



Tenne see Valley Authority, Post Office Box 2000, Soddy-Daisy, Tennessee 37379

September 12, 1994

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) - INSPECTION REPORT NOS. 50-327, 328/94-17 -
REPLY TO NOTICE OF VIOLATION (NOV) 50-327, 328/94-17-02

Enclosure 1 contains TVA's response to William E. Cline's letter to Oliver D. Kingsley, Jr. dated August 11, 1994, which transmitted the subject NOV. The NOV involves inadequate corrective action (a violation of 10 CFR 50, Appendix B, Criteria XVI) to prevent recurrence of an adverse condition. The adverse condition involved reactor coolant water overflowing the Unit 2 postaccident sampling system collector drain tank. Commitments are listed in Enclosure 2.

If you have any questions concerning this submittal, please telephone C. H. Whittemore at (615) 843-7210.

Sincerely,

O. J. Zeringue
Acting Site Vice President
OPS 4A-SQN

Enclosures
cc: See page 2

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U.S. Nuclear Regulatory Commission

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cc (Enclosures):

Mr. D. E. LaBarge, Project Manager
U.S. Nuclear Regulatory Commission
One White Flint, North
11555 Rockville Pike
Rockville, Maryland 20852-2739

NRC Resident Inspector
Sequoyah Nuclear Plant
2600 Igou Ferry Road
Soddy-Daisy, Tennessee 37379-3624

Regional Administrator
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323-2711

ENCLOSURE 1

RESPONSE TO NRC INSPECTION REPORT
NOS. 50-327, 328/94-17
WILLIAM E. CLINE'S LETTER TO OLIVER D. KINGSLEY, JR.
DATED AUGUST 11, 1994

Violation 50-327, 328/94-17-02

"Technical Specification (TS) 6.8.4.e for both units required the licensee to establish, implement, and maintain a program which would ensure the capability to obtain and analyze samples of reactor coolant, radioactive iodines and particulates in plant gaseous effluents, and containment atmosphere under accident conditions. The program was required to include training of personnel, procedures for sampling and analysis, and provisions for maintenance of sampling and analytical equipment.

"10 CFR 50, Appendix B, Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants, Criterion XVI, Corrective Actions, requires that measures shall be established to assure conditions adverse to quality, such as, failures, malfunctions, deficiencies, deviations, defective material and equipment, and non-conformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action to preclude repetition. The identification of the significant conditions adverse to quality, the cause of the condition, and the corrective action taken shall be documented and reported to the appropriate levels of management.

"Contrary to the above, on or about September 10, 1992, and July 5, 1994, reactor coolant overflowed the Unit 2 Post Accident Sample Collector Drain Tank and spilled into a ventilation duct. Also, on or about October 8, 1993, reactor coolant overflowed the Unit 2 Post Accident Sample System sample sink and spilled onto the floor of the Post Accident Sampling Facility. These events were documented by the licensee in Problem Evaluation Reports. As evidenced by the repetition [sic] of this problem, licensee corrective actions have not been effective in precluding recurrence.

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

Reason for the Violation

The reason for the violation is management's failure to ensure that adequate compensatory measures had been established and would be maintained until the appropriate permanent corrective action could be implemented to correct and prevent recurrence of an adverse condition. The adverse condition was reactor coolant system (RCS) water leaking through postaccident sampling system (PASS) containment isolation valve (CIV) seats and overfilling the PASS collector drain tank. The tank was vented to a ventilation duct and as the tank filled up, RCS water

subsequently overflowed into the duct. The reason for this condition was that the CIVs were installed in an application for which they were not well suited. The appropriate corrective action at that time was determined to be either replace the valves or cap the lines; however, because of resources, the modification was postponed. In the interim, compensatory measures were recommended, i.e., periodically cycling the valves to clear the seats and monitoring tank levels. The subject isolation valves had experienced leakage through the seats, and in previous instances, the PASS collector drain tank had overflowed as a result. The cycling of the valves reduced the leakage and therefore reduced the chances for the drain tank to overfill. However, the cycling of the valves was discontinued because it exposed the plant to a possible TS containment integrity action statement (3.6.1.1) requiring the plant to be shut down within six hours should the valves not re-seat. The monitoring of tank levels was discontinued because of a lack of formalization of compensatory actions. Management failed to provide additional interim actions to prevent the overfilling of the subject tank once the cycling of the CIVs was discontinued.

Corrective Steps That Have Been Taken and the Results Achieved

Daily checks of the PASS collector drain tank have been established and will be maintained with directions to drain the tank, if required. A study has been initiated to determine the appropriate long-term corrective action.

Corrective Steps That Will be Taken to Avoid Future Violations

This event has been reviewed by management with specific emphasis on lessons learned, i.e., the importance of evaluating and making a conscious decision as to whether additional compensatory measures are needed when an activity is discontinued.

Date When Full Compliance Will be Achieved

With respect to the incident cited, TVA is in full compliance with 10 CFR 50, Appendix B, Criteria XVI with the implementation of the corrective action stated.

ENCLOSURE 2

COMMITMENTS
INSPECTION REPORT 94-17

This event will be reviewed by management with specific emphasis on lessons learned, i.e., the importance of evaluating and making a conscious decision as to whether compensatory measures are needed whenever an activity is discontinued. This will be accomplished by October 7, 1994.