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OCT 03 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.
50-390, 391/96-09 - 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 each of the specific conditions are provided in Enclosure 1 to this letter. Enclosure 2 provides the list of specific commitments for this submittal.

Like NRC, WBN management is also concerned with the human performance aspects of the conditions identified in the report. Our review of the causes of each condition has not, however, identified issues that are outside the scope of the human performance improvement initiatives discussed with NRC staff at the last management meeting on August 9, 1996. As part of those initiatives, WBN is continuing to investigate and implement innovative approaches to improve human performance across the site.

The initial campaign to heighten employee awareness of human performance issues is beginning to show results. A pilot program for crew feedback similar to the process used in simulator training has begun in Operations. A special site bulletin has been issued to focus attention on status control during the mid-cycle outage. Further, observers have begun to monitor the differences between operating crews to identify areas for improvement, and a working level team of craft and auxiliary

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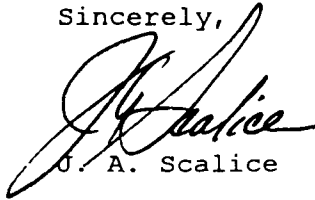
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operators has been assembled to address status control problems from their hands-on perspective. Our Nuclear Assurance and Licensing personnel continue to closely monitor and trend human performance items through the WBN Corrective Action Program.

WBN management recognizes that improvement in this area must be achieved and sustained. The management team is committed to continue its focus in this area until that sustained performance is accomplished. Should you have any questions on these responses or WBN's commitment, please contact me at (423) 365-8767.

Sincerely,



J. A. Scalice

Enclosure

cc (Enclosure):

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ENCLOSURE 1
WATTS BAR NUCLEAR PLANT UNIT 1
REPLY TO NOTICES OF VIOLATION
390/96-09-02, 390/96-09-03, 390/96-09-06,
390/96-09-07 AND 390/96-09-08

NOTICE OF VIOLATION 50-390/96-09-02

"Technical Specification 5.7.1.1 requires that written procedures shall be established, implemented, and maintained for activities recommended in Appendix A of Regulatory Guide 1.33, Quality Assurance Program Requirements, Revision 2, February 1978. This includes procedures required for the performance and control of surveillance tests.

Watts Bar Technical Instruction (TI)-57.002, Verification of Normal Position for Nor-Aux Switches, Revision 4, Appendix A, requires verification that auxiliary control room switches and feeder breakers are positioned properly should they be required in an emergency.

Contrary to the above, as of July 17, 1996, the licensee had not properly verified that six auxiliary control room controllers were correctly positioned in accordance with TI-57.002. Specifically, residual heat removal heat exchanger A and B outlet flow controllers 1-HIC-74-16C and 1-HIC 74-28C were positioned to the full closed position although TI-57.002 required them to be full open. Four other controllers were positioned to slightly different settings than required by the surveillance."

TVA RESPONSE

TVA agrees that this violation example occurred.

REASON FOR THE VIOLATION

The improper positioning of the controllers is attributed to insufficient administrative controls in that a formal process did not exist to ensure that plant equipment would be properly configured when procedural changes were made that changed or impacted component status.

The six auxiliary control room controllers listed below were identified by NRC to be improperly positioned:

Controller Identifier	Controller Function
1-PIC-1-13C	Steam generator number 2 main steam pressure relief controller.
1-HIC-62-56C	Excess letdown flow controller.
1-HIC-62-89C	Charging flow control valve controller.
1-HIC-63-65C	Safety Injection accumulator number 2 header vent valve controller.
1-HIC-74-16C	Residual Heat Removal (RHR) heat exchanger A outlet flow controller.
1-HIC-74-28C	RHR heat exchanger B outlet flow controller.

TVA's review of the procedural requirements associated with these devices found four of the controllers were positioned within the expected range. The positions of the remaining two controllers, 1-HIC-74-16C and 1-HIC-74-28C, were found to be inconsistent with current procedural requirements. TI-57-002 was performed as a restoration measure after performance of Power Ascension Test, 1-PAT-8.5, "Shutdown from Outside the Control Room." During a review of the completed TI-57.002 package, Operations personnel noted that the RHR controller should be placed in the "open" position and initiated a revision for the configuration change in TI-57.002. However, prior to this violation, informal instructions existed which were intended to ensure that revisions made primarily to the System Operating Instructions (SOIs) were reviewed by Operations personnel to establish whether changes in component configuration were required. This process did not include the TIs, and therefore the configuration change made to the RHR controllers in the revision to TI-57.002 was not implemented.

CORRECTIVE ACTION AND RESULTS ACHIEVED

As an immediate response to this condition, the two controllers were placed in the correct position in accordance with TI-57.002. Other actions taken included the issuance of a directive by the Operations Superintendent to the control room clerical staff. This directive requires the clerical staff to ensure that the senior reactor operator reviews procedure revisions which may impact component configuration prior to the procedures being filed in the control room library. A similar order was issued to the control room Operations shift personnel to ensure the basis for the review of the procedures was understood. These steps will prevent recurrence of this problem until proceduralized measures can be established.

A review of the System Operating Instructions (SOIs) was performed to establish whether further problems existed with component status control. The basis for reviewing this group of procedures is that the SOIs address routine and anticipated operation of a system. Therefore, the requirements of the SOIs have high potential to affect component status due to components being manipulated for system operation.

The survey of the SOIs reviewed the revision logs to identify previous changes which may have impacted component status. The results of this review identified 22 changes which impacted 125 components, 90 of which were accessible. The configuration of each of the accessible components was verified to comply with current procedural requirements. Operations personnel also reviewed the configuration of the controllers in the main control room and found no devices improperly positioned.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATION

To ensure future changes to procedures which may impact component status are properly controlled, a methodology for a formal administrative process for status control is being developed. Once developed, affected plant procedures will be revised or new procedures will be developed.

In addition, a final confirmatory measure will be taken to establish that revisions to TIs are being properly controlled. This will be accomplished by reviewing recent revisions to TIs to identify those which have the potential to impact component status. From those identified as potential status changes, a number of these changes will be verified to be appropriately implemented.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

TVA will complete the above actions by November 15, 1996.

NOTICE OF VIOLATION 50-390/96-09-03

"Technical Specification 5.7.1.1 requires that written procedures shall be established, implemented, and maintained for activities recommended in Appendix A of Regulatory Guide 1.33, Quality Assurance Program Requirements, Revision 2, February 1978. This includes procedures required for alarm conditions and for the performance and control of surveillance tests.

Contrary to the above, the licensee failed to adequately establish procedures in the following two examples:"

EXAMPLE 1

"As of July 18, 1996, adequate procedures were not established for disposition and periodic review of plant computer alarms. Specifically, the temperature element in the auxiliary feedwater supply line to steam generator 1 was in an alarm status on the P2500 plant computer reading 257°F with an alarm setpoint of 190°F. The alarm had been present since at least July 1, 1996, but had not been dispositioned to verify system operability. Periodic reviews of alarming points that could have alerted the licensee to the alarm condition were not required to be taken."

TVA RESPONSE - EXAMPLE 1

TVA agrees that this violation example occurred.

REASON FOR THE VIOLATION

WBN did not have formal procedural requirements to ensure the P2500 alarms were addressed in a timely manner. It was management's expectations that prompt action be taken for control room alarms. However, in this case, Operations personnel failed to take proper action during the initial response to the alarm to fully resolve the problem. Contributing to the cause of this failure was the improper closure of a TVA corrective action document which was written to assess the problem of Temperature Element (TE) 1-TE-3-6382 being in an alarm status on the plant computer. Operations personnel utilized this document to establish that the Auxiliary Feedwater (AFW) system was operable and then closed the document. In doing this, the full extent of the problem was not investigated.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

The piping upstream of the TEs was reverified to be at ambient temperature on July 23, 1996. Change Notice (CN) 4 to Revision 2 of Plant Instruction (PI) 1-PI-OPS-1-AB, "Auxiliary Building AUO Workstation Responsibilities and Checksheets," became effective on July 29, 1996, and requires verification each shift by Operations personnel that the affected piping is at ambient temperature. The personnel involved in the inappropriate closure of the initial corrective action document were counseled by Operations management. The counseling focused on the judgment errors made and the actions expected to be taken in similar situations.

CORRECTIVE STEPS TO AVOID FURTHER VIOLATION

In order to ensure proper attention is placed on P2500 alarms, Plant Administrative Instruction (PAI) 2.11, "Shift Relief and Turnover," was revised. CN 6 to Revision 1 of this instruction became effective on July 23, 1996, and requires Operations personnel to address points in alarm on the P2500 computer at shift turnover. This, along with existing guidelines for response to control room alarms, provides adequate measures to assure future problems in this area do not occur.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With regards to Example 1, TVA is in full compliance.

EXAMPLE 2

"As of July 19, 1996, Surveillance Instructions (SI) 1-SI-0-2A, Shift and Daily Surveillance Log, 1900 - 0700 Shift, Revision 0, and 1-SI-0-2B, Shift and Daily Surveillance Log, 0700 - 1900 Shift, Revision 0, did not verify bank overlap numerical criteria and were therefore not adequate to implement Technical Specification

Surveillance Requirement 3.1.7.3 to verify control bank rod overlap requirements."

TVA RESPONSE - EXAMPLE 2

TVA agrees that this violation example occurred. This condition was reported to NRC as Licensee Event Report (LER) 390/96022.

REASON FOR THE VIOLATION

This violation example is attributed to a misinterpretation of Surveillance Requirement (SR) 3.1.7.3 by the licensed Operations personnel that prepared and reviewed 1-SI-0-2.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

Limiting Condition for Operation (LCO) 3.1.7 is applicable in operational Modes 1 and 2. In an effort to establish that the sequence and overlap requirements of this LCO were met, performances of 1-SI-0-2, which occurred since initial entry into Mode 3, were reviewed. The 1-SI-0-2 packages documented the position of the control banks during periods of rod movement for power ascension. For periods of full power operation, control banks A, B, and C are fully withdrawn from the core. The position of the fully withdrawn banks was not routinely recorded because sequence and overlap requirements during full power operation are satisfied as long as the insertion limits for control bank D are met. Therefore, the 1-SI-0-2 packages for full power operation only reflected the verification that the insertion limit for control bank D was met. This data along with the 1-SI-0-2 data documented during power ascension was sufficient to establish that the requirements of SR 3.1.7.3 had been met.

CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

The Operations personnel that prepared and reviewed 1-SI-0-2 for adequacy have been counseled on this violation example. Included in the discussion with these individuals were the assumptions made in the evaluation of the requirements of SR 3.1.7.3 and how this resulted in the failure to perform the surveillance properly.

1-SI-0-2 has been revised to ensure that control bank sequence and overlap are verified and properly documented. Included in the revision was the addition of a data sheet, currently data sheet 7, which defines bank sequence and provides a means to determine bank overlap at any point during rod movement. In addition, the SI was revised to require verification of overlap using data sheet 7, if control bank D is inserted at 105 steps or below. During full power operation, periods when control banks A, B, and C are fully withdrawn from the core, sequence and overlap are satisfied as long as the insertion limits for control bank D are met. 1-SI-0-2 now includes a step which verifies and documents that the insertion limit for control bank D is not being violated.

Further actions taken included a review of 1-SI-0-2 to ensure that it contained no additional deficiencies. This review compared a matrix of SRs to 1-SI-0-2 to establish that it addresses all applicable SRs.

In addition, a sample population of SRs listed in the SR scheduling matrix were reviewed to establish that the implementing instruction contained requirements appropriate to satisfy the SRs. No areas of concern were identified from either review.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With regards to Example 2, TVA is in full compliance.

NOTICE OF VIOLATION 390/96-09-06

"Technical Specification 5.7.1.1 requires that written procedures shall be established, implemented, and maintained for activities recommended in Appendix A of Regulatory Guide 1.33, Quality Assurance Program Requirements, Revision 2, February 1978. This includes procedures required for the safe performance and control of safety-related maintenance activities.

Modification/Addition Instruction (MAI)-4.7A, Hydro Testing of Pipe, Revision 12, Section 6.3.3 requires, in part, that the possibility of pressurization on systems and components adjacent to the hydrostatic test boundary be considered in the event of boundary valve leakage. Section A.3.3 of Attachment D requires, in part, that to ensure required hydrostatic test pressure is not exceeded by more than six percent, a full capacity relief valve may be installed and preset. Section 6.1.F requires hydrostatic test pressures to be determined using the appropriate section of Attachment C. Attachment C, Hydro Test Parameters Calculation Sheet, requires the minimum test pressure to be the design pressure multiplied by a multiplier factor obtained from Site Standard Practice (SSP)-8.05.

SSP-8.05, ASME Section XI System Pressure Test Program, Revision 4, Appendix A, states, in part, that American Society of Mechanical Engineers (ASME) Code Class 3 components rated for less than 200°F are to be tested at 110 percent of system design pressure.

Contrary to the above, the licensee failed to adequately implement quality-related procedure MAI-4.7A while performing hydrostatic testing of ASME Code Class 3 auxiliary feedwater recirculation piping rated at 150°F in the following three examples:"

EXAMPLE 1

"On July 23, 1996, the possibility of pressurization to hydrostatic test pressure was not considered for the adjacent water solid leg of auxiliary feedwater (AFW) piping between the pressure control valve and level control valves. Specifically, pressure in this portion of the system was not being monitored and consideration of the effects on AFW operability had not been evaluated."

TVA RESPONSE - Example 1

TVA agrees that this violation example occurred.

REASON FOR THE VIOLATION - Example 1

This violation example occurred because the applicable procedure provided inadequate guidance for monitoring the systems and components adjacent to the hydrostatic test boundary for the possibility of over pressurization. The Test Director was also considered responsible because he was ultimately responsible for the test.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN & RESULTS ACHIEVED - Example 1

The initial hydrostatic test performed on AFW piping has been reviewed by Operations using historical data from the Emergency Response Facilities Data System (ERFDS) and was found to be within acceptable limits for those systems and components outside of the hydrostatic test boundary. The remaining hydrostatic testing performed thereafter for completion of the AFW piping modifications was monitored by Operations and no over pressurization was observed.

The appropriate Modifications personnel have been briefed on the conditions that led to the subject violation.

The Test Director has been disciplined and counseled on the reason for the subject violation.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATIONS - Example 1

MAI-4.7A has been revised to prevent future occurrences of the subject violation example. Additional precautions have been incorporated into the procedure to consider the possibility of over pressurization on systems and components adjacent to the test boundary in the event of valve leakage or other boundary violations. Operations will be notified to monitor adjacent system pressures outside the isolated test boundary. The appropriate System Engineer will be involved in the evaluation and monitoring of the adjacent system outside the test boundary and a relief valve will be used as applicable to prevent over pressurization during testing.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED - Example 1

With respect to the subject violation example, TVA is now in full compliance.

EXAMPLE 2

"On July 24, 1996, the licensee failed to verify that the capacity of an installed relief valve was adequate to relieve the full capacity of the hydrostatic test pump and ensure the required hydrostatic test pressure was not exceeded."

TVA RESPONSE - Example 2

TVA agrees that this violation example occurred.

REASON FOR THE VIOLATION - Example 2

This violation example occurred because the applicable procedure did not require verification of relief valves (when used) to ensure they were adequate to relieve the full capacity of the hydrostatic test pump and ensure that the hydrostatic test pressure limit was not exceeded. The Test Director was also considered responsible because he was ultimately responsible for the test.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN & RESULTS ACHIEVED - Example 2

The relief valve capacity cited in the subject violation example has been verified to be acceptable.

The appropriate Modifications personnel have been briefed on the conditions that led to the subject violation.

The Test Director was counseled and disciplined for this example of the subject violation.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATIONS - Example 2

Precautions have been incorporated into MAI-4.7A to ensure that relief valves are appropriately sized for future testing.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED - Example 2

With respect to the subject violation example, TVA is now in full compliance.

EXAMPLE 3

"On July 23, 24, and 26, 1996, hydrostatic tests were performed at an inadequate test pressure of 2140 pounds per square inch gage (psig) and a range of 2100 to 2180 psig. The required minimum hydrostatic test pressure was 2173 psig which was 110 percent of the design pressure of 1975 psig."

TVA RESPONSE - Example 3

TVA agrees that this violation example occurred.

REASON FOR THE VIOLATION - Example 3

This violation example occurred because of personnel error. The test pressure data was incorrectly transposed from the calculation data sheet to the hydrostatic test data sheet by the Test Director. Quality Control (QC) independent verification of the test pressure failed to detect the error.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN & RESULTS ACHIEVED - Example 3

Hydrostatic testing on the piping was reperformed at the correct pressure. The testing met the requirements of SSP-8.05.

A review of the previous Section XI hydrostatic tests was performed and no similar instances were identified.

The Test Director has been disciplined for failure to follow procedure and counseled on the reason for the subject violation example.

The appropriate Modifications personnel have been briefed on the conditions that led to the subject violation.

QC management expectations concerning the subject violation have been provided in a QC group training session.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATIONS - Example 3

Procedures have been revised in order to improve performance. MAI-4.7A has been revised to strengthen the requirements for verifying test parameters (cross references incorporated on the hydrostatic test data sheet to the applicable calculation section and the System Engineer are now required to verify pretest data) and to further clarify the procedural requirements for American National Standard (ANSI) B31.1 and ASME Section III piping hydrostatic testing. SSP-6.02, Maintenance Management System, has been revised to require that ANSI B31.1 and ASME Section III pipe hydrostatic testing be performed in accordance with MAI-4.7A and ASME Section XI pipe hydrostatic testing in accordance with SSP-8.05.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED - Example 3

With respect to the subject violation example, TVA is now in full compliance.

NOTICE OF VIOLATION 390/96-09-07

"Technical Specification 5.7.1.1 requires that written procedures shall be established, implemented, and maintained for activities recommended in Appendix A of Regulatory Guide 1.33, Quality Assurance Program Requirements, Revision 2, February 1978. This includes procedures for operations and maintenance of Emergency Core Cooling Systems.

Instrument Maintenance Instruction (IMI)-150, Essential Instrumentation Operability Verification, Revision 6, Attachment C, page 32, requires valve 1-ISIV-74-102D/H for flow switch 1-FIS-74-12 for the Residual Heat Removal system to be open.

Contrary to the above, valve 1-ISIV-74-102D/H was found closed on June 27, 1996, which rendered flow switch 1-FIS-74-12 inoperable."

TVA RESPONSE

TVA agrees that this violation occurred. TVA reported this issue as voluntary Licensee Event Report 390/96-020.

REASON FOR THE VIOLATION

The root cause of this condition could not be determined. The last known work package to have manipulated this valve occurred on June 1, 1996. The investigation determined, based on interviews and documentation, that the manifold valve was left in the open position with second party verification. TVA's review of the maintenance work orders performed since June 1, 1996, did not identify any work orders which would have closed the valve. A review of equipment hold orders issued during this period did not reveal any work associated with this valve.

TVA also reviewed surveillance instructions involving differential pressure instruments. It was found that SIs used by Operations personnel involving connection of Measuring and Test Equipment (M&TE) required second-party verification of valve position. This verification differed from maintenance SIs which employed independent verification on all valves (except the equalization valve) unless a functional post maintenance test can be performed.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

As previously discussed, once the manifold valve was found to be in the closed position, plant personnel took steps to place the valve into the open position.

TVA has reviewed maintenance work orders performed since June 1, 1996, but did not identify any work orders which would have affected the manifold valve position. A review of equipment hold orders issued during this period was conducted, but also did not reveal any work associated with this valve. In addition, no valve mispositions were identified when a sample of 60 other valves were inspected. Sixteen valves were also inspected which require calibration equipment to be attached to plant equipment. None of these valves were found in the improper position.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATIONS

Surveillance Instructions requiring enhancement for instrument valve verification was limited to those used by Operations personnel to connect M&TE to differential pressure instruments. As a result, TVA has clarified Site Standard Practice (SSP) - 12.06, "Verification Program," to require independent verification of valve position. Equalization valves continue to be second-party verified to minimize any misposition which could result in actuation of a protective function.

Discussions were held with Maintenance and Operations personnel to relate the events of this issue and the importance of valve positions and verifying their proper alignment.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With respect to the subject violation, TVA is in full compliance. [Note: An auxiliary feedwater steam trap valve was recently found mispositioned. This condition will be addressed as part of an issue identified by NRC Inspection Report 390/96-10.]

NOTICE OF VIOLATION 390/96-09-08

"Technical Specification 5.7.1.1 requires that written procedures shall be established, implemented, and maintained for activities recommended in Appendix A of Regulatory Guide 1.33, Quality Assurance Program Requirements, Revision 2, February 1978. This includes procedures required for the safe performance and control of safety-related maintenance activities.

Site Standard Practice (SSP) 7.58, Criteria for the Erection of Scaffolding/Temporary Work Platforms and Ladders Including Those in Seismically Qualified Structures, revision 1, Sections 2.1.A and Section 2.2.I state, in part, that scaffolding and their horizontal restraints erected in Category I structures such as the intake pumping station will have a minimum clearance of four inches from all fragile safety-related items which include valves, instrument lines, flexible conduit, and instruments. If these items penetrate the decking of the scaffolding, the clearance may be reduced to two inches if the scaffolding is restrained.

Contrary to the above, as of July 19, 1996, scaffolds erected above the essential raw cooling water (ERCW) strainers in accordance with scaffold permit numbers MMG960404, MMG960160, MMG950248, and MMG950247, did not meet the four and two-inch clearance requirements for fragile safety-related items. The ERCW strainers are safety-related and located in the intake pumping station."

TVA RESPONSE

TVA agrees that this violation occurred.

REASON FOR THE VIOLATION

The violation occurred because both the carpenters and the scaffolding inspectors incorrectly interpreted the clearance requirements of Site Standard Practice (SSP)-7.58, "Criteria for the Erection of Scaffolds/Temporary Work Platforms and Ladders Including Those in Seismically Qualified Structures." SSP-7.58, Revision 1, Section 2.2.I, required, "Scaffolding and horizontal restraints shall have a minimum clearance of 4 inches from all fragile safety-related items." These items were defined as valves, instrument lines, one inch and smaller, and conduit, flex conduit, exposed cables

instruments, and switches. The personnel incorrectly interpreted that as long as the item was not fragile, then the 4 inches did not apply. This interpretation by both the above parties resulted in subject violations.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

TVA has retrained Modifications carpenter craft in the SSP-7.58 scaffold and ladder acceptance criteria. TVA has also reinspected existing scaffolds in both Category I and non-Category I structures against the SSP-7.58 acceptance criteria and have brought those scaffolds identified as deficient into conformance with SSP-7.58.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATIONS

TVA has assigned a Modifications field engineer as a scaffold coordinator to oversee the scaffold erection program. TVA has also developed a report to management to monitor the scaffold program. These actions will remain in place until management considers that they are no longer required to ensure compliance.

In addition, Maintenance personnel responsible for erecting welded frame scaffold have been provided details of identified problems found from the above described scaffolding reinspection.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With respect to the subject violation, TVA is full compliance.

ENCLOSURE 2
WATTS BAR NUCLEAR PLANT UNIT 1
LIST OF COMMITMENTS

Violation 390/96-09-02

1. To ensure future changes to procedures which may impact component status are properly controlled, a methodology for a formal administrative process for status control is being developed. Once developed, affected plant procedures will be revised or new procedures will be developed.
2. In addition, a final confirmatory measure will be taken to establish that revisions to TIs are being properly controlled. This will be accomplished by reviewing recent revisions to TIs to identify those which have the potential to impact component status. From those identified as potential status changes, a number of these changes will be verified to be appropriately implemented.

Violation 390/96-09-08

1. TVA has assigned a Modifications field engineer as a scaffold coordinator to oversee the scaffold erection program. TVA has also developed a report to management to monitor the scaffold program. These actions will remain in place until management considers that they are no longer required to ensure compliance.