

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

85 OCT 11 P 1 : 0 October 7, 1985

U.S. Nuclear Regulatory Commission
Region II

ATTN: Dr. J. Nelson Grace, Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Dear Dr. Grace:

SEQUOYAH NUCLEAR PLANT UNITS 1 AND 2 - NRC-OIE REGION II INSPECTION REPORT
50-327/85-26 AND 50-328/85-26 - RESPONSE TO VIOLATIONS

Enclosed is our response to R. D. Walker's September 6, 1985 letter to
H. G. Parris transmitting IE Inspection Report Nos. 50-327/85-26 and
50-328/85-26 for our Sequoyah Nuclear Plant which cited TVA with two Severity
Level IV Violations.

The violation cited on page three, paragraph two of the report has been
renumbered in accordance with our September 10 and 13, 1985 telephone
conversations with members of your staff. The subject violation has been
designated 85-26-11.

If you have any questions, please get in touch with R. E. Alsup 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

J. A. Domer
J. A. Domer, Chief
Nuclear Licensing Branch

Enclosure

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

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RESPONSE - NRC-OIE INSPECTION REPORT
NOS. 50-327/85-26, 50-328/85-26
ROGER D. WALKER'S LETTER TO H. G. PARRIS
DATED SEPTEMBER 6, 1985

Violation 50-328/85-26-11

Technical Specification 6.8.1 requires that written procedures be implemented and maintained covering safety-related activities stated in Appendix A of Regulatory Guide 1.33, Revision 2, which includes use of Administrative Procedures. The licensee has established Administrative Instruction, AI-12, Adverse Conditions and Corrective Actions, to provide measures which assure that conditions adverse to quality are promptly identified, documented, and corrected, and that actions are taken to prevent their recurrence.

Contrary to the above, the licensee failed to implement AI-12 in that documented identification and appropriate corrective actions were not taken to reduce vibration of an Individual Rod Position Indication (IRPI) module. Instead, a paper wedge was placed between IRPI modules by plant operators in an attempt to reduce vibration and prevent the modules from becoming electrically disconnected while required to be operable.

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

1. Admission or Denial of Alleged Violation

TVA admits the violation occurred as stated.

2. Reason for Violation

The violation occurred due to the unit operator inserting a paper wedge in the rod position indication module to reduce vibration in a loose connection instead of initiating a maintenance request (MR) to correct the problem. The MR should have been issued in accordance with Sequoyah Standard Practice SQM-2, "Maintenance Management System," and the condition reported per Sequoyah Administrative Procedure AI-12, "Adverse Conditions and Corrective Actions."

3. Corrective Steps Taken and Results Achieved

- A. A maintenance request was initiated, and the loose connector was tightened (MR A545763).
- 3. A maintenance request was also initiated to replace worn connectors with new connectors (MR A545764).

4. Corrective Steps Taken to Avoid Further Violations

A required reading of an operations section training letter will be issued to all licensed and non-licensed operators. The subject of the letter will be:

- A. Details of Violation 50-328/85-26-11
- B. AI-12 Requirements

5. Date When Full Compliance Will Be Achieved

The loose connection on the rod position indicator was repaired on July 18, 1985. The operators section training letter will be issued and reviewed by section personnel by November 1, 1985. Additional parts required to replace worn connectors have been ordered; however, a delivery date has not been established.

Violation 50-327/85-26-03, 50-328/85-26-03

Technical Specification 6.11 requires that procedures be prepared consistent with the requirements of 10 CFR Part 20 and shall be approved, maintained and adhered to for all operations involving personnel radiation exposure. The licensee has established Radiological Control Instructions RCI-1, Radiological Hygiene Control, and RCI-14, Radiation Work Permit (RWP) Program, to meet certain of these requirements. RCI-1 states that whole body frisking is required when existing a contamination zone to prevent spread of contamination to other areas. RCI-14 requires each employee to be responsible for meeting the requirements listed on the RWP and RWP Timesheet. RWP 02-0-85663, issued for entry to the waste gas compressor room on July 16, 1985, required a whole body frisk upon exit from the contaminated area.

Contrary to the above, on July 16, 1985, two licensee employees failed to perform a whole body frisk upon exit from the waste gas compressor room.

1. Admission or Denial of Alleged Violation

TVA admits that the violation occurred as stated.

2. Reasons for Violation

The violation occurred because the two individuals involved failed to follow established site radiological control instructions.

3. Corrective Steps Taken and Results Achieved

The two individuals were required to return to the health physics office to perform a whole body frisk. No contamination was detected on either individual.

4. Corrective Steps Taken to Avoid Further Violations

- A. A radiological incident report was issued to each individual for failure to perform a whole body frisk.
- B. The responsible section supervisor issued a formal warning letter to each individual.
- C. Both individuals were required to attend refresher training on frisking requirements.

D. SQN has an on-going program to inform personnel of the site health physics (HP) requirements and the need to follow established procedures. The effectiveness of this program can be measured by comparing quality assurance (QA) surveillances performed in 1984 and 1985 in the area of personnel monitoring. Surveillance 9b-84-A-004 was performed in March 1984 and identified an 83 percent failure rate in the performance of frisking techniques for personnel monitored. Based on the results of this surveillance, the QA supervisor issued a memorandum to the HP supervisor requesting input to help improve this area. The above memorandum was also sent by the plant superintendent's office to the affected section for action to improve performance in this area. In July 1985, another memorandum was issued by the HP supervisor to the plant manager identifying the steps to be taken to increase management awareness and involvement in the personnel frisking program. These steps included:

1. Discussing the nature of the problem at the morning staff meeting and Plant Manager's weekly supervisor's meeting.
2. The HP Staff has made daily observations of known RWP work areas to ensure proper frisking techniques. These observations were performed through August 5, 1985.
3. In September the QA staff began a surveillance for personnel monitoring including the issuance of DRs and/or CARs as required. This was completed September 1985.
4. Radiological Incident Reports will be issued for any subsequent violations based upon observations, strong evidence of improper frisking based upon contamination reports -- alarms from portal monitors or hand and foot monitors.

At the request of the Maintenance Superintendent, the HP section has temporarily assigned an HP technician to the maintenance section to provide additional training for supervisors and craftsmen to increase their awareness of HP practices and procedures. This assignment will continue until January 3, 1986. Finally, in support of the above actions, the QA section completed Surveillance 9b-85-5-008, "Personnel Monitoring," in September 1985 and the results indicated a 90 percent success rate in the performance of frisking techniques for personnel monitored. However, on September 26, 1985 the SQN NRC residents observed an individual not following the proper techniques in that the person observed did not frisk his hands. An investigation of the event indicated the incident was a failure to follow established frisking procedure by an individual and not a programmatic problem.

5. Date When Full Compliance Will Be Achieved

The plant was in full compliance on July 31, 1985 for the identified violation. The additional corrective actions will be completed on January 3, 1986.