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R.J. Adney  
Site Vice President  
Sequoyah Nuclear Plant

June 9, 1997

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

Gentlemen:

In the Matter of	)	Docket Nos. 50-327
Tennessee Valley Authority	)	50-328

SEQUOYAH NUCLEAR PLANT (SQN) - UNITS 1 AND 2 - REPLY TO NOTICE OF VIOLATION (NOV) - NRC OFFICE OF INVESTIGATIONS - REPORT NO. 2-96-009

This letter responds to Johns P. Jaudon's letter to Oliver D. Kingsley, Jr., dated March 14, 1997, that transmitted the subject NOV. The NOV addresses one violation associated with the failure to maintain complete and accurate records of firewatches.

The NRC letter transmitting the subject NOV expressed NRC's concern relative to NRC reliance on complete and accurate documentation to ensure compliance with regulatory requirements. TVA is fully cognizant of the need for maintaining complete and accurate documentation. In fact, disciplinary actions taken against the involved employees were the direct result of the generation of inaccurate records.

TVA does not agree that this incident is an example of less than fully effective management oversight which 1) permitted poor documentation by firewatch personnel, 2) permitted discontinuance of the bar code recording system in November 1995, or, 3) failed to provide adequate supervision and training for firewatch patrol personnel.

As indicated in LER 50-327/96001, the two inaccurately logged firewatches represented two of 8,064 firewatches conducted from January 3 through January 30, 1996. These two incidents were discovered as a direct result of management oversight and review of the firewatch program. Since then, there have been no missed firewatch patrols at SQN. The routine reviews conducted as part of the firewatch program and the prompt and direct actions taken as a result of these two incidents are in no way conducive to, or in any way tolerant of poor documentation by firewatch personnel.

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The NRC statements regarding the November 1995 discontinuance of the bar code recording system are an inaccurate portrayal of that decision.

As stated in LER 50-327/76-01, alternative methodologies have been considered as enhancements to allow a more timely identification of firewatch routes that were not properly conducted. A method was originally instituted where the firewatch carried a timeclock device while they walked the assigned route. Keys were located at certain strategic locations along the route and were permanently attached to the building. Upon entry into the area, the firewatch would insert the key into the timelock which would cause the timeclock to record the current time. This methodology was abandoned because the weight and size of the device made it difficult to open certain doors in the plant while carrying the timeclock, and as a result, one individual aggravated a previous injury.

The subsequent system used, and referenced in the NOV, was discontinued when the program was revised to establish new firewatch routes which were much smaller in scope than the previous routes. This change was made to facilitate the addition or deletion of specific areas to the firewatch routes as the status of fire protection equipment changed. The bar code reader system did not provide the flexibility to work effectively with the changing routes because the route had to be loaded into the bar code reader each time changes were made and prior to its use. These changes were difficult to implement because of the almost continuous use of the reader except during shift turnovers. These limitations did not allow for the effective use of the bar code reader with the revised routes.

In March 1997, SQN began using a system where metal labels are permanently affixed at strategic points along the assigned route. The individual uses a scanner to "read" the labels upon entry into the area. The information from the scanners is periodically downloaded and reviewed to verify that the firewatch was performed as assigned. The scanner information is used to validate that the routes have been performed as assigned. During that time, there have been instances identified where the scanner records have indicated that a particular area was missed. However, upon further examination, it was determined from the times and plant locations before and after the missing data point that the area was not missed but the metal label for the area was not properly recorded by the scanner.

Any system designed to determine the presence of a given individual in a particular area must rely in some part on the integrity of the individual to perform the firewatch duties. TVA's use of the scanner system as an enhancement to the firewatch program provides an effective tool to ensure that firewatch routes not performed properly can be identified independently of the documentation records that are kept by the individual performing the firewatch.

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We believe that the scanner system presently in use is the most efficient means available to oversee the conduct of firewatches at SQN. Moreover, we believe that our responsibility for the safe conduct of the firewatch program mandates that we fully consider our previous first-hand experiences in administering and managing that program.

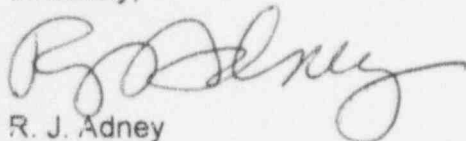
The statement that management failed to provide adequate supervision and training for firewatch patrol personnel is incorrect. TVA conducts firewatch training and supervises the conduct of firewatches on a day-to-day basis in full conformance with TVA management expectations and NRC requirements. While we regret that the two instances in question took place, they stand out as entirely uncharacteristic of the conduct of firewatch operations. TVA's prompt identification of events and strong disciplinary corrective action provide ample evidence of this fact.

As indicated in the enclosure to this letter, TVA admits that a violation of 10CFR50.9 occurred relative to firewatch patrol documentation. However, it is also the case that TVA discovered the incident, took immediate and effective corrective action, and reported the incidents in LER 50-327/96001. We believe these factors warrant consideration as a non-cited violation in accordance with NRC's enforcement policy. Accordingly, we respectfully request that the NRC reconsider its characterization of the violation as such.

The enclosure contains TVA's response to the NOV.

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

Sincerely,



R. J. Adney

Enclosure  
See Page 4

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Enclosure  
cc (Enclosure):

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ENCLOSURE  
RESPONSE TO NRC OFFICE OF INVESTIGATIONS REPORT NO. 2-96-009  
JOHNS P. JAUDON'S LETTER TO OLIVER D. KINGSLEY, HR.  
DATED MARCH 14, 1997

VIOLATION [2-96-009]

"10 CFR 50.9, states in part, that information required by regulations, orders or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

Technical Specifications, Sections 3.3.3.8, 3.7.11.1 through 3.7.11.4, and 3.7.12, require compensatory measures be established for degraded fire protection components. One of the specified compensatory measures consists of an hourly firewatch patrol.

Procedure FPI-0180, Revision 0, "Compensatory Firewatch Responsibilities and Control," Section 6.0, requires a firewatch logsheet (FPI-0180, Attachment 1) to be initiated every morning at the beginning of dayshift and each firewatch to document firewatch activities on the logsheet.

Contrary to the above, the licensee failed to maintain information required by Commission regulations that were complete and accurate in all material respects. Specifically, on January 8, 17 and 21, 1996, firewatch personnel documented in the firewatch log that the required hourly patrols were completed for the control building when in fact, they were not. This inaccuracy was material in that an hourly firewatch patrol was not performed in a number of areas which could have identified a fire or any act that might result in a fire before damage to safety-related components. (01014)

This is a severity Level IV Violation (Supplement 1)."

Reason for the Violation

This violation occurred because the personnel responsible for conducting the actual firewatch patrols did not complete the entire route as assigned, but completed the documentation as if the route had been completed in its entirety.

Corrective Actions That Have Been Taken and the Results Achieved

Following identification of the first occurrence, an additional 8,064 firewatch performances were reviewed. This review resulted in the identification of a second individual that had failed to perform the firewatch as assigned. The personnel involved in both occurrences received the appropriate disciplinary action.

Management expectations were reviewed with firewatch personnel regarding proper procedure adherence, proper completion of documentation, and the importance of properly conducting the assigned firewatch route. The circumstances surrounding the incidents in question and the disciplinary actions taken as a result of these incidents were also reviewed with firewatch personnel.

The Corrective Steps That Will be Taken to Avoid Future Violations

Corrective actions to prevent future violations are stated above and were stated in LER 50-327/96001.

Date When full compliance Will Be Achieved

The completed corrective actions stated above bring TVA into full compliance.