TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401

6N 38A Lookout Place

JUN 13 1990

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) - NRC INSPECTION REPORT NOS. 50-327, 328/90-17 - RESPONSE TO NOTICE OF VIOLATION 50-327, 328/90-17-01

Enclosed is TVA's response to B. A. Wilson's letter to O. D. Kingsley, Jr., dated May 16, 1990, which transmitted the subject notice of violation.

If you have any questions concerning this submittal, please telephone M. A. Cooper at (615) 843-6651.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

Mark O. Medford

Mark O. Medford, Vice President
Nuclear Technology and .icensing

Enclosure
cc (Enclosure):
Ms. S. C. Black, Project Chief
I-IV
U.S. Nuclear Regulatory Commission
One White Flint, North
11555 Rockville Pike, MS 13H2
Rockville, Maryland 20852

NRC Resident Inspector
Sequoyah Nuclear Plant
2600 Igou Ferry Road
Soddy Daisy, Tennessee 37379

Mr. B. A. Wilson, Chief
of TVA Projects
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

IE01
11

ENCLOSURE 1

RESPONSE TO NRC INSPECTION REPORT
NOS. 50-327/90-17 AND 50-328/90-17
B. A. WILSON'S LETTER TO O. D. KINGSLEY, JR.,
DATED MAY 16, 1990

Violation 50-327, 328/90-17-01

"Technical Specification 6.8.1 requires that procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, be established, implemented and maintained. This includes administrative and surveillance procedures. The requirements of TS 6.8.1 are implemented in part by the following procedures:

SI-90.82, Surveillance Testing of the Unit 2 Train B SSPS
AI-47, Conduct of Testing

SI-90.82 specifies that the steps in the procedure be completed in the order in which they are written, and that the provisions of AI-47 apply. AI-47 requires that step sequence deviations are to be dispositioned as test deficiencies. This would require analysis of sequence errors and concurrence from management and the Shift Operating Supervisor prior to implementation of corrective actions to recover from a sequence error.

Contrary to the above, Instrument Maintenance personnel did not implement the requirements of AI-47 after discovering that steps were performed out of sequence during performance of SI-90.82. Instead, the test director continued the test. A reactor trip was generated due to the errors when the test was resumed.

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

Admission or Denial of the Alleged Violation

TVA admits the violation.

Reason for the Violation

The violation resulted when a test director (TD) performing Surveillance Instruction (SI) 90.82, "Reactor Trip Instrumentation Monthly Functional Test (SSPS)," failed to perform the SI steps in sequence as required by Administrative Instruction (AI) 47, "Conduct of Testing." While trying to recover from performing the SI steps out of sequence, the TD failed to follow AI-47 resulting in a reactor trip. AI-47 requires an out-of-sequence situation to be documented as a test deficiency and requires the proposed corrective action to be reviewed and approved by the responsible supervisor and by the shift operations supervisor. A review of instruction prerequisites, preceding steps, control logic, and equipment configuration is also required. AI-47 urges the TD to exercise caution and judgement before proceeding and advises the TD to resist the strong tendency to simply skip back and perform the omitted steps. AI-47 training is a prerequisite before becoming a TD. Although review of the personnel errors indicated there may

have been minor contributing factors, it was concluded that the root cause of this event was inattention to detail (i.e., unacceptable performance given the subject procedures and training). Resolution of this issue was documented in Licensee Event Report 50-328/90008.

Corrective Steps That Have Been Taken and Results Achieved

Several corrective actions have been implemented as recurrence controls. The TD and supervisor involved have been given the appropriate level of disciplinary action. To provide a lesson learned to site personnel, a sitewide message was issued by the Site Director describing this event and its cause and emphasizing the personal responsibility of each employee for performing his or her work correctly. The message also reiterated the policy on what to do if a mistake is made in performing a task, i.e., work is stopped immediately and any problems are resolved as required before proceeding.

Corrective Steps That Will Be Taken to Avoid Further Violations

As a long-term effort to reduce personnel errors, a Human Performance Enhancement System (HPES) program and a personnel error awareness seminar program are being implemented at SQN. This aggressive program, recommended by the Institute of Nuclear Power Operations, consists of an 11-part seminar developed from industry experience gained through the evaluation of hundreds of situations involving human performance. These seminars describe the major variables that have been identified as impacting human performance and are designed to provide a better understanding of human performance and the factors that influence human behavior. The information presented builds on previously acquired technical, academic, and practical knowledge and is expected to result in a reduction of the number of events resulting from human errors. Additionally, SQN has implemented a personnel error reduction board to review personnel errors to ensure the root cause is determined, and event investigators are being trained in accordance with the HPES program.

Date When Full Compliance Will Be Achieved

TVA is in full compliance.

0875h / 3705m