



Tennessee Valley Authority, Post Office Box 2000, Spring City, Tennessee 37381-2000

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MAY 14 1997

✓ 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 )

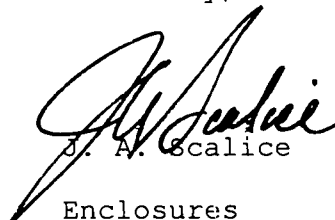
WATTS BAR NUCLEAR PLANT (WBN) - UNIT 1 - NRC INSPECTION REPORT NO.  
390/97-01 - REPLY TO NOTICES OF VIOLATION

The purpose of this letter is to reply to the Notices of Violation  
390/97-01-02 and 390/97-01-06 identified in the subject inspection  
report. TVA's actions to address these violations are provided in  
Enclosure 1. Enclosure 2 provides the list of commitments.

In addition, NRC's cover letter discussed the installation of the  
wrong gasket material in a feedwater line and inadvertent safety  
injections. TVA's actions to address these issues have been  
provided in Licensee Event Reports 390/97-006 and 390/97-008,  
respectively.

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

Sincerely,

  
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 NOTICES OF VIOLATION  
390/97-01-02

NOTICE OF VIOLATION 50-390/97-01-02

"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, Section 1.

Plant Administrative Instruction (PAI) 2.13, Operation Key Control, Revision 0, requires, in part, the following:

"All keys and key rings, other than Operations section vehicle keys and keys signed out, shall be stored in the key cabinets."

Contrary to the above, on February 1, 1997, three keys (#2482, #28, and #2484) were placed on the shift clerk's desk and remained there until 4:30 p.m. on February 2, 1997, instead of being stored in the key cabinet as required."

TVA RESPONSE

TVA agrees that this violation occurred.

REASON FOR THE VIOLATION

The violation occurred due to ineffective change management involving a reduction in shift clerks in the shift operation office. Normally, the clerk is responsible for Operations key control during each shift. When a reduction of the number of shift clerks occurred resulting in no weekend shift coverage, the impact on key control was not recognized. When the keys were returned to the shift office during the weekend of February 1, 1997, no clerk was available to place the keys back into the storage cabinet

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

A key audit has been performed for those keys owned by Operations. As a result of this audit, no additional key discrepancies were identified. Operations personnel assigned key control responsibilities have been trained to the requirements of PHYSI-13, "Key Control."

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS

A permanent drop off box has also been installed for those times when a person is not available to receive previously checked-out keys. In addition, a key lock box has been installed at the shift manager's

desk for keys that management has determined that only the shift manager should distribute.

The Operations change management checklist has been reviewed to ensure that process changes get adequate review for administrative impact.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

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

NOTICE OF VIOLATION 50-390/97-01-06

Technical Specification 5.11.2, High Radiation Areas With Dose Rates Greater Than 1.0 rem/hour, But Less Than 500 rads/hour, requires that each entryway to such an area shall be conspicuously posted as a high radiation area and shall be provided with a locked door or gate that prevents unauthorized entry, and, in addition, all such door and gate keys shall be maintained under the administrative control of the shift operations supervisor or health physics supervisor on duty.

Contrary to the above during the period from approximately August 5, 1996 to February 3, 1997, the master key for the locked high radiation area doors that was assigned to the shift operations supervisor located in the control room was not maintained under adequate administrative control.

TVA RESPONSE

TVA agrees that this violation occurred.

REASON FOR THE VIOLATION

This violation occurred due to a failure to follow procedure PHYSI-13 which requires that an Appendix E, "Permanent Key Assignment Authorization Form," be completed each time a key is transferred from one owner to another. On January 29, 1997, during an audit of the Radiological Control's Locked High Radiation area (LHRA) keys, key #491 that had been issued to the Operations section could not be located in the Operations key lock box. A search for the missing key was performed which included a search of Operations owned key boxes, Security key boxes, and Radcon key boxes. In addition, a search was performed in offices where the key might have been located. None of these searches located the key.

A review of the Operations clerk key sign-out log identified that the key was issued and returned by the shift manager on June 20, 1996. No other entry could be found where this key was issued. On August 4, 1996, a Radcon audit of the LHRA keys recorded that key #491 was located in the Operations clerk key box. This was the last time the key was documented to have been observed prior to January 29, 1997 audit.

On February 3, 1997, during a routine shift inventory of the LHRA keys, key #491 was found in the Radcon lock box door compartment in an area not normally used for key storage. TVA could not identify a record required by PHYSI-13 where the key #491 was transferred from the Operations clerk key box to the Radcon key box. Although no paper trail could be found, there is no evidence to suggest that the locked high radiation areas were ever unlocked or access to these areas was made without proper authorization.

#### CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

The cores associated with missing master key #491 were replaced except for two areas inaccessible while the plant is at power. The two inaccessible cores will be replaced during the fall refueling outage.

Those keys controlled under PHYSI-13 assigned to the Radcon department were inventoried. The currently locked doors have been reviewed to determine if the need for locking stills exists and changes made where appropriate. The keys contained in the Radcon key cabinets have been labeled. Operations key inventory was audited as discussed above in NOV 390/97-01-02.

#### CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS

Plant Administrative Instruction (PAI)-2.13 has been revised to strengthen the content of the procedure as to what constitutes an "Emergency," with respect to the use of the Radcon issued Locked High Radiation Rooms. In addition, Security has revised Administrative Order 2.12 to include appropriate controls of High Security (including potentially compromised) locks, cores, and keys.

The Radcon LHRA key box shift inventory list has been revised to include key code, cabinet hook, number of keys on hook, date added to shift inventory list, and an approval signature. In addition, RCI-100 has been revised to require the shift key inventory be documented prior to assuming shift.

Since it could not be determined which individual failed to complete the required PHYSI-13 form for the transfer of key #491, the event was reviewed with Operations personnel to reinforce the importance of adherence with procedures as part of "standdown" meetings held in February 1997. Existing training of Operations personnel in the requirements of PHYSI-13 discussed above in 390/97-01-02 is considered adequate recurrence control for this issue.

#### DATE WHEN ACTIONS WILL BE COMPLETED

The remaining two cores discussed above will be replaced by the end of the first refueling outage.