TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401
5N 157B Lookout Place

APR 20 1988

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Gentlemen:

In the Matter of) Docket Nos. 50-327
Tennessee Valley Authority) 50-328

SEQUOYAH NUCLEAR PLANT (SQN) UNITS 1 AND 2 - NRC INSPECTION REPORT NOS. 50-327, AND 50-328/88-23 - RESPONSE TO RECOMMENDATIONS

Enclosed is TVA's response to S. D. Richardson's March 17, 1988 letter to S. A. White that transmitted the subject recommendations.

Enclosure 1 provides TVA's response to the recommendations. Enclosure 2 provides the commitment in this response.

If you have any questions, please telephone M. R. Harding at (615) 870-6422.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

R. Gridley, Director
Nuclear Licensing and
Regulatory Affairs

Enclosures
cc (Enclosures):
Mr. K. P. Barr, Acting Assistant Director
for Inspection Programs
TVA Projects Division
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Mr. G. G. Zech, Assistant Director
for Projects
TVA Projects Division
U.S. Nuclear Regulatory Commission
One White Flint, North
11555 Rockville Pike
Rockville, Maryland 20852

Sequoyah Resident Inspector
Sequoyah Nuclear Plant
2600 Igou Ferry Road
Soddy Daisy, Tennessee 37379

IE01
1/1

ENCLOSURE 1

RESPONSE TO NRC INSPECTION REPORT
NOS. 50-327, AND 50-328/88-23
REQUEST FOR RESPONSE TO RECOMMENDATIONS

NRC RECOMMENDATIONS

"1. TVA should have periodic audits of its LER generation process, conducted by the QA or EA organizations, to evaluate the effectiveness of TVA's event analysis and reporting, to ensure continued compliance with the regulations, and to ensure high quality and accurate event reporting. This is especially important since there have been a number of personnel, organizational, and programmatic changes in TVA's event analysis and reporting process. TVA should determine whether or not they feel these changes have had a positive impact on their LER reporting.

2. TVA should formalize what are currently considered 'good practices'. Examples of these practices are: a) reporting events 'voluntarily' based on the worst-case results of ongoing evaluations; b) the addition of recurrence control to LERs, and; c) reduction in the use of compensatory measures as a means to correct design deficiencies.

3. TVA should establish a process that would provide a timetable for event evaluation and reporting. Establishing milestones for generating LERs would ensure that PORC has sufficient time to correct any deficient LERs before they are due to the NRC.

4. TVA should establish a program or process to follow through on LER corrective action to assure that root causes are corrected. The audit team suggested that the items be placed in the appropriate tracking system (CCTS, CAQR, etc.), and the tracking system item written into the LER to establish an auditable trail for tracking correction of root causes. This reduces the likelihood of 'throwing the LER over the wall' once it is issued."

TVA'S RESPONSE

1. TVA has, as part of its overall Quality Assurance (QA) program, periodic audits of the Licensee Event Report (LER) process, which includes evaluation of the effectiveness of TVA's compliance with the regulations. These audits include a review of event analysis, root cause determinations, and adequacy of corrective actions performed in association with LERs, but do not include evaluation of the effectiveness of programmatic changes in TVA's event analysis and reporting process because these were programmatic changes recently implemented. Future audits of the LER program will include the evaluation of the effectiveness of event analysis and reporting as appropriate.

2. TVA has a formalized condition adverse to quality report (CAQR) and potential reportable occurrence (PRO) process. During the review of a CAQR or PRO, reporting of operational events that do not meet the requirements found in 10 CFR 50.73 are considered, and based on the worst-case results of ongoing evaluation, may be reported voluntarily.

Thirteen LERs have been submitted as voluntary LERs. The process of reporting LERs voluntarily based on the worst-case results of ongoing evaluations was deemed necessary because of the large number of "indeterminate" issues outstanding at that time. Currently, with SQN in the restart phase, the number of indeterminate issues has decreased, and new indeterminate issues are resolved expeditiously in support of unit operations.

Sequoyah Standard Practice SQA186, "Root Cause Assessment For Adverse Actions/Condition," provides the formalized methods for determining root causes and recurrence controls to events. Administrative Instruction 49 provides formalized control in order to minimize the use of compensatory measures.

3. 10 CFR 50.73 states that LERs are to be submitted to NRC within 30 days of discovery of the event or condition. SQN has consistently met this requirement. Plant Operations Review Staff management has set a timetable to prepare LERs and present for Plant Operations Review Committee (PORC) approval, at approximately 25 days, so that PORC will have sufficient time to review LERs before they are due to NRC. A recent trend of the timetable of LER evaluation and reporting has shown that, on the average, LERs are reviewed by PORC at least three days before they are due to NRC. A number of these LERs are ones that have been to PORC earlier and are being returned for formal review.

4. As stated in our Nuclear Performance Plan, Corporate Commitment Tracking System (CCTS) was implemented in January 1986, and one of its functions is to track action items associated with LERs. This program provides an auditable trail for tracking corrective action of root causes. Additionally, PROs that initiate LERs are tracked and trended in Tracking and Reporting of Open Items. An auditable trail exists between LERs and PROs and between LERs and CCTS by doing sorts on the PRO and CCTS systems without having to write/record the PRO and CCTS numbers on the LER.

ENCLOSURE 2

List of Commitments

1. Future audits of the LER program will include the evaluation of the effectiveness of event analysis and reporting as appropriate.