

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

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October 24, 1983

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

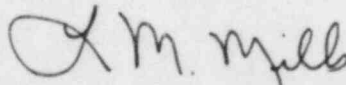
Dear Mr. O'Reilly:

Enclosed is our response to R. C. Lewis' September 21, 1983 letter to H. G. Parris transmitting Inspection Report Nos. 50-259/83-33, -260/83-33, -296/83-33 regarding activities at our Browns Ferry Nuclear Plant which appeared to have been in violation of NRC regulations. We have enclosed our response to Appendix A, Notice of Violation. If you have any questions, please call Jim Domer at FTS 858-2725.

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

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RESPONSE - NRC INSPECTION REPORT NOS.  
50-259/83-33, 50-260/83-33, AND 50-296/83-33  
R. C. LEWIS' LETTER TO H. G. PARRIS  
DATED SEPTEMBER 21, 1983

Appendix A

Item A (260/83-33-02)

10 CFR 50, Appendix B, Criterion V, requires activities affecting quality shall be prescribed by documented procedures and shall be accomplished in accordance with these procedures. Recirculation system Special Test Instruction (STEAR) 83-01 delineated certain requirements with respect to Unit 2 recirculation system vibration and leak detection. The special test was implemented to satisfy commitments as delineated in TVA/NRC Meeting of January 6, 1983, and TVA letter dated January 25, 1983.

Contrary to the above, the requirements of STEAR 83-01 were not met in that several procedural requirements were not satisfied. Examples of failure to adhere to STEAR 83-01 include:

- (1) STEAR 83-01 requires recirculation system vibration readings be taken twice a day (once every 12 hour shift) by the Shift Technical Advisor (STA).

Contrary to this, over the reviewed period from July 1 to August 16, 1983, 22 vibration readings were not logged on the data log (figure 25 of STEAR 83-01) as being taken.

- (2) STEAR 83-01 requires recirculation system leak detection readings be taken twice a day by the STA.

Contrary to this, over the reviewed period from July 1 to August 16, 1983, 36 leak detection readings were not logged on the required data log (figure 25 of STEAR 83-01) as being taken. In addition, on 7 days, no leak detection readings were recorded as being taken.

- (3) STEAR 83-01 requires data logs be taken in accordance with the Plant Operations Review Committee (PORC) approved figure 25 logsheet in STEAR 83-01.

Contrary to this, data logs were taken from July 1 to August 16, 1983, on a non-PORC approved hand-generated log sheet. The hand-generated log sheet did not incorporate the log checkoff requirements for verifying leak detection equipment status as required by STEAR 83-01.

This is a Severity Level IV Violation (Supplement I) applicable to Unit 2.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated. However, some clarification is required with regard to the vibration readings required by figure 25 of STEAR 83-01. These vibration readings originated in STEAR 82-08 and are not related to STEAR 83-01 requirements other than the fact that they were recorded on a common logsheet to reduce duplication of effort. These vibration readings are not in any way related to the commitments delineated in the TVA/NRC meeting of January 6, 1983, and the TVA letter dated January 25, 1983.

2. Reasons for the Violation if Admitted

The violation occurred due to inadequate administrative control procedures. There was inadequate management follow-up action (with the exception of the first two weeks the special test was in place) to ensure the required information was being logged and reviewed.

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

A stamp has been developed that delineates the minimum information to be gathered by the STA each shift. This stamp is being used by the STA as part of the STA logbook for each shift and requires acknowledgement that STEAR 83-01 readings have been taken. This provides continuity from one STA shift to the next. Sufficient figure 25 logsheets have been provided for the remainder of this operating cycle to ensure the data is logged as required.

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

As a result of a review of the STA program, improvements in the program, including better defining STA duties and responsibilities, the necessity for establishing a formal STA shift turnover procedure, and improving communications with on-shift STA, are being evaluated.

5. Date When Full Compliance Will Be Achieved

Full compliance will be achieved by December 1, 1983.

Item B (259, 260, 296/83-33-01)

10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

Contrary to the above, this requirement was not met in that electrical cable tray seismic hold-down clip restraints required to be installed in the Unit 1, 2, and 3 cable spreading rooms in accordance with TVA drawings 48N1040, 48N1041 and 45N830 were not properly installed. A licensee survey of the cable spreading rooms indicated the following deficiencies: Unit 1: 25 deficiencies; Unit 2: 18 deficiencies; and Unit 3: 21 deficiencies.

This is a Severity Level IV Violation (Supplement I) and applicable to all units.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

During the unit 1 refueling outage, numerous modifications which involved cable pulls through the units 1 and 2 spreader rooms were currently in progress at the time of the NRC inspection. Because the modification work was still in progress, the missing and/or loose holddown clips and missing bolts and braces in unit 1 were not noticed. The units 2 and 3 spreader room deficiencies resulted from both damage that incurred during recent modifications (bent clips) and incomplete reinstallation after the modifications (missing bolts and braces). The damaged clips and the incomplete reinstallation were not discovered because no inspection of the spreader rooms was conducted following completion of the modification work.

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

All deficiencies were corrected per maintenance requests by August 1, 1983, after notification of the condition by the NRC inspector. A separate maintenance request was prepared for each unit to inspect and correct any deficiencies identified for the seismic restraints on electrical cable trays.



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

A work item has been placed on the outage schedule to be performed at the end of each outage before startup. This work item will cover the inspection of all three spreader rooms and the repair of any deficiencies noted during the inspection.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on October 7, 1983, when the work items were added to the outage schedule.

Item C (260/83-33-06)

Technical Specification 6.3.A.6 requires that detailed written procedures shall be prepared to cover surveillance and testing requirements.

Contrary to the above, this requirement was not met in that no procedure was written or used to address the method of APRM gain adjustments as performed by the shift nuclear engineer at 7:58 p.m. on July 16, 1983. The shift nuclear engineer was directed by the shift engineer to reset APRM gain factors in order to effectively reduce the R factor as required by Technical Specification 2.1.A.1.b.

This is a Severity Level IV Violation (Supplement I) applicable to Unit 2.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

An adjustment to the APRM trip point was required to maintain unit 2 within the limits of Technical Specification 2.1.A. This adjustment is normally performed by plant instrument mechanics using Surveillance Instruction (SI) 4.1.B-15. However, no instrument mechanics were available to place the R factor back within limits within the technical specification required time limit. The nuclear engineer, at the direction of the shift engineer and using accepted industry practices, conservatively increased the APRM gain to meet the technical specification requirements, even though there was no procedure available that covered such action. The nuclear engineer completed his adjustment of the APRM gain at 1958 hours on July 16, 1983. The instrument mechanics set "R" to the appropriate value using SI-4.1.B-15 at 2340 hours of the same day.

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

SI-4.1.B-2, which is the approved procedure for setting the APRM gain, was revised to allow an adjustment of APRM gain using the method followed by the nuclear engineer on July 7, 1983, to compensate for unit operation with FRP/CMFLPD less than 1.0. TVA considers this method of APRM gain adjustment to be conservative and consistent with accepted industry practice. In addition, the nuclear engineers have been cautioned to observe plant procedures and to not take any actions that are not specifically covered by approved plant procedure.

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

No further corrective action is required.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on October 12, 1983, when SI-4.1.B-2 was revised to provide an alternate method for the R factor adjustment.

Item D (259, 260, 296/83-33-C3)

10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Instrument setpoint drawings are required to be updated in accordance with Browns Ferry Standard Practice 8.3.

Contrary to the above, adequate drawings were not maintained in that TVA drawings 47B601-64-7R and 47B601-64-8R were not revised to reflect a setpoint revision for drywell pressure required by Amendments 54, 49, and 26 of the respective units operating license.

This is a Severity Level V Violation (Supplement I) applicable to all units.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reasons for the Violation if Admitted

The violation occurred due to personnel oversight.

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

A field setpoint change will be initiated to update mechanical instrument tabulation drawings.

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

This is considered an isolated incident. Existing procedures should be adequate to prevent recurrence. No further corrective action is required.

5. Date When Full Compliance Will Be Achieved

Full compliance will be achieved by January 1, 1984, when the mechanical instrument tabulation drawings will be updated.