TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401
400 Chestnut Street Tower II

November 7, 1979



Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Region II - Suite 3100
101 Marietta Street
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

SEQUOYAH NUCLEAR PLANT UNIT 1 - NRC-OIE REGION II LETTER
RII:WTC 50-327/79-46 - INSPECTION REPORT - RESPONSE TO INFRACTION

The subject letter dated October 16, 1979, cited TVA with one infraction in accordance with 10 CFR 2.201. Enclosed is our response to that infraction.

If you have any questions concerning this matter, please get in touch with D. L. Lambert at FTS 854-2581.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

L. M. Mills, Manager
Nuclear Regulation and Safety

Enclosure
cc: Mr. Victor Stello, Jr., Director (Enclosure)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

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ENCLOSURE

SEQUOYAH NUCLEAR PLANT UNIT 1
RESPONSE TO INFRACTION 327/79-46-01

Description

As required by 10 CFR 50 Appendix B, Criterion V, activities affecting qualify shall be accomplished in accordance with documented instructions. The licensees accepted QA Program, FSAR Section 17.1A.5 states that activities affecting quality are prescribed by documented instructions in the form of drawings, specifications, and procedures. Administrative Instruction AI-9, Temporary Alterations, which provides instructions for implementing this requirement, states that alterations will be properly documented and approved.

Contrary to the above, on August 31, 1979, a temporary alteration was identified on the control switch for FCV-30-8, a safety related containment purge isolation valve, which met none of the approval and documentation requirements of Administrative Instruction AI-9.

Corrective Action Taken and Results Achieved

An operator had secured the control switch for FCV-30-8 in the open position by attaching a rubber band to the switch handle and an adjacent protrusion on the control panel.

This had been done to allow purging of welding and burning smoke from the containment building during a time that an isolation signal was in effect because of incomplete work in the isolation circuitry. This incident did not create a radiation safety problem since there was no fuel in the reactor.

The shift engineer placed the control switch in its normal position upon becoming aware of the alteration and informed the persons involved that this action constituted an alteration of the control circuit and required issuing a temporary alteration form.

Action Taken to Avoid Further Noncompliance

The operations group was informed of the incident. The importance of complying with temporary alteration instructions has been discussed with operations employees.

The operator requalification program also provides periodic review of procedures addressing temporary alterations.

Date When Full Compliance Will Be Achieved

We are now in full compliance.