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TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

85 OCT 28 P 1: 50 October 24, 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
50-327/85-24 AND 50-328/85-24 - REVISED RESPONSE TO VIOLATION

Enclosed is our revised response to R. D. Walker's August 7, 1984, letter to H. G. Parris transmitting IE Inspection Report Nos. 50-327/85-24 and 50-328/85-24 for our Sequoyah Nuclear Plant which cited TVA with two Severity Level IV Violations.

Violation 85-24-03, "Reason for Violation," should have stated that a routine inspection was performed on June 10, 1985 at 0900 CST rather than June 19, 1985.

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, Chief
Nuclear Licensing Branch

Enclosure

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

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REVISED RESPONSE - NRC-OIE INSPECTION REPORT NOS.
50-327/85-24 AND 50-328/85-24
R. D. WALKER'S LETTER TO H. G. PARRIS
DATED AUGUST 7, 1985

Violation 50-328/85-24-03

Technical Specification 3.6.5.3 states that, the ice condenser inlet doors, intermediate deck doors, and top deck doors shall be closed and operable for modes 4 through 1. Additionally, with one or more ice condenser doors inoperable, power operations may continue for up to 14 days provided the ice bed temperature is monitored once per 4 hours and the maximum ice bed temperature is maintained less than or equal to 27⁰F.

Technical Specification 4.6.5.3.2 states, in part, that each intermediate deck door shall be verified closed and free of frost accumulation by visual inspection at least once per 7 days.

Contrary to the above, on June 10, 1985, ice buildup was observed on the intermediate door and ice bed temperature was recorded once per eight hour shift vice the required once per four hours due to a lack of adequate post maintenance criteria.

This is a Severity Level IV violation (Supplement 1).

1. Admission or Denial of the Alleged Violation

TVA admits a violation occurred.

2. Reason for the Violation

The alleged violation states that the ice bed temperature must be recorded once per four hours if ice is observed on the intermediate deck doors. Technical Specification 3.6.5.3 actually allows the flexibility, in lieu of recording the ice bed temperature, to ". . . otherwise, restore the doors to their closed positions or OPERABLE status (as applicable) within 48 hours"

On June 10, 1985, at 0900 CST, a routine inspection of the unit 2 ice condenser revealed ice buildup on several intermediate deck doors. At 1331 CST on June 10, 1985, employees entered the unit 2 containment to remove the ice. This action was verified by reviewing the radiation work permits (RWP) and Administrative Instruction (AI)-8, "Access to Containment," data sheets which document names, dates, times, and purpose of containment entry. Verification of ice removal was documented by performance of Surveillance Instruction (SI)-3, "Daily, Weekly, and Monthly Logs," which was started at 1700 CST on June 10, 1985, and completed on June 11, 1985, at 2015 CST. SI-3 is the procedure used to fulfill the weekly Technical Specification Surveillance Requirement

4.6.5.3.2.a which requires the intermediate deck doors be free of frost accumulation. The cited documentation provides positive assurance that the ice was removed and operability verified within 48 hours allowed by Technical Specification 3.6.5.3.

The NRC inspection report stated that additional icing was observed on June 16, 1985, during containment entry to complete maintenance request (MR) A-553690. As a result of a review of the completed MR, RWPs, and AI-8 data sheets, it was discovered that this containment entry was actually made at 1024 CST on June 19, 1985. Through discussion with the NRC resident inspector, it was verified that the June 16, 1985 date referenced in the inspection report was in error. The inspection report stated that this ice buildup was caused by inleakage of humid air through torn insulating tape on the overhead upper ice condenser doors. TVA has evaluated this condition and determined that the torn insulating tape does not constitute a significant contribution to the buildup of ice. Unit 2 has experienced a history of ice condenser inleakage, primarily through the existing vent blankets, which in conjunction with the high humidity, has resulted in additional ice accumulation. To address this problem, maintenance personnel established a routine of periodically entering the ice condenser and removing the ice buildup. This was in addition to performance of the weekly surveillance instruction required to meet Technical Specification Surveillance Requirement 4.6.5.3.2.a. The periodic maintenance routine was considered to be acceptable because the ice removal activity was the same as that performed for any ice buildup discovered during the weekly surveillance. A further review shows that RWPs and AI-8 data sheets document containment entry on June 19, 1985, to remove additional ice buildup. Door operability was verified by performance of a pull test in accordance with SI-108, "Ice Condenser Doors," on the affected doors at 1600 CST on June 20, 1985. SI-108 is the procedure used to comply with the 18-month Technical Specification Surveillance Requirement 4.6.5.3.2.b. The cited documentation provides positive assurance that the doors were returned to operable status within the 48 hours allowed by Technical Specification 3.6.5.3.

As documented above, TVA complied with all action requirements for both events on June 10 and June 19, 1985. During discussion of these findings with the NRC resident inspector at Sequoyah and the cognizant NRC Region II inspector, it was ascertained that the principal NRC concern resulted from performance of ice removal activities without formal procedures needed for work on safety-related equipment. After reevaluation of the periodic ice removal routine, TVA agrees that the potential for problems may exist due to the fact that this practice may not always be controlled by formal procedures.

3. Corrective Steps Which Will Be Taken and the Results Achieved

With respect to the two incidents of ice buildup found on June 10 and June 19, 1985, the only corrective step needed was the removal of the ice. This was completed, and the intermediate deck doors returned to operable status within the 48 hours prescribed by technical specifications.