

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

02 JUN 25 1982 June 23, 1982

U.S. Nuclear Regulatory Commission  
Region II  
Attn: Mr. 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 INSPECTION REPORT  
50-327/82-10 AND 50-328/82-10 - RESPONSE TO VIOLATION

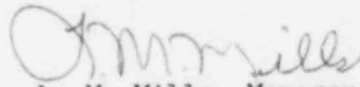
The subject OIE inspection report dated May 21, 1982 from F. J. Long to H. G. Parris cited TVA with two Severity Level IV Violations. Enclosed is our response to the subject inspection report.

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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ENCLOSURE  
RESPONSE - NRC INSPECTION REPORT NOS.  
50-327/82-10 AND 50-328/82-10  
F. J. LONG'S LETTER TO H. G. PARRIS  
DATED MAY 21, 1982  
SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2

Item A - (327/82-10-01)

Technical Specification 6.8.1.a requires that written procedures be implemented covering activities referenced in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978 including operation of the Control Rod Drive System.

Contrary to the above, the licensee did not implement System Operating Instruction SOI-85.01 "Control Rod Drive and Rod Position Indication System" in that on April 21, 1982 a Unit 1 operator attempted to parallel the #1 Rod Drive Motor Generator (RDMG) with the operating #2 RDMG by closing the output breaker with the manual control switch. This action which is contrary to the instructions in SOI-85.01 caused both RDMG output breakers to trip and resulted in an unnecessary reactor trip.

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

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

After completing tests which were performed on the 1A control rod drive motor generator (MG) set protective relays, an attempt was made to close the output circuit breaker with the control switch but it would not close. A second attempt was made by using the mechanical closing device which bypasses all closing interlocks including the automatic synchronizer. This caused the 1A MG set to be closed out of phase with the running MG set 1B which caused both 1A and 1B output circuit breakers to trip. These operations were performed without implementing SOI-85.1 which covers paralleling the two MG sets.

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

The operator involved was given a verbal warning for failure to use the available instruction and to take more precautions in the future when performing manipulative operations that could result in damaging equipment or cause a reactor trip.

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

The appropriate administrative instructions are being revised to spell out exactly which procedures must be used while performing a specified task. After the revisions are completed the necessary training for operations personnel will be made to ensure the requirements for proper use of operating instructions are understood. These revisions will be implemented by August 13, 1982.

5. Date When Full Compliance Will Be Achieved

We are now in full compliance; however, the above corrective actions will provide additional assurance that the operating instructions are correctly used and followed.

Item B - (327/82-10-02, 328/82-10-02)

Technical Specification 3.7.8 requires that two independent Auxiliary Building Gas Treatment (ABGTS) filter trains shall be operable when either unit is in mode 1, 2, 3 or 4.

Contrary to the above, two trains of ABGTS were not operable with Unit 1 in Mode 2 and Unit 2 in mode 1 in that on April 26, 1982 the inspector found both elevation 690 auxiliary building doors propped open. At least one door of each entry portal to the auxiliary building must remain shut in order to maintain the integrity of the Auxiliary Building Secondary Containment Enclosure and ensure that the ABGTS can maintain the required negative pressure in the auxiliary building during an accident.

This is a Severity Level IV Violation (Supplement I.D.2). This violation applies to both Units.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

The inner auxiliary building door (A57) was propped open for maintenance on the lock with the appropriate administrative controls in effect. The outer auxiliary building door (A56) was only being opened for personnel entry and exit. During one exit some craft personnel had propped open A56 to remove some heavy equipment but failed to shut A56 following their exit. Public Safety Service (PSS) personnel who were stationed at the door and responsible for monitoring all entrances and exits were unaware of the technical specification requirements for maintaining at least one door closed.

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

Door A56 was immediately shut.

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

PSS personnel have been instructed on the technical specification requirements and the importance of meeting them by ensuring one of the auxiliary building doors is shut at all times.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on April 26, 1982.