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MAR 07 1994

U.S. Nuclear Regulatory Commission
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Gentlemen:

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

WATTS BAR NUCLEAR PLANT (WBN) - NRC INSPECTION REPORT 50-390, 391/93-77 - RESPONSE TO CONCERNS

The purpose of this letter is to provide the 60 day written response required by NRC Inspection Report 50-390, 391/93-77. The inspection report identified several issues associated with the closure of Significant Corrective Action Report (SCAR) WBP870036SCA. Additionally, the inspection report identified two inspector followup items involving examples of hardware deficiency conditions which were not considered safety significant. However, because they reflected inadequate work controls, TVA was requested to also respond to these items.

The enclosure provides a response to the issues associated with the closure of SCAR WBP870036SCA and to the two inspector followup items. No new commitments are being made in this submittal.

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

Very truly yours,

W. J. Museler

William J. Museler

Enclosure
cc: See page 2

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MAR 07 1994

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ENCLOSURE

NRC INSPECTION REPORT 50-390, 391/93-77
RESPONSE TO CONCERNS

NRC Inspection Report 50-390, 391/93-77 identified several issues associated with the closure of Significant Corrective Action Report (SCAR) WBP870036SCA. The issues were of concern because the SCAR process is used to resolve and document the most safety significant adverse conditions. As a required record, the completed SCAR should clearly document important aspects of the resolution process and provide a means of readily verifying adequate resolution. The inspection report also identified two inspector followup items involving examples of hardware deficiency conditions which were not considered safety significant. However, because they reflected inadequate work controls, TVA was requested to respond to these items.

NRC Inspection Report 50-390, 391/93-77 requested that TVA provide a response within 60 days which addresses the issues associated with the closure of SCAR WBP870036SCA and the two identified inspector followup items. Each issue and inspector followup item is restated below, along with TVA's response.

ISSUE #1

Although the completed SCAR contained over 3000 pages of documentation there was no summary, introduction, or table of contents at the beginning of the SCAR to aid in its use as a required record of "significant" condition resolution. Also, some information was included in an order that appeared illogical. Four examples of the latter were:

A. A list detailing missing documentation was provided on Pages 8 - 15 of the SCAR, when details regarding other discrepant conditions were given hundreds of pages later.

B. The SCAR closure summary pages were provided in reverse order, Pages 49 and 50 should have been reversed. Note: Informed of this error, the licensee reversed and renumbered the pages in a final version of the SCAR provided following the inspection.

C. Component identifiers, test numbers, and dates provided in early pages of the SCAR (e.g., Page 13) were altered from those in previous revisions with no explanation or reference to the reason until Pages 3325 - 3328, where the changes were stated to be the result of typographical errors discovered in the closure review.

D. The first four pages (3227 - 3230) in the "Attachments" volume of the SCAR were not attachments but were misplaced documentation presumably required elsewhere in the SCAR. Note: The licensee corrected this in a final version of the SCAR provided following the inspection.

TVA RESPONSE TO ISSUE #1

General: On February 3, 1994, TVA provided a written response to Notice of Violation 50-390, 391/93-77-01. Under the heading "Corrective Steps That Have Been/Will Be Taken To Avoid Further Violations," TVA stated that SCAR closures between Nuclear Engineering and Modifications had been consolidated/integrated into a single group with a new CAQ manager. That manager reports to the Engineering Manager. Additional technical resources had been added to the group to provide for effective CAQ corrective actions and assure adequate closure of those CAQs for which Modifications or Nuclear Engineering is the responsible organization.

Also in the same letter, TVA stated that Site Nuclear Assurance had reviewed its role in the SCAR closure process. As a result, the "lessons learned" from that review had been fed back to the individuals performing QA verification activities. As part of that feedback, it was re-emphasized that special care must be exercised to ensure that closure packages are presented in a logical manner such that it would be understandable to an independent reviewer without recourse to the preparer.

Item A: This item involved placement of description of conditions in several different places within the SCAR. The SCAR had been revised six times. Other Conditions Adverse to Quality (CAQs) had been "rolled" into this SCAR, clarifications were incorporated, and Unit 2 items were transferred from the SCAR into other CAQs. As additional deficiencies were added to the SCAR, they were not always placed in the same location as the other description of conditions. WBN agrees that the descriptions of conditions could have been more obvious. As identified above, actions taken in response to Notice of Violation 50-390, 391/93-77-01 should resolve this issue for SCARs closed in the future.

Item B: The subject page numbering error occurred during final preparation of the SCAR for transmittal to the Records and Information Management System (RIMS). Based on the inspection team's questions related to packaging of the SCAR, TVA reformatted the SCAR to provide a more logical presentation of the closed document. During this process, TVA verified page numbering (over 3000 pages) and found only one other page numbering discrepancy. Page 3329 should have been located immediately after Page 3253. This deficiency was corrected.

Item C: During implementation of the SCAR corrective actions, a number of typographical errors were identified. In lieu of revising the original description of condition TVA provided the corrected information on Pages 3325 - 3328, in closer proximity to the corrective action and closure review portions of the SCAR. WBN agrees that the corrected information should have appeared earlier in the SCAR. As identified above, actions taken in response to Notice of Violation 50-390, 391/93-77-01 should resolve this issue for SCARs closed in the future.

Item D: The first four pages (3227 - 3230) in the "Attachments" volume were not attachments and were not identified as such. For ease of handling, the SCAR had been divided and placed into 3-inch binders for the inspection team. No "Attachments" volume existed in the RIMS version of the closed SCAR. To avoid confusion, the subject pages should have been placed in the preceding binder of the SCAR.

Programmatic changes to SSP-3.04, "Corrective Action Program," are not merited. No problems were identified which required hardware changes and a relatively small number of the approximately 3000 pages contained in the SCAR required change or clarification. However, TVA acknowledges that the SCAR closure package could have been organized to provide a more easily understood document. As identified above, actions taken in response to Notice of Violation 50-390, 391/93-77-01 should ensure that SCARs closed in the future are presented in a more logical manner.

ISSUE #2

On Page 3 of the SCAR a note states "Locate a copy of Licensing's Reportability memorandum and include in this file." The documented reportability determination was omitted from the completed SCAR. It was not clear to the inspectors whether this was required to be included. Subsequently, the inspectors were provided with a copy of the determination memo.

TVA RESPONSE TO ISSUE #2

The note on Page 3 of the SCAR was added by the Management Review Committee during the rollover process from the Condition Adverse to Quality Report (CAQR) program to the SCAR program. The note was administrative in nature and not a procedural requirement. The CAQR form did document whether the described deficiency was considered to be potentially reportable and whether the CAQR had been forwarded to Site Licensing for a reportability evaluation. Documented reportability evaluations are assigned a RIMS number and are retrieveable from RIMS under the associated CAQR number.

ISSUE #3

SSP-3.04 required the Site Nuclear Assurance organization to perform and document an independent verification of the completion of the corrective actions. The inspectors reviewed the verification that had been documented and included in the SCAR. The verification, which was documented in the SCAR, was less than a page in length for a SCAR that was over 3000 pages long. Note: The licensee provided a more detailed description of the verification performed by the Site Nuclear Assurance organization in a final version of the SCAR provided following the inspection.

TVA RESPONSE TO ISSUE #3

In TVA's response to Issue #1 above, reference was made to "lessons learned" developed by Site Nuclear Assurance as a result of the review of their role in the SCAR closure process. In addition to providing closure verification guidelines to Nuclear Assurance personnel, a management expectation was communicated that the verification process used should be thorough and documented so that a knowledgeable independent reviewer could understand and reconstruct the verification process.

initiated to investigate the closure of Workplan KP04063A-1 with work being incomplete. This item was identified as an inspector followup item to review TVA's resolution of WBPER930443. (The subject cable provides annunciation for a containment spray valve that is not fully closed.)

TVA RESPONSE TO IFI 50-390, 391/93-77-02

The subject IFI concerns the failure to re-land a nonsafety-related annunciator cable as required by Work Plan procedures. The IFI was initiated because the condition reflected an instance of inadequate work controls for nonsafety-related equipment.

Problem Evaluation Report WBPER930443 was initiated to address the nonsafety-related annunciator cable lifted lead. This PER is closed and retrieveable from RIMS under number T46 940214 861. The cause for the deficiency was determined to be personnel error in that the workplan writer overlooked cable 1A3244 during generation of workplan K-P04063A-1. Recurrence controls for the deficient condition were determined not to be required. The deficiency occurred under the "old" work control program in effect prior to the 1990 WBN Stop Work Order (WBN 90-01). The "new" work control program instituted upon restart of construction activities provides sufficient recurrence controls. Also as a result of the 1990 Stop Work Order, craft personnel were released and Significant Corrective Action Report (SCAR) WBN900602SCA was generated. Corrective actions for this SCAR included employee training sessions on "Total Quality" and "Employee Responsibilities." These sessions emphasized each employee's responsibilities for quality and the importance of procedural compliance.

Further, during the process of implementing the Additional Systematic Records Review (ASRR) task at WBN, 72 Class 1E cables and their associated terminations (approximately 250) were reinspected. The findings of this review concluded that the cable installations met the 95/95 criteria established by the ASRR. This review provides confidence that lifted leads associated with Class 1E cables have been adequately controlled.

Also, cable 1A3244 is associated with the Containment Spray System (System 72) which had not been turned over to Startup. Implementation of Startup Manual Procedure (SMP)-4.0, "Transfer of Jurisdiction," for System 72 would have the identified the lifted cable.

Finally during the extent of condition review for WBPER930443, a number of nonsafety-related cables lifted by MR-609582 were found to have been terminated. However, documentation of this condition was not retrieveable under Workplan K-P04063A-1. WBPER940127 has been initiated to address this issue. Sufficient records to ensure the adequacy of these installations would have been generated from a number of subsequent activities performed during testing and turnover of equipment and systems. These activities include system completion (MAI-1.9), transfer walkdowns (SMP-4.0), component testing (SMP-6.0), and preoperational testing (SMP-8.0).

IFI 50-390, 391/93-77-03: FOLLOWUP OF MINOR SEISMIC SUPPORT DISCREPANCY

Seismically qualified electrical panel 1-PNL-31-L572/-A in the Post Accident Sampling Room of the Auxiliary Building had been mounted with only three of four anchor bolts installed. This installation deviated from design, and the records did not demonstrate that the deviation had been evaluated and accepted as an

approved design variance. This item is identified as an inspector followup item to be reviewed further as part of the NRC Equipment Seismic CAP inspection for Seismic Category I(L) items.

TVA RESPONSE TO IFI 50-390, 391/93-77-03

As part of the implementation of the QA Records CAP, Record Plans were developed to provide a means to indicate which construction/installation records were the primary records required for the licensing of WBN. Record Plans are a matrix of the critical construction/installation attributes for plant elements and the records which provide evidence of the qualification of the installed items. Record Plans identify technical attributes and cross-reference QA records or programs that produce QA records addressing the attributes, aiding in future records retrieval. The original construction/installation records and/or supplemental/alternate records provide the documented evidence that the design requirements have been met for the particular attributes.

The Record Plan specifically addressing panel 1-L-572 is Element 04 - Electrical Equipment. This Record Plan does not rely on the original construction record to qualify the installation/configuration attribute. The record which TVA is relying on for the verification of installation of Category 1(L) items is produced by the Integrated Interaction Program. This program has produced walkdown packages on a system/area basis. Panel 1-L-572 is located in area 11D (Post Accident Sampling Room) and was verified as acceptable and documented in calculation 50052-C3-1770.