



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

January 30, 1995

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, 328/94-41 -
REPLY TO NOTICE OF VIOLATION (NOV) 50-327, 328/94-41-01

Enclosed is TVA's reply to Ellis W. Merschhoff's letter to Oliver D. Kingsley, Jr., dated December 30, 1994, which transmitted the subject NOV. The violation involves the failure to follow procedures. The violation is associated with the fuel handling supervisor not being present in the spent fuel pit area during the shuffle of spent fuel. The violation also states that a procedure was inadequate in that it did not provide adequate precautions or instructions regarding the retrieval and storage of the spent fuel handling tool in its storage rack. TVA feels that this example was a result of inattention to detail rather than an inadequate procedure.

TVA shut down all work associated with the spent fuel pit rerack project in early January 1995 as a result of several problems that had occurred during the course of the project. These problems were relatively minor and appeared to be unrelated to one another. However, in aggregate, the number of problems was indicative of a larger common problem. The problems involved an incorrect reference to an exhibit in a procedure, lack of instructions for a functional test for the debris basket lifting tool, intermittent versus continuous Radiological Control coverage, a senior reactor operator not being present at the storage pool during fuel movement, the spent fuel handling tool being caught on an object, and an auxiliary building isolation as a result of a vacuum hose being lifted out of the storage pool.

The Site Vice President requested that an independent team be assembled to examine the problems and the project as a whole. The objective of the team was to evaluate the problems for possible common causes and to recommend improvements in the overall conduct of the project.

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U.S. Nuclear Regulatory Commission

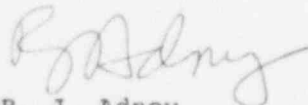
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As a result of the team's findings, floor managers were established who would be present on the refuel floor during the performance of significant work associated with the rerack project. After these managers were identified and before the restart of the rerack project, the Site Vice President, as well as the Manager of Projects, counseled the managers on their responsibilities and on management's expectations. The floor managers will provide increased management attention and a single source contact with the overall responsibility for the project. This corrective action, as well as other actions taken for each of the above problems, will provide the necessary focus for the continuation of the rerack project. It should also be noted that actions have been taken for the example of this violation noted in the exit meeting for Inspection Report 95-02.

If you have any questions concerning this submittal, please telephone S. D. Gilley at (615) 843-7427.

Sincerely,



R. J. Adney
Site Vice President

Enclosure

cc (Enclosure):

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ENCLOSURE

REPLY TO NOTICE OF VIOLATION
NRC INSPECTION REPORT NOS. 50-327, 328/94-41
ELLIS W. MERSCHOFF'S LETTER TO OLIVER D. KINGSLEY, JR.
DATED DECEMBER 30, 1994

Violation 50-327, 328/94-41-01

"Technical Specification 6.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A of Regulatory Guide 1.33 includes administrative procedures for authorities and responsibilities for safe plant operation and general plant operating procedures for refueling equipment operation. Implicit in these requirements is that the procedures be adequate.

"SSP-12.1, Conduct of Operations, Revisions 10, was established, in part, to delineate the responsibilities of the Fuel Handling Supervisor. Section 3.1.15 requires that the Fuel Handling Supervisor be present during any fuel movement, including fuel shuffle.

"FHI-3, Movement of Fuel, Revision 26, was established, in part, to provide prerequisites, precautions, and instructions for the transfer of fuel assemblies within the auxiliary building.

"Contrary to the above:

1. Procedure SSP-12.1, was not implemented in that on November 25, 1994, the Fuel Handling Supervisor was not present in the spent fuel pit area during the shuffle of spent fuel.
2. Procedure FHI-3, was inadequate in that it did not provide adequate precautions or instructions regarding the retrieval and storage of the spent fuel handling tool in its storage rack.

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

Reason for the Violation

Example 1

The reason for the violation is that during a review of plant documents conducted to establish the role of the fuel handling supervisor, the site procedure on conduct of operations (Site Standard Practice [SSP] 12.1) was not reviewed adequately. A standing order was issued stating that a senior reactor operator was not required to be continually at the spent fuel pit site during the shuffle of spent fuel for the rerack project. In accordance with the standing order, a fuel handling supervisor was

designated but was not present at the spent fuel pit continuously. SSP-12.1 requires the fuel handling supervisor to be present during any fuel (new or spent) movement, receipt, transfer, or shuffle. This resulted in the failure to meet the requirement for the fuel handling supervisor to be present during fuel movement.

Example 2

TVA denies the example which states that Fuel Handling Instruction (FHI) 3 was inadequate because it did not provide adequate precautions or instructions regarding the retrieval and storage of the spent fuel handling tool in its storage rack.

While the spent fuel handling tool was being moved from its storage bracket, a substantial jar was felt on the bridge. An investigation revealed a scraped area near the bottom of the tool indicating that the tool had caught on an object and then became free, resulting in the jar felt by the assistant unit operator (AUO) and the spotter on the bridge.

TVA reviewed FHI-3 and feels that the procedure was adequate for the work that was being performed. The AUO operating the hoist had previously performed this operation numerous times without incident. TVA feels that this incident was a result of the lack of attention to detail and not a procedural inadequacy.

TVA also believes that there is an inherent risk in putting statements in procedures which indicate to the performer that every detail of every activity will be delineated by the procedure. Procedures written under this philosophy indicate to the performer that the responsibility for the correct performance of the work lies solely with the procedure rather than a shared responsibility between the individual and the procedure. Additionally, procedures written this way generally discourage the performer from applying his knowledge and expertise.

Corrective Steps That Have Been Taken and the Results Achieved

The standing order that allowed the fuel handling supervisor to be at other locations other than the spent fuel pit was revoked.

Corrective Steps That Will be Taken to Avoid Future Violations

As noted in the cover letter, steps have been taken to address concerns with the spent fuel pit rerack modification from a broad perspective. These actions also serve to focus management attention for the project.

Date When Full Compliance Will be Achieved

TVA is in full compliance.