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

84 NOV 26 P2:37

November 23, 1984

U.S. Nuclear Regulatory Commission
Region II
Attn: Mr. James P. O'Reilly, Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Dear Mr. O'Reilly:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC-OIE REGION II INSPECTION REPORT 50-327/84-25 AND 50-328/84-25 - RESPONSE TO VIOLATIONS

The subject OIE inspection report dated October 17, 1984 from R. C. Lewis to H. G. Parris cited TVA with three Severity Level IV Violations. Enclosed is the response to the items of violation in the subject inspection report.

The delay in submittal of this response to the items of violation was discussed with S. Weise of your staff in a telephone conversation on November 14, 1984.

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

J. A. Domer

J. A. Domer
Nuclear Engineer

Enclosure
cc (Enclosure):
Mr. Richard C. DeYoung, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Records Center
Institute of Nuclear Power Operations
1100 Circle 75 Parkway, Suite 1500
Atlanta, Georgia 30339

ENCLOSURE
RESPONSE - NRC INSPECTION REPORT
NOS. 50-327/84-25 AND 50-328/84-25
R. C. LEWIS' LETTER TO H. G. PARRIS
DATED OCTOBER 17, 1984

Item 1 - (Violation 328/84-25-03)

Technical Specification 6.8.1.c requires that written procedures be implemented for surveillance and test activities of safety-related equipment. Surveillance Instruction (SI)-267.74.2 "Inservice Pressure Testing of Residual Heat Removal System - Outside Containment" provides prerequisites, precautions, and instructions for inservice testing of the Residual Heat Removal System (RHR).

Contrary to the above, written procedures for testing the RHR syst 1 were not properly implemented in that on July 10, 1984, the 2A-A RHR pump was started for test purposes prior to the establishment of the correct valve lineup as required by section 5.3 and 5.4 of SI 267.74.2.

This is a Severity Level IV violation (Supplement I). This violation applies to unit 2 only.

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reason for the Violation If Admitted

A priority sheet is issued daily to inform plant sections of work scheduled so that adequate coordination between plant sections can be maintained. Our investigation has determined that the priority sheet for July 10, 1984 stated to start the 2A-A pump in preparation for performance of SI-267.74.2, "Inservice Pressure Testing of Residual Heat Removal System - Outside Containment." A history file of previous priority sheets is maintained for one week only, and therefore, the actual priority sheet used to start the RHR pump is not available.

Surveillance instructions normally require starting of pump and valve lineups to be in accordance with System Operating Instructions (SOIs). In this case, SI-267.74.2 was a new instruction which required a valve lineup different from the lineup required by the SOI followed by starting and running of the pump. The pump was required to be run for 4 hours before the visual inspection to allow for temperature and

pressure equalization of the system. There was no safety significance in starting of the RHR pump before establishing the valve lineup required by SI-267.74.2. The only effect ws the impact on the daily work schedule in that the 4-hour hold time was required to be restarted after the valve lineup was made.

3. Corrective Actions Taken and Results Achieved

The RHR pump was stopped, the valve lineup required by SI-267.74s.2 was completed, and the pump restarted.

4. Corrective Actions Taken to Avoid Further Violations

Priority sheets will be more specific in requirements for preparation for performance of Surveillance Tests. For example, in this case the priority sheet could have stated both to align the RHR system and start the RHR pump in accordance with SI-267.74.2.

5. Date When Full Complaince Will Be Achieved

Full compliance was achieved on July 10, 1984 when the proper valve lineup was complete.

Item 2 - (Violations 327/84-25-01 and 328/85-25-01)

Technical Specification 3.7.8 requires that two independent Auxiliary Building Gas Treatment System (ABGTS) filter trains shall be operable when either unit is in modes 1, 2, 3, or 4.

Contrary to the above, two trains of ABGTS were not operable with the units in mode 1 in that on August 17, 1984, on two occasions on August 20, 1984, and on one occasion on September 5, 1984, Auxiliary Building Secondary Containment Enclosure (ABSCE) doors were opened. The integrity of the ABSCE was not maintained as required to ensure that the ABGTS can maintain the required negative pressure in the auxiliary building during an accident.

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

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reason for the Violation If Admitted

SQN management recognized the problems associated with breaching of ABSCE boundaries before the events described in LERs 327/84053 and 328/84055. In February of 1984, management assigned the Mechanical

Test Group of the Engineering Section the tasks of controlling ABSCE boundary breaches and the coordination between plant sections involved with the breach and Operations personnel. Technical Instruction TI-77, "Breaching the Shield Building, ABSCE, or Control Building Boundaries," was written by the Mechanical Test Group and PORC approved on February 2, 1984 to address requirements for control of these boundaries. However, it became apparent after the second LER incident on September 5, 1984, that controls were not adequate, and subsequent correction action was implemented on September 7, 1984 by plant management.

3. Corrective Actions Taken and Results Achieved

The involved doors were closed, reestablishing the ABSCE boundary.

4. Corrective Actions Taken to Avoid Further Violations

1. A Night Order was issued on September 7, 1984 by the Operations Supervisor to require all Auxiliary Building door breaches to be evaluated by the Shift Engineer.

2. On September 11, 1984, Plant Procedure TI-77 was revised to include a list of all ABSCE doors and add a permit form for conditional ABSCE door breaches.

3. All ABSCE doors were labeled with a reference to TI-77. This item was completed on October 9, 1984.

4. On October 12, 1984, a second revision to TI-77 was made to further clarify ABSCE requirements and to remove the permit forms. The PHYSI-13, Attachment F Form, was then revised to include the ABSCE breach signoffs. This change now requires all fire barrier breaches and ABSCE breaches to be documented on the same form.

5. Date When Full Compliance Will Be Achieved

Full compliance was restored on August 17, August 20, and September 5, 1984 when the respective doors were reclosed.

Item 3 - (Violations 327/84-25-02 and 328/84-25-02)

10 CFR 50.73 requires licensees to submit a Licensee Event Report (LER) for any of the several specified events and requires tht this report be complete and contain dates and times of all occurrences associated with the event. LER 50-327/84055 was submitted on September 20, 1984, concerning breaches of the Auxiliary Building Secondary Containment Enclosure.

Contrary to the above, as of October 5, 1984, LER 50-327/84055 was inadequate in that the licensee investigation of the event did not identify breaches of the ABSCE which occurred several days before the reported event and which were associated with related maintenance activities.

This is Severity Level IV violation (Supplement I).

1. Admission or Denial of the Alleged Violation

TVA admits the violation occurred as stated.

2. Reason for the Violation If Admitted

The investigation by the Compliance Staff used for preparation of LER 50-327/84055 failed to uncover the Friday, August 17, breach due to the following reasons. First, the Compliance Engineer only investigated logs for Monday, August 20, since the Potential Reportable Occurrence (PRO) forms were issued only on the Monday incident. The investigation included conversations with Operations and Maintenance personnel, and Public Safety Officers invovled in the Monday, August 20, breach. During these conversations, no mention of the Friday, August 17, breach was made to the engineer performing the investigation. Therefore, he had no knowledge of the August 17 breach. Additionally, the doors involved in this incident were doors A208 and A209. Doors A206 and A207 were mistakenly reported in LER 50-327/84055 as being the involved doors.

3. Corrective Actions Taken and Results Achieved

An investigation has been performed to determine the exact sequence of events for the Friday, August 17, breach. The results of this investigation will be included in a revision to LER 84055, which will be completed by November 30, 1984.

4. Corrective Action to Avoid Further Violations

The Compliance Staff will continue to perform investigations for reportable conditions in a professional and conscientious manner. This violation is considered to be an isolated case and no further corrective action is deemed necessary.

5. Date When Full Compliance Will be Achieved

Full compliance will be achieved by November 30, 1984.