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DEC 29 1987

Docket Nos. 50-327, 50-328
License Nos. DPR-77, DPR-79
EA-118

Tennessee Valley Authority
ATTN: Mr. S. A. Whit
Manager of Nuclear Power
6N 38A Lookout Place
1101 Market Street
Chattanooga, TN 37402-2801

Gentlemen:

SUBJECT: NRC INSPECTION REPORT NOS. 50-327/86-37, 50-328/86-37, 50-327/86-49,
50-328/86-49, 50-327/86-53, 50-328/86-53, 50-327/86-32, 50-328/86-32,
50-327/86-44, 50-328/86-44, 50-327/86-26, 50-328/86-26, 50-327/86-50,
50-328/86-50, 50-327/86-61, 50-328/86-61

The purpose of this letter is close out issues raised previously in a number of Nuclear Regulatory Commission (NRC) inspections. Specifically, this letter refers to the NRC inspections conducted at the Sequoyah facility on March 19 - May 30, 1986; May 19 - July 11, 1986; June 6 - July 5, 1986; July 29-30, 1986; September 6 - October 5, 1986, September 15 - October 3, 1986, and September 29 - October 3, 1986. Violations were identified during these inspections. These were discussed during enforcement conferences and management meetings held on May 30, 1986, August 25, 1986, and October 29, 1986 between your staff and Region II staff. The reports documenting these inspections, enforcement conferences, and management meetings were sent to you with letters dated October 2, 3, and 28, 1986, November 14 and 24, 1986, and January 8, 1987.

The inspections included 1) a review of the circumstances surrounding TVA's failure to take adequate corrective actions for conditions adverse to quality; 2) a review of TVA's failure to ensure operability of Sequoyah's 480 volt electrical containment penetration overcurrent protection devices; and 3) a review of selected surveillance procedures and instructions to verify technical adequacy and accomplishment of Technical Specification (TS) surveillance requirements. As a result of these inspections, significant failures to comply with NRC regulatory requirements were identified. The specific examples that were identified are described in the enclosure to this letter.

The inspections identified several failures to promptly correct identified conditions adverse to quality. The issue of failure to promptly identify and correct conditions adverse to quality has been identified in five previous inspections from February 1981 to March 1985. In February 23, 1987, TVA implemented a Condition Adverse to Quality (CAQ) program at Sequoyah. Early 1987 inspections at Sequoyah indicated that the CAQ Program was not being effectively implemented and that additional work was required to assure resolution of this problem prior to restart of the Sequoyah units. A recent NRC inspection indicates management attention to the CAQ program now appears adequate. The NRC will ensure that the program is properly implemented prior to startup.

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The subject inspections also identified nine examples of surveillance instructions (SI) that were not properly established, reviewed, or performed. The nine examples were not isolated to a specific area, but indicated an overall problem with the ability of Sequoyah surveillances to demonstrate equipment operability as required by the TS. These examples included failures that existed since plant licensing, such as in the testing of molded case circuit breakers, examples of improper surveillance performance such as ERCW pump performance testing, and examples of improper reviews such as the surveillance review program checklist not being performed on pertinent instructions referred to in the SI. Several examples were identified by the Sequoyah TS review team established in response to the March 1986 NRC inspection. The previous Sequoyah program had not identified any substantial technical deficiencies. A recent NRC inspection of the SI program indicates management has now provided a program that appears to include the thorough technical review necessary to provide assurance that properly performed surveillances will adequately demonstrate system operability for plant startup.

Normally, the NRC would issue a Notice of Violation for the violations described above. The violations would be categorized in the aggregate in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action," 10 CFR Part 2, Appendix C (1987) (Enforcement Policy), as Severity Level III problems and a civil penalty would normally be considered. However, after consultation with the Deputy Executive Director for Regional Operations, I have been authorized to exercise discretion in accordance with Section V.G of the Enforcement Policy published in 52 Fed. Reg. 36215 (September 28, 1987) regarding licensees forced into extended shutdowns and will not issue a Notice of Violation or a civil penalty in this case. Some of the violations in the enclosure are licensee-identified and others are NRC identified. However, I have determined that issuance of an enforcement action is not necessary to achieve remedial action since you have initiated significant corrective action since the violations occurred. Since your programmatic corrective actions for these violations have already been examined and found acceptable by the NRC, no response to this letter is required. Successful implementation of your program, and NRC verification of the implementation, is considered a prerequisite to restart of Sequoyah.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

This letter and its enclosure are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, PL 96-511.

Sincerely,

original signed by Jane A. Axelrad

Stewart D. Ebnetter, Director
Office of Special Projects

Enclosure: As stated

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 S. J. Plant Manager
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SUMMARY OF INSPECTION FINDINGS

1. During the inspection from September 29, 1986 to October 3, 1986, six audit findings (SQ-8400-14, CH-8200-11, QSS-A-85-0006, QSS-A-85-0010, QSS-A-86-0001-2 findings) were identified that had not been promptly corrected. Correction of these audit findings had been delayed from a few months to over a year.
2. During the inspection from June 6, 1986 to July 5, 1986, it was determined that although containment sump level transmitters were found out of Technical Specification (TS) tolerance 6 times during normal 18 month surveillances from 1983 thru 1986, the licensee failed to identify this as a Condition Adverse to Quality or to initiate corrective actions.
3. During the inspection from September 6, 1986 to October 5, 1986, it was determined that although the upper head injection (UHI) system isolation valves response times were found out of tolerance in 20 of 24 surveillances conducted between 1981 and 1985, the licensee failed to take adequate corrective actions to preclude repetition of upper head injection (UHI) system isolation valve response time surveillance failures.
4. In March 1986, when the licensee identified numerous breakers needed for containment electrical penetration protection that required additional testing to satisfy TSs, the measures to document and correct that condition were not promptly implemented until the licensee was notified by the NRC Inspector on April 9, 1986 of the failure to take required actions.
5. In October 1986, the NRC discovered that although the licensee was notified by its Nuclear Safety Review Staff in March 1985 about commercial grade items that were being installed as replacement components in safety related equipment causing the equipment seismic and environmental qualifications to be degraded, the licensee failed to take actions to identify the equipment in non-conformance and failed to promptly correct the problem.
6. The surveillance tests conducted on the molded case and lower voltage circuit breakers prior to March 21, 1986, were not adequate to demonstrate operability in that the thermal overloads were tested by an inappropriate method. Additionally, on March 21, 1986, it was discovered that the licensee had inadequately established and maintained SIs-258 and 258.2 for the testing of circuit breakers and fuses associated with containment electrical penetration protection in that devices (approximately 120 breakers, and 318 fuse sets) required to be tested had never been added to the instructions. This condition existed since respective plant licensing and affected the sample size used when surveillance procedures were performed.

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7. During the performance of SI 45.1 on January 18, 1985, the KA ERCW pump did not meet the acceptable or allowable criteria as defined in SI-45.1 and was not declared inoperable as required by SI-45.1 and TS 3.7.4. On January 25th the licensee declared the KA ERCW Pump inoperable based on the January 18 test. Although SI-45.1 was reperformed at this time, prior to declaring the pump operable, the implementation of the performed test was not adequate to demonstrate operability. The KA ERCW pump was declared operable by the licensee on January 25, 1985 and was subsequently selected to auto start under accident conditions from February 12 to February 23, 1985. During this time period both units were in mode 1.
8. Step I.A.9 of the SI-1 Appendix F checklist was not performed in June 1986, for SI-102E/SA, SI-7 R34, and SI-6 R18, in that supporting documents were not reviewed.
9. On April 2, 1986, procedures SI-132 and SI-149 were discovered by the licensee to have been inadequately established in that an incorrect duct area was being utilized in SI-132 and SI-149 to calculate ABGTS flow rates. Recalculations using the correct duct area indicated that ABGTS train flow rates were less than the TS acceptance criteria and, therefore, inoperable during various periods of time since June 11, 1980.
10. On April 15, 1986, the licensee discovered that SI-166.1 specified stroke timing of 13 TS CIVs per unit to the open position instead of the requisite closed isolation position. Consequently, the valves had been stroke tested in the wrong direction since each unit had received its operating license.
11. On April 1, 1986, SI-3 was discovered by the licensee to have been inadequately established in that a channel check of the steam generator wide range level instrumentation was specified in lieu of the narrow range level instrumentation. Consequently, the TS required channel checks had not been previously performed.
12. On April 19, 1986, SI-6.1 was discovered by the licensee to have been inadequately established in that it failed to require verification of CVI from the containment purge air exhaust radiation monitoring channels. Consequently, the purge air exhaust radiation monitors had not been previously tested as required by TS.
13. On April 21, 1986, SI-7.1 was discovered by the licensee to have been inadequately established in that it did not include provisions to record available voltage on either the start buses or the 6.9 KV shutdown boards as required by SR 4.8.1.1.1.a.
14. On April 3, 1986, surveillance instructions to properly test the manual ESF actuations were discovered by the licensee to have been inadequately established or implemented. Consequently, some portions of the control circuitry for manual actuations of ESF valves, pumps, and fans were not tested or verified.