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John A. Scalice
Site Vice President, Watts Bar Nuclear Plant

DEC 3 0 1996

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

Gentlemen:

In the Matter of ) Docket No. 50-390
Tennessee Valley Authority )

WATTS BAR NUCLEAR PLANT (WBN) - UNIT 1 - NRC INSPECTION REPORT NO. 390/96-11 - REPLY TO NOTICES OF VIOLATION

The purpose of this letter is to reply to the Notices of Violation identified in the subject inspection report. TVA's actions to address these violations are provided in Enclosures 1 and 2. Enclosure 3 provides the list of commitments for this submittal.

If you should have any questions, please contact P. L. Pace at (423) 365-1824.

Sincerely,

for

J. A. Scalice

Enclosures
cc: See page 2

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cc (Enclosures):
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ENCLOSURE 1
WATTS BAR NUCLEAR PLANT UNIT 1
REPLY OF NOTICE OF VIOLATION
390/96-11-01

NOTICE OF VIOLATION 50-390/96-11-01

"Technical Specification 5.7.1.1 requires, in part, that procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Quality Assurance Program Requirements (Operations). Appendix A of Regulatory Guide 1.33, Section 1, includes procedures for administrative controls, which includes authorities and responsibilities for safe condition.

Site Standard Practice (SSP)- 3-04, Corrective Action Program, Revision 19, provides the requirements for documenting and resolving deficiencies identified on problem evaluation reports (PERs). Section 3.1 of SSP-3.04 provides the procedural steps for promptly initiating a PER for adverse conditions.

Contrary to the above, on October 22, 1996, the NRC identified that the licensee failed to initiate a PER for an adverse condition as required by SSP-3.04. Specifically, on October 9, 1996, the licensee identified that a pressurizer power operated relief valve block valve was incorrectly left in the closed position after the completion of a surveillance test. After the valve was positioned properly on October 10, no PER was initiated to document and resolve the deficiency."

TVA RESPONSE

TVA agrees that this violation example occurred. To clarify, although the issue was initially documented, the Problem Evaluation Report (PER) did not reach the tracking organization for assignment of a number and therefore did not get processed within the corrective action program.

REASON FOR THE VIOLATION

The violation occurred because of personnel error. The condition involving the power operated relief valve block valve was identified and paperwork generated to document the condition on a PER form. The initiating supervisor was in the process of coordinating the correct organization for resolution of the PER and was carrying the PER initiation form with him. The PER was apparently lost during this time. An extensive search was performed to locate the lost form, but it could not be found.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

Problem Evaluation Report WBPER961032 was written to address the original issue involving the power operated relief valve.

The individual that was the last known person with possession of the PER has been counselled on the importance of properly dispositioning a document that is a Quality Assurance (QA) record. This counselling included emphasizing ownership of the process until a new owner is found for the problem.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS

The Operations superintendent has briefed each shift crew on the ownership of QA records and the responsibility of each person to process PERs that are generated, in a timely manner. In addition, the Operations Support superintendent has briefed personnel reporting to him on the ownership of QA records and the responsibility of each person to process PERs that are generated, in a timely manner.

A word search using the words "Lost" and "Missing" of the Tracking and Reporting of Open Items (TROI) database identified no other event involving a lost or missing PER. It is concluded that this is an isolated problem and therefore, no further actions are deemed necessary by TVA.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With regards to this violation, TVA is in full compliance.

ENCLOSURE 2
WATTS BAR NUCLEAR PLANT UNIT 1
REPLY TO NOTICE OF VIOLATION
NOV 50-390/96-11-02

NOTICE OF VIOLATION 50-390/96-11-02

Technical Specification Limiting Condition for Operation (LCO) 3.6.3, Actions Section, Note 1, states that for an inoperable penetration, "Penetration flow path(s) may be unisolated intermittently under administrative controls."

Technical Specification Bases, Section B3.6.3, Actions Section, states "Administrative controls consist of stationing a dedicated operator at the valve controls, who is in continuous communication with the control room."

Contrary to the above, on June 12, 1996, the licensee unisolated the inoperable containment pressure release penetration flowpath by opening valves 1-FCV-30-37 and 1-FCV-30-40 without adequate administrative controls. Specifically, a dedicated operator with no other duties was not stationed at the valve controls. The licensee had entered Action Condition A of LCO 3.6.3 on June 11, 1996, due to valve 1-FCV-30-37 being inoperable following an unsatisfactory stroke time test.

TVA RESPONSE

TVA agrees that this violation occurred.

REASON FOR THE VIOLATION

The root cause of this condition has been attributed to inadequate work practices. Operations personnel did not consult the Technical Specification Bases for definition of the administrative controls required for the action taken which resulted in failure to station an operator with no other duties at the valve controls. Interviews with the previous shift indicate that the occurrence was isolated.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

The responsible senior reactor operator (SRO) has been counseled.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATIONS

Formal training will be provided to operating personnel required to participate in licensed and non-licensed requalification training. This training will address management expectations for dedicated

personnel, the responsibilities of personnel assigned dedicated duties, and management expectations for verbatim compliance with Technical Specifications and utilization of associated Bases to achieve compliance. This action will be completed by March 7, 1997.

The Technical Specification Bases has been revised under Change Package No. 96-015 and approved on November 11, 1996. It clarifies that for valve controls located in the control room, an operator may monitor containment isolation signal status rather than be stationed at the valve controls, and allows performance of other secondary duties provided that the primary responsibility is rapid isolation of the penetration when needed for containment isolation.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With respect to the subject violation, TVA will be in full compliance by March 7, 1997.

ENCLOSURE 3
WATTS BAR NUCLEAR PLANT UNIT 1
LIST OF COMMITMENTS

390/96-11-02

1. Formal training will be provided to operating personnel required to participate in licensed and non-licensed requalification training. This training will address management expectations for dedicated personnel, the responsibilities of personnel assigned dedicated duties, and management expectations for verbatim compliance with Technical Specifications and utilization of associated Bases to achieve compliance.