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

June 16, 1983

U.S. Nuclear Regulatory Commission
Region II
Attn: Mr. James P. O'Reilly, Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC-OIE REGION II INSPECTION REPORT 50-327/83-08 AND 50-328/83-08 - RESPONSE TO VIOLATION

The subject OIE inspection report dated May 17, 1983 from R. C. Lewis to H. G. Parris cited TVA with one Severity Level IV 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, D.C. 20555

ENCLOSURE

RESPONSE - NRC INSPECTION REPORT NOS.
50-327/83-08 AND 50-328/83-08
R. C. LEWIS' LETTER TO H. G. PARRIS
DATED MAY 17, 1983

Item 327, 328/83-08-01

10 CFR 19.12 requires in part that all individuals working in or frequenting any portion of a restricted area shall be kept informed of the storage, transfer, or use of radioactive materials or of radiation in such portions of the restricted area; shall be instructed in the health protection problems associated with exposure to such radioactive materials or radiation, in precautions or procedures to minimize exposure, and in the purposes and functions of protective devices employed.

Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained covering the activities as recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978, Section 7.e.(6), Training in Radiation Protection and Section 7.e.(7), Personnel Monitoring.

Radiological Hygiene Training Procedure, RCI-2, Revision 10, Section IV.B, Regulated Area Escorted Access, requires that individuals must have completed a special health physics orientation commensurate with potential radiological health protection of assigned work areas.

Radiological Hygiene Program, RCI-1, Revision 19, Section III.A, Regulated Areas, requires that TLD badges and pocket dosimeters to be worn when entering regulated areas.

Personnel Monitoring Procedure, RCI-3, Revision 13, Section VI.A, Requirements, states all personnel requiring Regulated Area access shall be issued personnel monitoring devices.

Contrary to the above, on April 8, 1983, two individuals entered separate regulated areas, one in the turbine building and one in the radwaste packaging area railroad bay, without the required radiation protection training and proper personnel monitoring devices.

This is a Severity Level IV Violation (Supplement IV.D).

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

The individual that was inside the temporary turbine building regulated area without proper dosimetry was an offsite vendor (visitor) representative that was escorted by a qualified badged individual from another TVA nuclear plant. The escort was onsite during required turbine acceptance testing.

The individual lacking proper dosimetry in the auxiliary building regulated area was a TVA employee from another TVA nuclear plant that was onsite to pick up needed equipment. He and his vehicle were escorted by qualified onsite personnel.

The primary reason for the turbine building event was inadequate training in that, although the escort was qualified and trained in escort responsibilities, adequate site-specific training was not given to this individual. The primary reason for the auxiliary building event was personnel error in that the escort failed to thoroughly check the individual to ensure that he had all the required dosimetry. Prior to entry into the regulated area, a pocket dosimeter was noticed by the escort, and the escort assumed a TLD badge was on the individual's person.

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

A radiological incident report was immediately written in both cases documenting the incidents. An independent investigation was performed to gather information and assess consequences. Upon discovery, both individuals were escorted out of the regulated area. It is estimated that the cumulative time spent in regulated areas without proper dosimetry for both cases was less than 30 minutes. Estimated exposure to each individual was less that 30 minutes. Estimated exposure to each individual was less than 5 mrem based on conservative calculations and methods; therefore, no 10 CFR limits were exceeded.

4. Corrective Steps Which Have Been Taken to Avoid Further Violations

a. All individuals with standing (offsite) access badging were identified and required, when applicable, to read and sign an instructional memorandum defining escort responsibilities. This instructional memorandum covers general escort responsibilities including dosimetry requirements and transfer or relief responsibilities. Also on the memorandum are appropriate statements stressing the adherence to escort regulations.

b. A site-specific training program was developed to provide nonstation employees with information that is pertinent to the Sequoyah Nuclear Plant site.

c. Appropriate disciplinary action was taken.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on April 8, 1983.