



Tennessee Valley Authority, 1101 Market Street, Chattanooga, Tennessee 37402-2601

O. J. "Ike" Zeringue
Senior Vice President, Nuclear Operations

SEP 19 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) UNITS 1 AND 2 - NRC INSPECTION REPORT
NO. 50-390, 391/95-52 - REPLY TO NOTICE OF VIOLATION

The purpose of this letter is to provide a reply to Notice of
Violation 50-390/95-52-01. This notice of violation identified
three examples of failure to follow procedures. TVA's reply to the
notice of violation is provided in the enclosure to this letter.

No new commitments are made in this submittal.

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

Sincerely,


O. J. Zeringue

Enclosure
cc: See page 2

9509260106 950919
PDR ADDCK 05000390
Q PDR

TEO/
11

U.S. Nuclear Regulatory Commission
Page 2

SEP 19 1995

cc (Enclosure):

NRC Resident Inspector
Watts Bar Nuclear Plant
Rt. 2, Box 700
Spring City, Tennessee 37381

Mr. P. S. Tam, Senior Project Manager
U.S. Nuclear Regulatory Commission
One White Flint North
11555 Rockville Pike
Rockville, Maryland 20852

U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

ENCLOSURE

WATTS BAR NUCLEAR PLANT UNITS 1 AND 2
REPLY TO NOTICE OF VIOLATION (NOV)
NOV 50-390/95-52-01

NOTICE OF VIOLATION 50-390/95-52-01

"10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, and TVA Nuclear Quality Assurance Plan TVA-NQA-PLN89A, Revision 4, Section 6.1, require that activities affecting quality be prescribed by documented instructions or procedures and be accomplished in accordance with these instructions or procedures.

Contrary to the above, activities affecting quality were not accomplished in accordance with documented instructions or procedures in the following examples:"

EXAMPLE 1

"Plant Administrative Instruction PAI-2.08, Annunciator Disabling/Enabling, Revision 1, delineated the following procedural requirements:

Step 2.2.L.4) required the following action associated with a disabled annunciator: Place an Orange Sticker on affected alarm window to indicate an input to that alarm has been disabled.

Attachment 1, Disabled Alarm Checklist, Step 5, required the performer's signature and a second party verification signature indicating completion of the following actions: This alarm has been disabled as described in Section 1 of this form and Orange Stickers have been placed on affected alarm windows.

Step 2.2.L.3) required the unit operator and the shift operations supervisor/assistant shift operations supervisor to perform the following documentation actions: Log alarm disablement on Index Sheet Attachment 2 and in unit operator and shift operations supervisor/assistant shift operations supervisor daily journals when alarm is disabled. The entry should include alarm location, method used to disable the alarm, date and time removed, justification for disablement, and Tech Spec action requirements, if applicable.

Use of Revision 1 of Plant Administrative Instruction PAI-2.08 effective May 11, 1995.

Contrary to the above, as of July 27, five of seven disabled main control room annunciators did not have orange stickers attached to the annunciator windows; disabled main control room annunciators 85F, 89C, and 135F were not logged in the unit operator's daily journal; and, five different Attachment 1 forms from Plant Administrative Instruction PAI-2.08 were initiated after the effective date of Revision 1 (May 11, 1995) using Revision 0 forms."

TVA REPLY TO EXAMPLE 1

TVA agrees that the violation example occurred.

REASON FOR THE VIOLATION

The failure to log disabled annunciators in the Unit Operator's Daily Journal was caused by personnel error. The affected individual did not self-check to ensure all paperwork was completed following the disabling of the affected annunciators.

The failure to attach orange stickers to the annunciator window of disabled annunciators and to use Revision 0 of Attachment 1 to Plant Administrative Instruction (PAI)-2.08 for disabling annunciators was also caused by personnel error. The requirement to attach orange stickers to the annunciator window of disabled annunciators, and placing the step-by-step instructions for removing and enabling the Ronan Annunciator System into System Operating Instruction (SOI)-55, were established by Revision 1 to PAI-2.08. Prior to discovery of this example, Operations crews had made copies of Attachment 1 to PAI-2.08, Revision 0, and had placed them in a file at the assistant shift operations supervisor (ASOS) desk in an effort to save time when disabling annunciators. Attachment 1 to PAI-2.08 was not verified for use against a controlled copy of the procedure before use.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

The Disabled Annunciator Index was reviewed. Disabled annunciators were verified to have orange stickers in place, the correct revision of Attachment 1 to PAI-2.08 filled out, and the associated paperwork filled out correctly.

The ASOS file cabinet was checked to determine whether other out-of-date attachments or appendices were contained therein. Of the eleven attachments or appendices found, two were the wrong revision. The two wrong attachments and appendices were removed from the file cabinet.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

A memorandum has been issued to appropriate Operations personnel to emphasize the requirement to follow procedures and pay attention to detail. This memorandum also addressed journal entries and the use of an attachment that was not verified for use.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With respect to this example, TVA is in full compliance.

EXAMPLE 2

"Site Standard Practice SSP-12.56, Tracking of Technical Specification Equipment Out of Service, Revision 3, required the following:

Section 1.2 required all Technical Specifications-related equipment that is taken out of service to be tracked by completion of a Limiting Condition for Operation (LCO) Tracking Sheet in the LCO Tracking Log. This is required even if the plant is in a mode that does not require the equipment to be operable.

Section 2.2.F.2 required the shift operations supervisor to review all applicable requirements and sections of the LCO Tracking Sheet to ensure all applicable alignment checklists have been completed and that the equipment is ready for service before exiting the LCO and signing for returning the equipment to service.

Site Standard Practice SSP-12.56 [6.02], Maintenance Management System, Revision 15, Section 2.6.3, required work documents to be electronically in the Maintenance Tracking system to record status, condition, and location of a work document by using applicable status codes. Appendix U of Site Standard Practice SSP-6.02 defined the maintenance tracking system code "CR" as the status that applies to a work order that is field complete and is with the craft foreman for review.

Contrary to the above, procedures were not followed as described below:

On July 26 at 5:00 a.m., normally locked open Auxiliary Feedwater Valves 1-ISV-3-827, 828, and 0829 were found closed and were not tracked by an LCO Tracking Sheet in the LCO Tracking Log. Closing of the valves rendered the two motor-driven trains of the auxiliary feedwater inoperable in accordance with the requirements of Technical Specification 3.7.5, Auxiliary Feedwater System.

On July 25 at 1:00 p.m., the LCO Tracking Sheet for LCO Log Entry 95-207 was signed and removed from the LCO Tracking Log without verification that auxiliary feedwater isolation valves 1-ISV-3-827, 828, and 829 were restored from closed to locked open. The LCO Tracking Sheet for LCO Log entry 95-207 annotated that the LCO log entry was due to closing the auxiliary feedwater isolation valves.

A "CR" code was assigned to Work Orders 95-11064-02, 03, 04, 06, 07, and 08 prior to field completion of restoration work to lock open Valves 1-ISV-3-827, 828, and 829."

TVA REPLY TO EXAMPLE 2

TVA agrees that the violation example occurred.

REASON FOR THE VIOLATION

There are essentially three causes of this event:

1. SSP-6.02 guidance for when and under what circumstances to status-code work orders does not provide adequate instructions or sequencing. This contributed to Maintenance personnel prematurely statusing work order packages as being complete and to management incorrectly assuming that Operations had signed off work completion prior to the work order package being placed in a closure status in Maintenance Planning and Control (MPAC) database.
2. The instrument craft and testing engineer relayed information to the general foreman that the work was done, testing had been completed, and implied that the work order was complete. This led the general foreman to inappropriately change the MPAC code to complete status.
3. The intent of SSP-12.56 is that a hands-on evaluation be done. However, the procedural guidance is not specific and was interpreted otherwise. Due to the need to review a large number of open work documents associated with Limiting Condition for Operations (LCOs) required for Mode 3 entry, MPAC was used to determine work package completion status.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

The affected valves were returned to their normal alignment and the associated work orders were signed off by Operations as complete.

Operations issued Night Orders instructing senior reactor operators not to clear LCO Tracking Sheets without verifying completion of the work by review of the work order package.

Maintenance issued memorandums instructing that work orders were not to go to "CR" status until Operations has signed the completion form.

Plant Completions Group (PCG) and Maintenance work orders in closure (CR, CE, and CT for Maintenance; any "C" status other than "CX" for PCG) have been screened. Those with the potential for similar conditions were reviewed by a licensed senior reactor operator to determine if LCO Tracking Sheets had been prematurely removed. This review identified no other cases where components had not been returned to their appropriate lineup.

The alignment verification checklist for the Auxiliary Feedwater System (SOI-3.02) was re-performed.

SSP-6.02 has been revised to clearly identify the requirement that the Operations sign-off will be obtained on Appendix J prior to the work document being placed in any closure status on MPAC.

SSP-12.56 has been revised to clearly state the actions/reviews necessary before a LCO log entry can be cleared.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Changes to SSP-6.02 have been discussed with appropriate Maintenance and Plant Completions Group (PCG) personnel. Additionally, training sessions have been held for maintenance general foreman, foremen, and dual rates to clearly review their responsibilities for post work review and management's expectations for quality and completeness of the work document when it leaves the job site.

Changes to SSP-12.56 and a summary of this incident have been communicated to licensed senior reactor operators.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With respect to this example, TVA is in full compliance.

EXAMPLE 3

"General Operating Instruction GO-1, Unit Startup from Cold Shutdown to Hot Standby, Revision 1, Step 5.6(7)(e), required steam generator narrow range levels to be maintained between 32 and 60 percent.

Contrary to the above, a shift operations supervisor verbally authorized reactor operators to allow steam generator levels to reach 70 percent without processing a procedure change."

TVA REPLY TO EXAMPLE 3

TVA agrees that the violation example occurred.

REASON FOR THE VIOLATION

This example was caused by personnel error. The Shift Operations Supervisor (SOS) directed the Unit Operator to raise Steam Generator (SG) levels higher than the limits set forth in GO-1.

GO-1 had been changed earlier in the day to allow the SG level to be increased to 60 percent as a contingency for Reactor Coolant System (RCS) temperature control while testing the Residual Heat Removal (RHR) pumps. The SOS realized the need for an alternate means of cooling the RCS and researched the possibility of using cold feedwater as a cooling medium during the time RHR would be secured for testing. The SOS researched the basis for the SG level and procedurally raised the SG level limit to 60 percent.

When the RHR pump testing had not been completed and the SG levels had approached 60 percent level, the SOS permitted the Unit Operator to raise the SG levels greater than 60 percent level but not greater than 70 percent level.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

The individual involved has been counseled on the requirements of SSP-2.55, "Procedure Use and Adherence."

Operational crews have been briefed on this event. The requirements of SSP-2.55 were reemphasized during these briefings.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

No further corrective actions are considered necessary

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With respect to this example, TVA is in full compliance.