

DMB

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

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66 JAN 21 P 1: 46 January 9, 1986

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
50-327/85-35 AND 50-328/85-35 - RESPONSE TO VIOLATIONS

Enclosed is our response to R. D. Walker's December 10, 1985 letter to
H. G. Parris transmitting IE Inspection Report Nos. 50-327/85-35 and
50-328/85-35 for our Sequoyah Nuclear Plant which cited TVA with one Severity
Level V Violation.

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. 50-327/85-35 AND 50-328/85-35
ROGER D. WALKER'S LETTER TO H. G. PARRIS
DATED DECEMBER 10, 1985

Violation 50-327/85-35-01 and 50-328/85-35-01

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.

- a. Instrument Maintenance Instructions IMI-99 RT 611A, Response Time Testing Engineered Safety Feature Actuation, IMI-99 RT 7.23, Response Time Test Loop 4 Steam Generator Level Channel III (L-548) and IMI-99 RT 7.17, Response Time Test Loop 2 Steam Generator Level Channel III (L-528) were established to perform reactor trip response time testing. RT 611A Step 5.5.6 requires that components which are not returned to normal position be listed in the data sheet cover page as discrepancies. RT 7.17 and RT 7.23 require that status lights be verified in a non-illuminated condition except as allowed under Step 2.

Contrary to the above, the subject procedures were not adequately implemented in that components required to be returned to a normal position by Step 5.5.6 in procedure IMI-99 RT 611A had not been returned to normal position and had not been listed as discrepancies in the data sheet. Also, verification of status lights had not been made in accordance with procedures IMI-99 RT 7.17 and IMI-99 RT 7.23.

- b. Administrative Instruction AI-19, Part 4 - Plant Modifications After Licensing, was established to implement the use of Work Plans on major modification efforts on safety related equipment. Work Plan 11802 provided the procedure for assembly and testing of safety-related containment penetrations and required the use of a validated vendor's manual in the assembly of the feedthru tubes.

Contrary to the above, Work Plan 11802 was not adequately established or implemented in that the licensee assembled the penetration without the use of a validated vendor manual.

- c. Surveillance Instruction, SI-82.2 - Functional Tests for the Radiation Monitoring System, was established to implement Technical Specification radiation monitoring surveillance requirements.

Contrary to the above, SI-82.2 was not implemented in that the technician did not insert a test signal into the Unit 2 radiation monitor identified by the procedure. Instead, the technician inserted the test signal into the Unit 1 monitor causing a containment ventilation isolation.

- d. Instrument Maintenance Instruction IMI-134, Configuration Control of Instrument Maintenance Activities, was established to control work activities during safety related maintenance.

Contrary to the above, IMI-134 was not implemented in that a technician failed to adequately identify the power source for removal and reinstallation of spent fuel pool radiation monitor 0-RM-90-103 on the configuration control sheet. This resulted in plugging the monitor into a non-safety-related power source.

This is a Severity Level IV violation (Supplement I). This violation applies to both units.

1. Admission or Denial of Alleged Violation

TVA admits that the violation occurred as stated.

2. Reason for Violation

The violation occurred due to personnel error in that:

- a. Plant personnel were not totally familiar with the existing plant procedure concerning the use of "not applicable" (N/A) during the procedure performance.
- b. Plant personnel used a vendor letter and verbal instructions in place of an approved vendor manual for assembling a containment penetration.
- c. An instrument technician generated a high radiation signal for unit 1 instead of unit 2. This resulted in a unit 1 containment ventilation isolation (CVI).
- d. Removing the 120V power from RM-90-103 during maintenance was not logged in the Instrument Maintenance Instruction (IMI)-134 configuration control log. This resulted in plugging the monitor into a non-safety-related power source.

3. Corrective Steps Taken and Results Achieved

The following corrective steps have been taken:

- a. The subject violation was discussed with all Instrument Maintenance and Operations Section personnel. The above sections were given guidelines for using "N/A" in site procedures. In addition, the Operations Section issued a night order to ensure section personnel were aware of the guidelines for the use of "N/A" in site procedures.

- b. The vendor manual was not available during preparation of the workplan. Direction and oral instructions from a vendor representative were followed to perform work. The vendor manual was still not available by the date the violation was identified; however, written instructions obtained from the vendor were substituted for the vendor manual requirement. The penetration was reworked in accordance with these instructions. All personnel involved were counseled concerning the need to follow instructions verbatim. All other engineers and foremen were also apprised of the violation and its ramifications.
- c. The affected equipment (CVI) was immediately returned to normal per System Operating Instruction (SOI)-30.2, "Containment Purge System Operation."
- d. Maintenance Request (MR) A539519 was issued to change RM-90-103 from the non-safety-related power source to the required Train "B" plug mold, completed November 7, 1985. MR A539517 was submitted to verify all radiation analyzer power supply 120V plugs were inserted into the proper plug mold on panel O-M-12 per TVA drawing series 45N1651, completed November 7, 1985. Also the Train "A" plug mold was painted orange and Train "B" plug mold was painted brown to ensure the division plug molds could be easily recognized. Maintenance personnel were informed of potential problem of using wrong power plug mold and the consequences involved. They were made aware of the proper configuration control to use and the location of "TRAIN" power plug molds.

4. Corrective Steps Taken to Avoid Future Violation

- a. The Instrument Maintenance Section is preparing a section instruction letter (SIL) detailing the guidelines for using "N/A" in plant procedures.
- b. Surveillance Instruction (SI)-1, "Surveillance Program - Units 1 and 2," will be revised to provide additional guidelines for using "N/A" in plant procedures.
- c. The TVA Office of Engineering (OE) has generated a Human Engineering Concern Worksheet on the location of radiation monitors on panel O-M-12. When the OE study is completed, SQN will review any recommendations provided to determine if implementation is required.

In addition to the above, the plant maintenance superintendent held discussions with all instrument maintenance personnel concerning the increased incidents of personnel errors. Six Instrument Maintenance personnel errors occurred from January 1985 to October 1985. The errors were by different individuals and crews. The errors were attributed to lack of attention to detail while performing work. Topics discussed with Instrument Maintenance personnel were:

- A. Requirements for following established procedures.
- B. Exercising mental discipline in performing work by concentrating on work at hand, using methodical approach, and communicating clearly.
- C. Professionalism and attitude in performing work.

Also, maintenance personnel were instructed to review all instructions before beginning work to familiarize themselves with the instructions and to ensure the instructions are adequate for the assigned work. Communication between managers and craftsmen is being increased by more frequent involvement in work activities and group meetings. An example of this is the site director's meeting with instrument personnel on November 26, 1985, to discuss attitudes and employee concerns.

5. Date When Full Compliance Will Be Achieved

The plant was in full compliance on November 7, 1985. However, as stated in section 4 above, SI-1 will be revised by April 1, 1986, and the Instrument Maintenance Section SIL will be issued by February 1, 1986.

6. Corrective Action

4. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.

5. Surveillance instructions will be revised and issued by February 1, 1986.

6. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.

7. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.

8. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.

9. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.

10. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.

11. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.

12. The Instrument Maintenance Section SIL will be revised and issued by February 1, 1986.