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

October 11, 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, 328/94-25 - REPLY TO NOTICE OF VIOLATION (NOV) 50-327, 328/94-25-02

Enclosure 1 contains TVA's reply to Bruce A. Boger's letter to Oliver D. Kingsley, Jr., dated September 12, 1994, which transmitted the subject NOV. The violation is for inadequate corrective actions regarding missed technical specification surveillances, resulting in the failure to promptly identify and correct conditions adverse to quality. The specific examples identified in the violation were reported to NRC in Licensee Event Report (LER) 50-327/94012 dated August 15, 1994, and LER 50-327/94013 dated September 21, 1994. The commitment identified in this reply is contained in Enclosure 2.

If you have any questions concerning this submittal, please telephone J. W. Proffitt at (615) 843-6651.

Sincerely,

O. J. Zeringue
Acting Site Vice President

Enclosures
cc: See page 2

IE01
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ENCLOSURE

RESPONSE TO NRC INSPECTION REPORT
NOS. 50-327, 328/94-25
BRUCE A. BOGER'S LETTER TO OLIVER D. KINGSLEY, JR.
DATED SEPTEMBER 12, 1994

Violation 50-327, 328/94-04-01

"10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, requires, in part, that measures be established to assure that conditions adverse to quality such as failures, malfunctions, and nonconformances, are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall ensure that the cause of the condition is determined and corrective action taken to preclude repetition.

"In December of 1993, the licensee identified a Technical Specification (TS) Surveillance Requirement (SR) associated with Emergency [sic] Raw Cooling Water (ERCW) valves was not being performed within the required frequency. The licensee took corrective actions as outlined in incident investigation report No. SQ930836II, issued in February 1994. This issue was also the subject of Licensee Event Report (LER) 327/93-30, issued January 20, 1994.

"In March of 1994, the licensee identified a TS SR regarding testing of the emergency diesel generator fuel transfer pump, was not being performed on a monthly basis as required. Also in March 1994, the licensee identified a TS SR regarding the lower containment atmosphere particulate radioactivity monitor had not been performed at the proper frequency. The licensee took corrective actions as outlined in incident investigation report No. SQ940184II, issued April 1994. These two issues were the subject of LER 327/94-03, dated April 11, 1994, and revised August 15, 1994, and were also reviewed and a non-cited violation was identified in NRC Inspection Report 327, 328/94-09.

"Contrary to the above, licensee corrective actions for previous issues regarding missed TS SRs failed to promptly identify and correct conditions adverse to quality. Specifically:

a. On July 15, 1994, the licensee identified that TS SR 4.9.4, requiring that each containment building penetration be determined to be either in its closed/isolated condition or capable of being closed by an OPERABLE automatic containment ventilation isolation valve within 100 hours prior to the start of and at least once per 7 days during core alterations or movement of irradiated fuel in the containment building, had not been performed. The requirement to perform this TS SR at least once per 7 days should have been implemented during June 19, 1993, through July 12, 1993. This issue was also the subject of LER 327/94-12, issued on August 15, 1994.

b. On August 23, 1994, the licensee identified that TS SR 4.7.4.2.b, requiring at least once per 18 months during shutdown verification that each ERCW pump starts on a safety injection test signal, had not been performed at the required frequency. This TS SR was last performed approximately May 1990 for Unit 1 and November 1990 for Unit 2.

"This is a severity level IV violation (Supplement 1)."

Reason for the Violation

The reason for the violation was that management failed to provide proper guidance and expectations for the review of Operations' procedures. The expectation of the incident investigation (II) investigator, which was conveyed to Plant Operations Review Committee (PORC), was that Operations perform a technical review of their procedures. The details of the technical review were not defined, and Operations indicated that the review was expected to be performed within about one week. Operations only reviewed procedures to a level that verified that the SR was referenced and that the SI contained a section that was intended to fulfill the SR. Operations did not verify that the steps listed in the procedure fulfilled the SR. Operations considered this level of review appropriate based on the problems that had been identified up to that time.

A contributing factor is that verbal communication of the review that was performed by Operations did not clearly identify the depth of the review to PORC members. PORC members believed that a more in-depth review was performed to satisfy their request for a technical adequacy review.

Another contributing factor was the untimely corrective action dates specified in LER 50-327/94012. The corrective action included reviews that identified the at-risk population but did not ensure that the procedures were reviewed and corrected in a timeframe appropriate for the risk involved.

Corrective Steps That Have Been Taken and the Results Achieved

Upon discovery of the condition, the surveillances were revised and performed as necessary to comply with TS requirements.

A review of all Operations department surveillances was performed by the Site Quality organization to ensure that TS-required surveillances are properly implemented in instructions; no additional examples were identified.

There is no indication that the current review process is not effective. The missed surveillances that have been identified resulted from enhancement revisions in the 1991 timeframe, with the exception of Surveillance Instruction 137.1, which resulted from a misinterpretation of TSs in 1987. Independent qualified reviewer training was implemented after the enhancement project to strengthen the knowledge of the reviewers on what their responsibilities include.

A suspect population of Operations' SIs--procedures revised during the late 1991 timeframe--were identified, and a technical review was completed. This review did not identify any additional operability issues.

A memorandum has been issued to the Site Vice President's direct reports and other appropriate managers to communicate the need for precise communication between individuals and organizations. The memorandum identified the risk to the adequacy of management decisions that could occur if communication is not precise. The memorandum also reminded personnel that they should consider the significance of the issue involved as they choose corrective action dates to ensure timely completion. Cascading communication to site employees will subsequently occur.

The Plant Manager issued a memorandum to all shift operations supervisors, senior reactor operators, and independent qualified reviewers, which included guidance on their responsibilities as procedure reviewers and documented the problems that have been identified. This memorandum also reminded the reviewers that all intent changes must be reviewed by the Periodic Test Coordinator to ensure that the SI matrix is maintained accurate.

Corrective Steps That Will be Taken to Avoid Future Violations

A technical review of an additional 10 percent of Operations' SIs will be performed to provide a higher confidence that instructions not enhanced during the suspect timeframe do not contain similar SR deficiencies. The technical review will consist of reviewing electrical, flow, and logic prints down to the component level with the SI steps to ensure that technical specification testing is performed correctly. The review will also verify that the correct TS references are in the procedure and will compare the present revision of the procedure to the last revision before enhancement to ensure that test steps were not omitted or changed, which invalidates technical specification requirements.

Date When Full Compliance Will be Achieved

With respect to the specific examples cited, the corrective actions, when completed, will place TVA in full compliance.

ENCLOSURE 2

INSPECTION REPORT 94-25
COMMITMENT

A technical review of an additional 10 percent of Operations' SIs will be performed to provide a higher confidence that instructions not enhanced during the suspect timeframe do not contain similar surveillance requirement deficiencies. This action will be completed by December 2, 1994.