

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

May 5, 1982

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USNRC REGION II
ATLANTA, GEORGIA

U.S. Nuclear Regulatory Commission
Region II
Attn: James P. O'Reilly, Regional Administrator
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC/OIE REGION II INSPECTION REPORT
50-327/82-04 AND 50-328/82-04 - RESPONSE TO VIOLATION

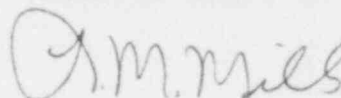
The subject OIE inspection report dated April 5, 1982 from R. C. Lewis to H. G. Parris cited TVA with one Severity Level IV Violation and one Severity Level V Violation. Enclosed is our response to the subject inspection report.

If you have any questions, please get in touch with R. H. Shell at
FTS 858-2688.

To the best of my knowledge, I declare the statements contained herein are complete and true.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



L. M. Mills, Manager
Nuclear Licensing

Enclosure

cc: Mr. Richard C. DeYoung, Director (Enclosure)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

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RESPONSE - NRC INSPECTION REPORT NOS.
50-327/82-04 AND 50-328/82-04
R. C. LEWIS' LETTER TO H. G. PARRIS
DATED APRIL 5, 1982

Appendix A

Item A (328/82-04-02)

10 CFR 50.59 requires that the licensee not make changes in the facility as described in the Final Safety Analysis Report (FSAR) if the change involves an unreviewed safety question. Prior to making a change in the facility as described in the FSAR the licensee shall perform a written safety evaluation which provides the basis for the determination that the change does not involve an unreviewed safety question.

Contrary to the above, the licensee changed a system as described in the FSAR without performing a written safety evaluation to determine that the change did not involve an unreviewed safety question. On February 10, 1982 the licensee blanked the floor drains in the unit 2 west main steam valve room and installed portable pumps to redirect the secondary steam leakage condensate to the yard drainage system. The floor drains in the west main steam valve room normally drain to the Floor Drain Collecting Tank in the Auxiliary Building per FSAR figures 9.3-9 and 9.3-10.

This is a Severity Level IV Violation (Supplement I.D.1.). Applicable to Unit 2.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

The floor drains were blocked in the unit 2 west main steam valve room in order that the condensate leakage could be discharged directly to the yard drainage system. This would eliminate the processing of significant amounts of secondary water that would have been collected in the floor drain collecting tank in the auxiliary building. It was determined that the condensing steam leakage was not contaminated and could be discharged to the yard drainage system. Since the steam generators and steam generator blowdown were monitored for radioactivity, this action was considered not to be an unreviewed safety question. However, a written safety evaluation was not documented before the drains were blocked and the portable pumps were installed to pump the steam leakage out to the yard drainage system.

3. Corrective Steps Which Have Been Taken and the Results Achieved

- (1) A safety evaluation was written and approved to document the unreviewed safety question determination as a result of the temporary change to the system. This was accomplished on February 11, 1982.

- (2) As an added precaution, periodic samples of the waste water were taken and monitored at the point of discharge to the yard drainage system. This is in addition to the normal monitoring of the condensate described above.
- (3) The steam leakage was repaired during shutdown after a trip on February 11, 1982, that was part of a startup test.

4. Corrective Steps Which Will Be Taken To Avoid Further Violations

- (1) A letter has been written and distributed to all appropriate personnel stressing the importance of the unreviewed safety question determination (USQD) and indicating the requirements for documentation of safety evaluations.
- (2) The need and requirements for USQDs have been discussed and emphasized in a PORC meeting on May 3, 1982.
- (3) The need and requirements for USQDs will be discussed and emphasized at an operations section personnel meeting by May 14, 1982.
- (4) Sequoyah Standard Practice SQA 119 will be revised to clarify those situations that require USQDs. The target date for completion is June 30, 1982.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on February 11, 1982.

Item B (327/82-04-01 and 328/82-04-01)

Technical Specification 3.1.3.3 requires that one rod position indicator (excluding demand position indication) shall be operable and capable of determining the control rod position within ± 12 steps for each shutdown or control rod not fully inserted in modes 3, 4 and 5 when the reactor trip breakers are closed.

Contrary to the above, the licensee did not maintain one rod position indicator operable for each shutdown rod not fully inserted capable of indicating rod position within ± 12 steps in modes 3, 4 and 5. At various times on both units since initial operation the licensee has maintained shutdown control rods withdrawn with the reactor coolant system below normal operating temperature (NOT). With rod position indication calibrated at NOT, it will not indicate actual rod position within ± 12 steps at less than NOT.

This is a Severity Level V Violation (Supplement I.E.). Applicable to Units 1 and 2.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

On February 17, 1982, it was discovered by the NRC resident inspector on unit 2 that the rod position indicators (RPI) of two rods in shutdown bank A were indicating greater than +12 steps with respect to the other RPIs in the bank.

Before this event, Sequoyah had been routinely maintaining the shutdown control rods fully withdrawn with the unit in modes 3, 4, or 5, regardless of system temperature, to provide additional safety in the event of a boron dilution or similar inadvertent criticality event. The rod position indication is calibrated at normal operating temperature (NOT). The rod position indicator will not indicate actual rod position when the system temperature is less than NOT. For these reasons, technical specification (tech spec) 3.1.3.3 was interpreted to be met if individual rod position indicators were within +12 steps of each other.

When the February 17, 1982, event and tech spec 3.1.3.3 interpretations were discussed, it was discovered that there were differing opinions on the interpretation of tech spec 3.1.3.3 and some confusion existed. It became apparent that no consistent clear interpretation of tech spec 3.1.3.3 existed among the operations personnel contacted. The misinterpretation of tech spec 3.1.3.3 and the operating procedures reflecting this misinterpretation were the primary reasons for this violation.

3. Corrective Steps Which Have Been Taken and the Results Achieved

- (1) A licensee event report and supplemental information was sent to NRC on March 2, 1982.
- (2) On February 18, 1982, a conference call was held with Nuclear Reactor Regulations (NRR) tech spec specialists concerning the tech spec 3.1.3.3 interpretation. NRR stated that the requirements of tech spec 3.1.3.3 are met if the rod position indicator indicates actual rod position within +12 steps with reactor trip breakers in the closed position. NRR was aware of the effects of temperature on the rod position indicators.
- (3) Since the unit 2 startup event of February 17, 1982, the requirements of tech spec 3.1.3.3 have been met by both units by keeping shutdown rods fully inserted until NOT is reached. This has been achieved by placing a statement to this effect in the operations night order book.

4. Corrective Steps Which Will Be Taken To Avoid Further Violations

A tech spec change request is being prepared to allow the shutdown rods to be withdrawn in modes 3, 4, and 5. This is based on the recommendations from Westinghouse Electric Corporation and is a revision of the NRC specification on RPI operability when not critical but with trip breakers closed.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on February 17, 1982.