

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

R.J. Adney
Site Vice President
Sequoyah Nuclear Plant

May 22, 1996

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Gentlemen:

In the Matter of)	Docket No. 50-327
Tennessee Valley Authority)	50-328

SEQUOYAH NUCLEAR PLANT (SQN) - NRC INSPECTION REPORT NOS. 50-327,
328/96-02 - REPLY TO NOTICE OF VIOLATION (NOV) 50-327, 328/96-02

Enclosed is TVA's reply to Mark S. Lesser's letter to Oliver D. Kingsley, Jr., dated April 22, 1996, which transmitted the subject NOV's. The violations are associated with the failure to follow procedures.

TVA is also concerned with procedural adherence at SQN. As a result of violations noted in NRC Inspection Reports 50-327, 328/95-26 and 95-27 and as part of continuing site improvement efforts, a review of several ongoing or recently completed evaluations and assessments was performed. The intent of the review was to identify common issues, associated root causes, and appropriate corrective actions. The review also included a common cause assessment of procedure compliance issues that were identified over a six-month period. The primary cause for the failure to follow procedures is that established standards had not been effectively and consistently enforced throughout site organizations.

A site-wide stand down was conducted to ensure that the standards which SQN management had developed are fully understood and that site personnel realize that individuals will be held accountable to these standards. Managers and supervisors were informed that they will be held accountable for the work practices of their

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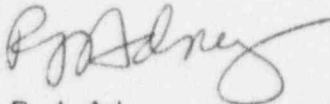
May 22, 1996

employees. The expectation that every employee be knowledgeable of and adhere to the policies established in the SQN Work Standards Manual was reinforced. Management has recently reemphasized accountability through the appropriate disciplinary actions taken, including removing managers from their positions and instituting a positive reinforcement program that recognizes examples of the proper demonstration of accountability. The violation examples cited in this inspection period occurred during the same timeframe that these actions were being taken. Recent experience indicates that these actions are beginning to improve procedure adherence and enforcement of work standards. I will have Nuclear Assurance evaluate the effectiveness of the actions in resolving site human performance issues.

Enclosure 1 contains TVA's response to the NOVs. Commitments associated with the submittal are included in enclosure 2.

If you have any questions concerning this submittal, please telephone R. H. Shell at (423) 843-7170.

Sincerely,



R. J. Adney

Enclosures

cc (Enclosures):

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ENCLOSURE 1
RESPONSE TO NRC INSPECTION REPORT
NOS. 50-327, 328/96-02
MARK S. LESSER'S LETTER TO OLIVER D. KINGSLEY, JR.
DATED APRIL 22, 1996

VIOLATION 50-327,328/96-02-01

"Technical Specification 6.8.1.a requires, in part, that written procedures shall 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 procedures for startup, operation, and shutdown of safety-related systems, including the component cooling system.

"System Operating Instruction (SO) O-SO-70-1, COMPONENT COOLING WATER SYSTEM "B" TRAIN, Revision 8, provided the steps necessary for operation of "B" train component cooling system, including train shutdown.

"Contrary to the above, on March 20, 1996, the licensee failed to provide an approved procedure for operating a "B" train component cooling system return isolation valve or failed to implement O-SO-70-1 to shutdown the "B" train, prior to operating the valve. The failure to establish a procedure or implement an existing procedure caused a component cooling system perturbation which overflowed a component cooling system surge tank, resulting in damage to nearby equipment and an automatic shutdown of all ice condenser glycol chillers.

"This is a Severity Level IV Violation (Supplement I)."

Reason for the Violation

The cause of the violation was poor decision making by the Unit Operator, two Assistant Shift Operations Supervisors (ASOS), and the test director. The decision was not to shutdown the B-train component cooling system pump and to proceed with the PMT. The decision to perform the valve stroke with Train B CCS in service placed the CCS system in an alignment which resulted in the CCS surge tank being over-filled. The test director and the licensed operators failed to properly evaluate whether procedural justification existed for the proposed CCS system alignment. The Unit Operator and two ASOSs did not perform a detailed review of the proposed PMT method as provided by the test director.

Corrective Actions That Have Been Taken and the Results Achieved

An engineering evaluation of the potential over-pressurization of the CCS surge tank was performed and concluded that the integrity of the CCS surge tank was not challenged during this event. Equipment damaged by the overflow through the relief valve has been repaired and returned to service.

A standing order was issued by the Operations Superintendent to clarify the requirements for control of the system alignment during the performance of a PMT.

The personnel involved received the appropriate disciplinary action.

The Corrective Steps Taken to Avoid Future Violations

A training letter was prepared and distributed to all licensed operators discussing the observed CCS system response for this event, the design of the CCS surge tank vent and the dry reference leg level indicators, and a review of operator responsibilities associated with the performance of PMT.

The administrative procedure governing PMTs was revised to require the Shift Operations Supervisor or Senior Reactor Operator to ensure that the system configuration necessary to perform the PMT is compatible with approved procedures.

A design issue will be submitted to address the CCS surge tank vent piping arrangement for potential modification of the system.

Date When Full Compliance Will be Achieved

With respect to the examples cited, TVA is in full compliance.

VIOLATION 50-327,328/96-02-05

"Technical Specification 6.8.1.a requires, in part, that written procedures shall 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 general procedures for control of maintenance, repair, replacement, and modification work.

"Site Standard Practice (SSP) SSP-9.3, PLANT MODIFICATIONS AND DESIGN CHANGE CONTROL, Revision 14, defined the responsibilities and requirements for the development, implementation, and closure of design changes and modifications to systems, components, and structures at Sequoyah Nuclear Plant. Section 5.3.2 of SSP-9.3 stated that field engineers will remain on clearances until equipment can be returned to service unconditionally (i.e. procedure reviews, primary drawing updates, return to operation (RTO), etc.), except as noted in section 5.4.3. Section 5.4.3 of SSP-9.3 allowed for lifting of the hold order for performance of post maintenance testing (PMT) that required the component or system to be in service. If after performance of the PMT, the equipment cannot be returned to service unconditionally (drawings and procedures updated, RTO walkdowns performed, etc.), the cognizant engineer shall insure operations issues a clearance to indicate that an open issue exist.

"Contrary to the above, on or before March 18, 1996, the licensee failed to follow the requirements of SSP-9.3 in that clearance control for several modifications in the plant was inadequate. Modifications without required clearance control included: Unit 1 cold leg accumulator sample system modification, steam generator blowdown radiation monitor 1-RE-90-124 modification, and Unit 1 boric acid blender sample system modification.

"This is a Severity Level IV Violation (Supplement I)."

Reason for the Violation

A review of modification activities and the modification/clearance interface identified that plant personnel have developed workarounds of these plant processes in order to complete work.

Corrective Actions That Have Been Taken and the Results Achieved

Hold orders were established as appropriate for equipment that had not been properly returned to service.

The personnel involved received the appropriate disciplinary action.

Stand downs were held with Modifications' foremen and engineers, component engineers and Nuclear Engineering supervisors to discuss the issues identified and to reinforce management expectations relative to the clearance and modification programs.

Each department manager reviewed his area of responsibility through in-plant walk-downs to ensure that hold orders, caution orders, or other protection notices were established where required by site procedures.

The Corrective Steps Taken to Avoid Future Violations

The clearance and modification processes have been revised to preclude the use of workarounds and to require the use of proper protection notices for plant equipment under physical modification. These revisions require that primary drawings and system operating instructions be issued prior to release of the equipment to perform the postmodification testing.

Date When Full Compliance Will be Achieved

With respect to the examples cited, TVA is in full compliance.

VIOLATION 50-327,328/96-02-07

"Technical Specification Section 6.8.1.f requires that written procedures shall be established, implemented and maintained covering the fire protection program implementation. The quality assurance (QA) program for fire protection is included in TVA-NQA-PL89-A, NUCLEAR QUALITY ASSURANCE PLAN.

"QA plan TVA-NQA-PLN89-A, Section 9.6, stated that measures shall be established such that items, including consumables, under the scope of the QA program are handled, stored, and shipped by qualified individuals in a manner to prevent deterioration, contamination, damage, or loss of identification in accordance with approved engineering and procurement documents.

"SSP 10.3, HANDLING AND STORAGE OF MATERIALS AND SPARE PARTS, Revision 5, Section 3.2.2.B, stated that site engineering/procurement engineering shall establish storage/preventive maintenance requirements and provide appropriate engineering output documents delineating the requirements.

"Contrary to the above, on February 29, 1996, SSP-10.3 was not implemented in that storage and preventive maintenance requirements had not been established for the long term storage of the pumps, motor, diesel engine, pump controllers and related components associated with the new fire protection water supply modification project.

"This is a Severity Level IV Violation (Supplement I)."

Reason for the Violation

The Procurement Engineering group personnel failed to properly follow through on resolution of the storage requirements. When the pump skid arrived onsite, the installation schedule had been revised, and interim storage was required. The procurement package for the pumps defined the storage requirement as Level B; however, there were no available Level B storage areas that could accommodate the equipment skid. The decision was made to temporarily store the pump skid in Level C storage (same as Level B except that heat and temperature control are not required). The Level C storage was intended to be temporary, but the documentation that revised the storage requirements did not identify any limitations.

The warehouse that was used to store the equipment skid suffered damage during a severe winter storm, exposing the skid to extreme temperatures. The damage to the storage building was not promptly repaired.

Corrective Actions That Have Been Taken and the Results Achieved

The storm damage to the storage building was repaired. The equipment skid was moved to a Level B storage area. A vendor representative examined the equipment and identified some minor freeze damage. The damage included cracked solder joints, a cracked joint at a check-valve, and a cracked check-valve. No damage to the

electronics, motor, or the diesel engine was identified. The minor freeze problems will be corrected during the installation of the skid. Preventive maintenance requirements were developed and implemented to ensure that the pump is properly maintained in storage.

The appropriate Procurement Engineering group personnel were counseled regarding the importance and ownership of properly identifying storage requirements for material and follow through on the resolution of problems. The appropriate warehouse personnel were counseled regarding the need to address storage facility damage through the corrective action process and escalate repair delays to management for resolution.

As part of the extent of condition review for this problem, a 100 percent walkdown of the warehouses was completed to determine if any other equipment was in storage that required preventive maintenance. This walkdown identified two motors that were not in the preventive maintenance program. Those motors were added to the preventive maintenance program.

The Corrective Steps That Will be Taken to Avoid Future Violations

The corrective actions to prevent future violations are complete as stated above.

Date When Full Compliance Will be Achieved

With respect to the examples cited, TVA is in full compliance.

ENCLOSURE 2
COMMITMENT FOR RESPONSE TO NRC INSPECTION REPORT
NOS. 50-327, 328/96-02
MARK S. LESSER'S LETTER TO OLIVER D. KINGSLEY, JR.
DATED APRIL 22, 1996

1. Nuclear Assurance will evaluate the effectiveness of the actions in resolving site human performance issues. This action will be completed by October 31, 1996.
2. A design issue will be submitted to address the CCS surge tank vent piping arrangement for potential modification of the system. This action will be completed by June 28, 1996.