instruction MI-5.3, Ice Servicing, requires independent verification of both installation and removal when the blocking devices are installed during an ice servicing outage. During other outages the MR process is used alone.

General Operating Instruction, GOI-1, Plant Startup From Cold Shutdown to Hot Standby, requires that prior to entering mode 4 the ice condenser door blocks be removed and temporary rubber drain covers be replaced with dissolvable paper.

Surveillance Instruction, SI-3, Daily, Weekly and Monthly Logs, requires instep 4.6.3.2.a, that the ice condenser intermediate deck doors to be visually inspected once every seven days to be free from frost accumulation and verified closed.

Operations Section Letter Administrative, OSLA-99, Assistant Unit Operator Duty Locations and Responsibilities, addresses the visual inspection of the ice condenser doors as part of the routine inspection activities during normal Assistant Unit Operator tours.

Surveillance Instruction, SI-108, Ice Condenser Doors, requires that the opening torque of the lower and intermediate deck doors be checked once a year and the upper deck doors be inspected once every 90 days. This surveillance is normally conducted after ice basket servicing and would verify the removal of the blocking devices used during the servicing period.

One deficiency noted was that these procedures do not control removal of blocking devices individually. Each blocking device used is not identified, and no signoff is required for each device. Instead, a signoff is made that all devices have been removed. This also reduces

the effectiveness of independent verification since the verifier does not know on which doors the blocks were installed. This deficiency was discussed with the licensee and a commitment obtained from the licensee to justify the practice or revise administrative controls.

6. Monthly Surveillance Observation (61726)

The inspectors observed Technical Specification (TS) required surveillance testing and verified that testing was performed in accordance with adequate procedures; that test instrumentation was calibrated; that limiting conditions for operation were met; that test results met acceptance criteria requirements and were reviewed by personnel other than the individual directing the test; that deficiencies were identified, as appropriate, and that any deficiencies identified during the testing were properly reviewed and resolved by management personnel; and that system restoration was adequate. For complete tests, the inspector verified that testing frequencies were met and tests were performed by qualified individuals.

The inspector witnessed/reviewed portions of the following surveillance test activities:

SI-90.6,	"Reactor Trip Instrumentation Quarterly Functional Tests"
SI-75	"Remote Shutdown Monitoring Instrumentation Steam Generator Level (Refueling Cycle)"
SI-166.6	"Post Maintenance Testing of Category "A" and "B" Valves"
SI-90.6	"Reactor Trip Quarterly Functional Tests"
SI-170.2,	"Periodic Calibration of the Standby Diesel Generator 1B-B (Annual Inspection) (Unit 1)"

The inspector reviewed documentation to assure completion of the following surveillance activities:

SI-13,	"Verification of ECCS Valves with Power Removed"
SI-3,	"Daily, Weekly and Monthly Logs"
SI-33.1,	"ERCW and Auxiliary ERCW Valves Servicing Safety Related Equipment"
SI-12,	"ECCS Valve Alignment Verification"

No violations or deviations were identified in this area.

7. Monthly Maintenance Observations (62703)

- a. Station maintenance activities of safety-related systems and components were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, industry codes and standards, and in conformance with TS.

The following items were considered during this review: LCOs met while components or systems were removed from service; redundant components operable; approvals obtained prior to initiating the work; activities accomplished using approved procedures and inspected if applicable; procedures adequate to control the activity; troubleshooting activities controlled and the repair records accurately reflect work activities; functional testing and/or calibrations performed prior to returning components or systems to service; quality control records maintained; activities accomplished by qualified personnel; parts and materials used properly certified; radiological controls implemented; QC hold points established and observed; fire prevention controls implemented; and housekeeping maintained.

- b. During the Unit 1 return to power on June 21, 1985, the inspector observed trouble shooting on the local speed controller for the turbine driven auxiliary feedwater pump (TDAFP). The defective controller was replaced when it was determined that the controller would drop the pump speed back to idle when output flow on the pump reached 880 gpm.

The inspector reviewed maintenance request (MR) A528966 and identified the following concerns. The MR stated that the equipment was not CSSC equipment; however, the instrument technician interviewed stated that the defective controller (in automatic) could have prevented the TDAFP from maintaining operating speed. This indicates that the controller should be designated as safety related equipment, i.e., CSSC equipment, in accordance with Appendix B of 10 CFR 50. Since the work was on equipment designated as non-CSSC, the work was done with a drawing that was not controlled, although two individuals independently stated that the circuitry in question on the drawing used was verified against a controlled print. Additionally, configuration control sheets in procedure IMI-1324 were attached to the MR and used to control the configuration changes. The equipment is designated as Class 1E.

The inspector discussed these concerns with the licensee. The licensee stated that an onsite CSSC Review Committee (formed under Administrative Instruction AI-39, "Critical Structures, Systems and Components - CSSC," which was issued March 19, 1985) had identified components in the Auxiliary Feedwater Turbine control system including the subject controller which should be included in the CSSC list. On May 20 and 21, the licensee had held meetings to instruct planners to handle future workplans involving the subject equipment as safety-related. A revision to include this equipment in SQA-134, "Critical Structures, Systems and Components (CSSC) List," was under review.

Appendix B of 10 CFR 50 requires the licensee to identify the structures, systems, and components to be covered by the quality assurance program. Failure to identify CSSC equipment and supply appropriate quality control measures to equipment that is safety-related is a violation; however, this violation meets the requirements

for a licensee identified violation. The failure to identify the controller as CSSC equipment was identified by the licensee, is a Severity Level IV violation, was not required to be reported, will be corrected with appropriate interim measures and measures to prevent recurrence, and was not a violation that could have been prevented by corrective action for a previous violation. Corrective action includes revision of SQA-134 by July 12, 1985, to include the equipment determined to be safety-related by the CSSC Review Committee. In the interim, the licensee stated that the equipment will be handled as safety-related equipment.

- c. The inspector observed maintenance on the incore probes on June 25, 1985. The maintenance consisted of removal of one incore detector, which was stored in a storage location in the incore instrument room, and replacement with a new detector.
- d. The inspector observed maintenance on the B train evaporator vent condenser water trap and vent valve which are CSSC equipment. The inspector reviewed the maintenance requests and procedures for the work. The following documents were reviewed:

- MR A545723
- MI 6.20 Configuration Control During Maintenance Activities
- MI 6.15 General Procedure, Tightening Bolted Joints
- MI 11.4 Maintenance of CSSC Valves

- e. Corrective maintenance on a Masoneilan 8005 electropneumatic transducer, current to pneumatic (I/P) converter, for a Unit 1 Auxiliary Feedwater system level control valve (1-LCV-3-148A) was observed on June 23, 1985. The following documents were reviewed:

- MR A528972
- Instrument Maintenance Instruction (IMI-134) Configuration Control of Instrument Maintenance Activities
- Surveillance Instruction (SI-75) Remote Shutdown Monitoring Instrumentation Steam Generator Level
- Drawings 47W610-3-3, 47W600-124, 45N603-4, 45N1630-56, and 45N2630-56
- Quality Assurance Form 575-558-85-0136
- Sequoyah Nuclear Plant Standard Practice (SQM-1) Sequoyah Nuclear Plant Maintenance Program
- Surveillance Instruction (SI-166.6) Post Maintenance Testing of Category A and B Valves
- Nuclear Quality Assurance Manual (NQAM)
- Masoneilan Technical Instruction 2035E

The inspector observed technicians performing the maintenance under MR A528972. The MR required the work to be performed in accordance with IMI-134. One purpose of IMI-134 is to provide explicit work instructions for the performance of maintenance activities.

Instructions on the IMI-134 maintenance work sheet used by the technicians stated (in the "Performance of Work" section), "verify proper operation and repair if required per vendors manual using as constructed drawings". No explicit work instructions or any other procedures were used to perform the maintenance. In addition, the vendor's manual did not provide instructions for replacement of the I/P converter.

TVA's Nuclear Quality Assurance Program (NQAM) states in section 3.3.1.2 that maintenance instructions shall contain enough detail to permit the task to be performed safely and expeditiously. The NQAM is implemented in part by SQM-1, which states that maintenance instructions shall be prepared to include a description of what work is to be done, in enough detail that further instructions are minimized. SQM-1 further states that this description should give a step-by-step sequence of events such that the job will be performed correctly, safely, and expeditiously, and shall include references to such documents as vendor drawings, TVA drawings, maintenance manuals, and other maintenance instructions.

The NQAM is also implemented in part by IMI-134. IMI-134 states that its purpose is to provide explicit precautions, prerequisites, work instructions, and pertinent information for the performance of maintenance activities. IMI-134 also states that work instructions are to clearly direct the work of the craftsman and/or refer to pre-written instrument maintenance instructions or manuals.

SQM-1 and IMI-134 were not adequately implemented in this case in that the "Performance of Work" section of the IMI-134 maintenance work sheet did not sufficiently describe the work to be performed on the level control valve; contained no details of the work to be performed; and, contained no reference to other procedures describing the activities to be performed. This is an unresolved item pending review of additional maintenance performances (327, 328/85-23-07).

The NQAM also states, in section 3.3.1.1, that the "Preparations for Maintenance" section of a maintenance instruction shall reflect special equipment requirements such as Measuring and Test Equipment (M&TE). SQM-1 states in the "Preparations for Work" section that maintenance procedures should state what special tools are needed. SQM-1 specifies that M&TE are special tools. M&TE used during the maintenance, a Heise gauge and digital volt meter, were not included in the "Special Equipment Section". While these procedural requirements were not implemented as stated, the IMI-134 maintenance work sheet did reference SI-75 in the "Performance of Work" section. Therefore, information on the special equipment needed was available by referencing SI-75 but not listed in the right section of the IMI-134 work sheet. The further review of proper inclusion of M&TE in the Special Equipment Section of IMI-134 is identified as an Inspector Followup Item (327, 328/85-23-08).

8. Licensee Event Report (LER) Followup (92700)

- a. The following LERs were reviewed and closed. The inspector verified that: reporting requirements had been met; causes had been identified; corrective actions appeared appropriate; generic applicability had been considered; the LER forms were complete; the licensee had reviewed the event; no unreviewed safety questions were involved; and violations of regulations or Technical Specification conditions had been identified.

LERs Unit 1

85006	Frozen Sense Lines
85020	Inadvertent Isolation of Unit 1 Residual Heat Removal While in Mode 5
84038	DNB Design Basis
84041	Pressurizer Indicator in ACR Inoperable
84043	Thermal Fire Detector Inoperable
84045	BB Compressor Out of Service
84066	Circuit Breaker Operating Error
84071	Surveillance Requirement Not Met
83003	Inoperability of Effluent Radiation Monitor
83016	Inoperability of Ice Condenser Temperature Monitoring System Recorder in the Main Control Room
83029	Two Ice Condenser Door Limit Switches Out of Adjustment
83031	Control Rod Position Indication Inoperable
83036	Train B Auxiliary Building Gas Treatment System Inoperable
83039	Inoperable Turbine Building Sump Liquid Effluent Radiation Monitor
83042	Opening of the Ice Condenser Lower Inlet Doors
83053	Blowdown Isolation Valve Failed Shut
83058	Inoperable Liquid Effluent Radiation Monitor

83076	Inoperable Liquid Effluent Radiation Monitor
83083	Inoperable Shield Building Stack Flow Rate Monitor
83096	Inoperable Gaseous Effluent Radiation Monitor for the Auxiliary Building Exhaust
83102	Waste Gas Decay Tank Oxygen Concentration Greater Than 2%
83103	Automatic Control Valve Failed Open
83106	Condenser Vacuum Exhaust Flow Rate Monitor Inoperable
83113	Inoperable Steam Generator Blowdown Radiation Monitor
83115	Auxiliary Building Gas Treatment System Discharge Damper Operator Found Disconnected
83123	Inoperable Train of Auxiliary Building Gas Treatment System
83125	Inoperable Condenser Vacuum Exhaust Effluent Monitor
83128	Inoperable Lower Containment Ventilation Isolation Radiation Monitor
83136	125 Volt DC Battery Bank Cell 2B Inoperable
83159	'D' WGDT High Oxygen Concentration
<u>LERs Unit 2</u>	
83032	Opening of the Ice Condenser Inlet Doors
83049	Ice Condenser Intermediate Deck Door Frozen Closed
83073	Inoperable Gaseous Effluent Radiation Monitor
83078	Inoperable Steam Generator Blowdown Monitor
83107	Average Ice Weight Below Minimum
83132	Inoperable Steam Generator Blowdown Radiation Monitors
85008	Missed One Hour Fire Watch Tour

85009

Unit 2 Reactor Trip

9. Event Followup (93702, 62703, 61726)

a. Pressurizer Heatup and Cooldown

On June 15, 1985, the licensee determined during review of SI-127, "RCS Temperature and Pressure Limits," that the pressurizer cooldown and heatup rates as indicated by the change in pressurizer liquid temperature over one hour had been exceeded during cooldown of Unit 1 on the morning of June 15th. The inspector reviewed Surveillance Instruction SI-127, RCS Temperature and Pressure Limits, performed on June 14 and 15, 1985, Potentially Reportable Occurrence Report 1-85-196, and operator logs for June 14 and 15, 1985. Concerns were identified in that the departure from the Limiting Condition for Operation occurred three times with no entry into the Technical Specification action statement indicated by the operator logs. The inspectors are interviewing operators on the sequence of events. This is identified as Inspector Followup Item (327, 328/85-23-09).

b. Inadvertent Engineered Safeguards Feature (ESF) Actuation

On June 25, 1985, while Unit 1 was operating in Mode 3, an ESF actuation occurred. At the time the ESF actuation occurred intermediate head safety injection was blocked in accordance with routine operating procedures. Therefore, no safety injection resulted. Other automatic actions responded normally including the isolation of the main steam isolation valves. Prior to the ESF actuation, Solid State Protection System (SSPS) steam flow channel 2, switch FS-1-28A, had been tripped to perform a troubleshooting procedures. A spurious steam flow signal tripped a second channel, resulting in the ESF actuation. Spurious steam flow signals have resulted in SSPS channel actuations on April 13, 1985, June 22, 1985, June 23, 1985, and June 25, 1985. The troubleshooting process was observed by the inspector, along with the recalibration of steam flow channel module 1-RC-1-73. The following documents were reviewed:

SI-483, Procedures for Removing a Reactor Protection Channel From Service
MR 528984
MR 530537
MR 543754
IMI-99 Section C.10.3, Offline Channel Calibration of Turbine Impulse Pressure Channel
Foxboro Technical Manual, Volume 2

No violations or deviations were identified during the troubleshooting or calibration of steam flow channel.

10. Inspector Followup Items (92701)

(Closed) Inspector Followup Item (327/79-45-03). This item concerned 10 CFR 21 evaluation worksheets that did not provide evidence that vendors or contractors had been informed of TVA identified noncompliances or defects. The licensee committed to change the reporting process by October 15, 1979. The current Significant Condition Report Processing Record Sheet (Revision SCRPRS 9/82) was reviewed and was found to require vendor notification if a condition required a Part 21 report. The licensee actions are considered complete.