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MAY 19 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) REVISED RESPONSE TO NRC INSPECTION REPORT NOS. 50-327/88-06 AND 50-328/88-06

Enclosed is TVA's response to Kenneth P. Barr's April 19, 1988 letter to S. A. White that requested a supplemental response clarifying the reason for violation 88-06-01 and whether the six additional loose items (found in 1E electrical panels) described in violation 88-06-03 have now been removed.

Enclosed is the revised response to violation 88-06-01 that clarifies the reason for the violation.

The remaining six loose items that were identified in an Operations plant inspection of 1E electrical panels on January 16, 1988, were subsequently removed by January 28, 1988.

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

Very truly yours,

TENNESSEE VALLEY AUTHORITY

R. Gridley, Director
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Enclosure
cc: See page 2

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MAY 19 1988

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ENCLOSURE

REVISED RESPONSE TO NRC INSPECTION REPORT NOS.
50-327/88-06 AND 50-328/88-06
KENNETH P. BARR'S LETTER TO S. A. WHITE
DATED MARCH 1, 1988

Violation 50-327, -328/88-06-01

"A. Technical Specification (TS) 6.8.1 requires that procedures recommended in Appendix 'A' of Regulatory Guide 1.33, Revision 2, be established, implemented, and maintained. This includes administrative procedures. The requirements of TS 6.8.1 are implemented by Administrative Instruction AI-37 titled 'Independent Verification' and Administrative Instruction AI-58 titled 'Maintaining Cognizance of Operational Status - Configuration Status Control'.

Contrary to the above, prior to January 4, 1988, the licensee failed to adequately establish, implement, and maintain procedures for configuration control as follows:

1. The licensee failed to specify the minimum qualification level for individuals performing independent verification of SOI checklists as required by AI-37. This resulted in a failure to perform and document adequate training for all individuals performing SOI checklist verifications.

2. The licensee failed to implement the requirements in AI-58 for maintaining configuration control after SOI checklist completion, in that the documented positions in the configuration control system for instrument root valve 1-268A, and the breakers for post accident sampling valves on 120 V vital instrument power boards 2-III and 2-IV (breaker 17 on each board) disagreed with the actual positions.

This is a Severity Level IV violation (Supplement I)."

Reason for the Violation

1. The failure to specify the minimum qualification level for individuals performing system operating instruction (SOI) checklist verifications was in part the result of a misinterpretation of Administrative Instruction (AI) 37. This instruction previously contained the minimum qualification requirements for Operations' personnel who can perform independent verifications. AI-37 was later revised to delete the qualification requirements for Operations' independent verifications. The qualifications were replaced with a more general statement, "Each plant section shall establish a minimum qualification level for individuals performing independent verification. Personnel should be trained, certified, or qualified for the job requirements." Operations' personnel responsible for preparation of AI-58, revision 0, (which was prepared subsequent to the AI-37 revision discussed above) believed that certification as a TVA assistant unit operator (AUO) satisfied the requirements of AI-37 and that additional documentation in AI-58 was not necessary.

Discussions held between Operations' management and NRC during a previous inspection on what additional training should be required for AUOs, who were on loan from other TVA sites, resulted in an agreement to provide SQN site-specific training so that these individuals would be fully cognizant of the SQN system alignment process. The agreement also included provision for documentation and validation of this training. Subsequent to this agreement, a change occurred in personnel responsible for overseeing the unit 2 system alignments. The replacement personnel had not been informed of the previous agreement between NRC and Operations management. Consequently, AI-58, revision 0, which was prepared following the change in personnel, did not include specific training requirements for AUOs on loan from other sites.

2. The reason for the mispositioning of the valve circuit breakers on the Postaccident Sampling Facility (PASF) was determined to be personnel error because the assistant shift supervisor/shift operator, who had closed the two breakers to allow performance of Surveillance Instruction (SI) 722.3, misinterpreted AI-58, section 2.2.2.1, and assumed that a configuration log entry was not required. AI-58 stated that, if a piece of equipment is controlled from the main control room control panels and had positive position indicators at the panel, its positioning does not have to be entered in the configuration log. The assistant shift engineer thought that the valve position indicating lights, which came on when the breakers were closed, were positive indication of their position. However, the breakers are not controlled from the control room panel.

   No reason could be determined for the mispositioning of instrument root valve 1-268A.

Corrective Steps That Have Been Taken

All employees who had participated in the independent verification of checklists were TVA-certified AUOs. Specific minimum qualification requirements were determined, and formal training in the appropriate areas was conducted and documented for all involved employees.

AI-58 was revised to include the minimum qualification requirements for independent verification personnel. Additionally, a form was added that will be used to document completion of the required training for AUOs on loan from other sites.

The mispositioning of instrument root valve 1-268A was entered in the configuration log. When no reason could be found for the valve to be closed, it was returned to its normal position; and the configuration log entry was cleared.

The PASF valve circuit breakers were returned to their normal positions.

The requirements for placing an entry in the configuration log were clarified for the senior reactor operator involved. To ensure that no others had the same misunderstanding, a letter was given to all shift supervisors directing them to ensure that all onshift Operations' employees had a clear understanding of the requirements of AI-58 concerning exceptions to configuration log entries. AI-58 was revised to clarify the exception statement. A letter was also sent to each shift supervisor, assistant shift supervisor, and unit operator relative to this revision. SI-722.3 was revised to require two-party independent verification when placing power on the PASF valve circuits and when opening the breakers at the conclusion of the test. Additionally, signs were placed at the units 1 and 2 PASF valve breakers that state, "Before closing breaker to PASF valves, consider requirements of T.S. LCO 3.6.1.1 and configuration log entry."

Corrective Steps That Will Be Taken to Avoid Further Violations

The AI-58 revision should be sufficient to prevent further violations relative to the qualification of independent verification personnel.

The corrective actions taken with respect to the PASF valve breakers are considered adequate to prevent recurrence of similar violations.

The mispositioning of instrument root valve 1-268A is considered an isolated event, and no further corrective actions are anticipated.

Date When Full Compliance Will Be Achieved

All corrective actions were completed by February 12, 1988.