



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

SEP 15 1995

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

Gentlemen:

In the Matter of the Application of) Docket Nos. 50-390
Tennessee Valley Authority) 50-391

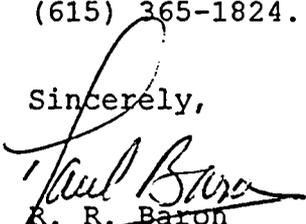
WATTS BAR NUCLEAR PLANT (WBN) - UNIT 1 AND UNIT 2 - REPLY TO THE
DEFICIENCY FROM NRC EXIT, AUGUST 10, 1995 AND REQUEST FOR
ADDITIONAL INFORMATION FROM NRC INSPECTION REPORT NOS. 50-390,
391/95-45.

The purpose of this letter is to provide a reply to the deficiency
identified by NRC during an exit conducted August 10, 1995, on the
inspection of the Vendor Information (VI) Corrective Action Program
(CAP).

This letter also addresses the request made in NRC Inspection
Report Nos. 50-390, 391/95-45 for an evaluation of the implications
Violation 390/95-45-01 and any other similar issues, including TVA
identified deficiencies, have on the adequacy and completeness of
the VI CAP and maintenance thereof after construction completion.

If you should have any questions, contact P. L. Pace at
(615) 365-1824.

Sincerely,


R. R. Baron
Nuclear Assurance and
Licensing Manager (Acting)

Enclosures
cc: See page 2

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ENCLOSURE 1

WATTS BAR NUCLEAR PLANT UNIT 1
RESPONSE TO NRC DEFICIENCY FROM EXIT, AUGUST 10, 1995

DESCRIPTION OF DEFICIENCY

Fittings on containment personnel air locks 1-PAL-304-0002A and 0002B are not lubricated in accordance with the vendor maintenance recommendations of Vendor Technical Manual (VTM) C310-0010, which indicated general lubrication is to be performed.

REASON FOR THE DEFICIENCY

The reason for the deficiency has been determined to be personnel error by a contract task group performing the reconciliation of vendor information with Preventive Maintenance Instructions (PMs). This was a one-time special task performed in 1992. The task was performed to Site Standard Practice (SSP) 2.10, Revision 3, "Vendor Manual/Information Control," using Appendix O data sheets. The Appendix O data sheets documented the extent of implementation of vendor recommended maintenance in plant instructions and procedures. However, the Appendix O recommendation could not be located for this specific VTM, therefore, a PM was not generated to implement the vendor recommendations. The contract personnel are no longer employed in this task. The exact cause of the oversight could not be determined.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

The appropriate PM has been established and scheduled for the lubrication of the personnel air lock.

A review equivalent to the Appendix O review was performed for 58 vendor technical manuals (VTMs) identified as not having completed Appendix O data sheets on file as of July 31, 1995. The review was limited to the Maintenance organization since the bulk of the recurring vendor reconciliation issues, including this deficiency, pertained to PM instructions. The results of the review indicated that PMs involving the Gas Stripper Feed Pump in the Chemical and Volume Control System and the Incore Flux Detector drive motors and indexer units should receive additional preventive maintenance. The appropriate PM has been established and scheduled for these components. The equipment has not seen wear since it has not had significant usage; therefore, there is no impact to plant hardware identified by the review.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER DEFICIENCY

Since the deficiency involves a special one-time review, and all documentation in question was replaced, no personnel training or procedural changes are required. Currently, the Open Item Status Log (OISL) process, as established in SSP 2.04, "Source Requirements Identification and Tracking," provides the ongoing methodology for ensuring appropriate use of vendor information in plant instructions and procedures.

See the attached discussion regarding TVA's actions to confirm the adequacy of the VI Program.

DATE FULL COMPLIANCE WILL BE ACHIEVED

With respect to the identified deficiency, TVA is in full compliance.

ENCLOSURE 2
WATTS BAR NUCLEAR PLANT UNIT 1
REQUEST FOR ADDITIONAL INFORMATION - NRC INSPECTION
REPORT NOS. 50-390/95-45 AND 50-391/95-45

NRC Inspection Report 50-390/95-45 and 50-391/95-45 was issued on August 15, 1995. TVA is responding to the specific deficiency cited in the report in a separate correspondence. This letter addresses the request in the subject report for an evaluation of the implications the cited deficiency and any other similar issues, including those self-identified deficiencies, may have on the adequacy and completeness of the Vendor Information (VI) Program and maintenance thereof after construction completion.

TVA agrees that the need for adequate vendor information spans both construction and operation. The VI Program Corrective Action Program (CAP) Plan has established a program that will ensure that this need has been and will continue to be met. The VI CAP has generated upgraded vendor technical manuals; improved procedures for vendor document control, evaluation, and use; and established a process for ensuring that vendor documents with value as design input/output are appropriately addressed.

The overall Vendor Information Program at Watts Bar Nuclear Plant is well established, functional, and effective. This conclusion is supported by a recent Nuclear Assurance (NA) review of conditions adverse to quality (CAQs) reports associated with vendor information. This review looked at various vendor information process attributes. Thirteen of the areas were trended. Trend analysis indicated that seven areas exhibited improvement during the last six months. The other six trend categories remained constant. Two specific areas, Maintenance Planning and Procurement Engineering, were identified that exhibited weaknesses in implementation. Corrective action documents have been written to address these areas. Although these two areas were identified, the overall program was shown to be functioning at a high level of performance.

Another part of the NA assessment involved the field walkdown of various predetermined attributes for installation. Using an approved sample plan, sixty-four components were surveyed with only one deficiency identified regarding the orientation of flow switches. Although these devices had previously been tested successfully, a problem evaluation report (PER) was written to document the need for an additional review. With the exception of this one deficiency, no other hardware impacts were identified. None of the deficiencies were determined to be safety significant.

A separate statistical analysis of program performance was also conducted by Risk Management Associates, Inc. This analysis examined the broad area of performance when compared to the total number of opportunities for error. The results indicated that the rate of implementation errors associated with steps involving vendor information is on a par with that predicted by the applied human reliability technique. This indicates that the events that have been observed are occurring at a rate expected for a well-trained staff.

During the recent inspection of the VI CAP (50-390,391/95-51), the NRC evaluated the Vendor Information Corrective Action Program for closure readiness. A major part of that inspection was based on a field review of twenty to thirty installed vendor-supplied components. As a result of that review, sixteen questions were identified, seven

directly related to attributes extracted from vendor technical manuals. All of the findings were evaluated by TVA. Corrective action documents were generated to evaluate two of the discrepancies in greater detail. None of the items, however, have apparent impacts on operability and none of the items can be considered safety significant.

Future inspections of plant equipment could result in the identification of a limited number of vendor information discrepancies; however, TVA reviews to date have shown that the discrepancies are not likely to be safety significant.

Based on the discussions above, TVA concludes that the Vendor Information CAP has been effectively implemented and that there is reasonable assurance that significant vendor information which could impact the safe function of plant equipment has been appropriately considered.