

Tennessee Valley Authority, Post Office Box 2000, Decatur, Alabama 35609-2000

John T. Herron  
Vice President, Browns Ferry Nuclear Plant

August 25, 2000

10 CFR 2.201

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

Gentleman:

In the Matter of	)	Docket Nos. 50-259
Tennessee Valley Authority	)	50-260
		50-296

**BROWNS FERRY NUCLEAR PLANT (BFN) - RESPONSE TO AN APPARENT VIOLATION IN NRC INSPECTION REPORT NO.50-259/00-03, 50-260/00-03, AND 50-296/00-03**

This letter provides TVA's response to an apparent violation which was documented in the subject inspection report, dated July 27, 2000.

TVA admits that the event occurred as documented in the inspection report. Enclosure 1 addresses corrective actions and recurrence controls taken for this violation. Enclosure 2 addresses management oversight concerning the violation and includes additional information that may not have been known by the NRC at the time the subject inspection report was written.

The information contained in Enclosure 2 of this letter is of a personal, private nature, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy. As such, the information contained herein is protected from mandatory disclosure under TVA's Freedom of Information Act (FOIA) regulations (18 CFR § 1301.1(a)(6)) and the NRC's FOIA regulations (10 CFR § 2.790(a)(6)). Accordingly, we request that Enclosure 2 not be placed in the NRC Public Document Room or in any way be released to the public.

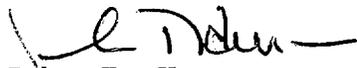
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I certify that I am a duly authorized officer of TVA, and that to the best of my knowledge and belief, the information contained herein is accurate pursuant to Commission requirements.

If you have any questions regarding this response, please contact T. E. Abney at extension (256) 729-2636.

Sincerely,

  
John T. Herron  
Site Vice President

Subscribed and sworn to before me  
on this 25th day of August 2000.

Barbara A. Blanton  
Notary Public  
My Commission Expires 9/22/2002

cc (Enclosures)

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ENCLOSURE 1

TENNESSEE VALLEY AUTHORITY  
BROWNS FERRY NUCLEAR PLANT (BFN)  
UNITS 1, 2, AND 3

INSPECTION REPORT NUMBER  
50-259/00-03, 50-260/00-03, AND 50-296/00-03  
RESPONSE TO AN APPARENT VIOLATION

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RESTATEMENT OF APPARENT VIOLATION

"An apparent violation of TS 5.4.1 was identified due to the apparent deliberate failure to implement Measuring and Test Equipment (M&TE) control procedures which resulted in approximately 500 non-conformance evaluations not being issued and/or completed for M&TE."

TVA's REPLY TO THE VIOLATION

1. Reason For The Apparent Violation

TVA admits that the apparent violation occurred as stated.

The cause for the failure to comply with M&TE procedures was due to the deceptive acts by a M&TE Program Administrator. Even though the M&TE Program Administrator had no history of willful misconduct, he intentionally ceased performing his duties in November 1997 and subsequently falsified four M&TE status reports to his management. These reports were intended to status the out-of-tolerance investigations (OOTIs) up to the time of each report, and to verify that such OOTIs were in fact performed for M&TE found to be out-of-tolerance by TVA's Central Laboratory Services (CLS) facility. The M&TE Program Administrator resigned on June 21, 1999, immediately after the problem was identified by TVA and the M&TE Program Administrator was questioned by his supervisor.

## Background Information

BFN M&TE is routinely calibrated in the TVA CLS facility located in Chattanooga, Tennessee. When M&TE is found to be out-of-tolerance, CLS issues an out-of-tolerance report (OOTR). These OOTRs are received by the M&TE Program Administrator who is responsible for ensuring that each OOTR item is recorded on a log sheet, seeing that an OOTI is initiated, and tracking each OOTI to completion. Each OOTI assesses the impact of failed M&TE on plant systems for every usage since it was last calibrated. The M&TE Program Administrator is able to assess some OOTIs for impact on the plant systems, while others are evaluated by a technical reviewer in the organizations (e.g., Engineering, Maintenance etc.) who used the M&TE.

From 1997 to 1999, four OOTI M&TE status reports were written by the M&TE Program Administrator which falsely reported that OOTIs were performed for all OOTRs. These M&TE status reports were instituted to provide feedback to management as a means to ensure that all OOTRs were being properly investigated in a timely basis. See Enclosure 2 for a complete discussion of the M&TE Program Administrator's work history and the methods used to manage his performance.

In June 1999, the M&TE Program Administrator's supervisor initiated a self-assessment and discovered some discrepancies in some of the OOTIs that had been processed over the previous three months. Based on these discrepancies, the supervisor expanded the self-assessment scope to compare each of the OOTRs received from the CLS facility over the previous three months to OOTIs initiated. An examination of a sample of the OOTRs received for the previous three months resulted in a finding that 37 OOTRs had no corresponding OOTI. A Problem Evaluation Report (PER) was initiated that compared the OOTRs generated by the CLS facility to the OOTIs generated by the M&TE Program Administrator. The PER established two years as a reasonable period in which to bound its review because all M&TE are calibrated at least once in a 12 month period, and the 2-year period would thus cover all M&TE for at least 2 calibration periods.

The PER review identified 148 OOTRs that did not have an associated OOTI package. In addition, 343 items had OOTI tracking numbers assigned but a search of the associated records found no evidence that an evaluation had been initiated or completed. Finally, several OOTIs were found that were not properly dispositioned.

## 2. Corrective Steps Taken And Results Achieved

TVA evaluated the impact of the unprocessed OOTRs/OOTIs and concluded that they did not affect operability of any safety-related system. In doing so, TVA first reviewed those OOTRs/OOTIs associated with M&TE that were used during the performance of a surveillance. Upon completion of those reviews, the remaining OOTRs/OOTIs were evaluated. All evaluations resulted in dispositions with acceptable results and had no effect on plant operations.

In each case, the OOTR from the CLS facility was matched to an existing OOTI. If no OOTI existed, one was initiated and fully dispositioned. The disposition process consisted of evaluating every case in which the out of tolerance M&TE was used and determining which category properly captured the equipment status. The categories evaluated were: M&TE not used, post checks used, follow-on action superseded M&TE condition, and technical/field evaluation of the condition. In cases of a post use check, the M&TE was verified to properly satisfy the applicable requirements when it was used. If follow on actions superseded the M&TE check of the affected system, the impacts of the out-of-calibration condition were negated. Technical evaluations used an engineering basis or field verification to determine that the out-of-calibration was inconsequential.

Finally, an overall assessment of the M&TE program was conducted in order to examine compliance with governing documents and policies. A sample of the OOTIs were reviewed and found to be properly processed and reviewed. Associated records were verified to be properly maintained and the OOTR tracking log was found to have associated documents from the CLS facility through the OOTI process to document control for permanent record keeping.

In order to raise the awareness of M&TE issues, Performance Indicators of the M&TE out-of-tolerance investigations are monitored and reviewed weekly at the Plan-Of-The-Day meeting. These performance indicators report the number of OOTRs received from the CLS facility and the status of the OOTIs. This gives a weekly status of the overall health of the program and provides for early identification of adverse trends.

Insofar as any individual corrective actions are concerned, the former M&TE Program Administrator resigned before TVA could take any personal corrective actions. However, the former M&TE Program Administrator's personnel record has been annotated so that the circumstances surrounding his resignation will be considered should he seek re-employment with TVA or a TVA contractor.

Senior managers have been briefed on the circumstances of the violation. Among other things, the briefing increased management awareness of the effects of deliberate misconduct. The briefing also discussed the fact that despite its rarity and the difficulties involved in avoiding and detecting deliberate misconduct and deception, management must remain sensitive to its potential in everyday settings.

3. Corrective Steps That Will Be Taken To Prevent Recurrence

BFN is developing a new training course for first-line supervisors. This course will include a module to give first-line supervisors an awareness of the potential for the type of problem behavior encountered in this instance. The training will address situations where a high degree of reliance is placed on the continued initiative of a single individual in performing his or her work. The training will also include sensitivity to warning signs of nonperformance and methods of detection.

Additionally, the BFN Self-Assessment Coordinator has developed a Programs and Process Core Assessment program which includes single-owner program self-assessments including the M&TE program. In this program, the M&TE program is currently scheduled to be assessed in June 2001.

As a part of the review of any assessment, the Self-Assessment Committee uses a check-off list which recommends that a vertical slice methodology be used when obtaining data to evaluate the health of the assessed program. Finally, the BFN Self-Assessment Coordinator will discuss with the Self-Assessment Committee willful misconduct problems and the effectiveness of the vertical slice methodology to detect willful misconduct.

#### 4. Date When Full Compliance Will Be Achieved

TVA was in full compliance when missing OOTIs were properly completed.

### CIVIL PENALTY AND SEVERITY LEVEL ASSESSMENT

#### Civil Penalty Assessment

In accordance with the terms of the NRC Enforcement Policy (NUREG-1600), TVA believes that the application of the civil penalty assessment process should result in no civil penalty.

First instance, BFN has not had any previous escalated enforcement (regardless of the activity area) during the past two years or past two inspections.

In addition, TVA identified the problem through a self-assessment. This self-assessment was initiated by the M&TE Program Administrator's supervisor, who discovered discrepancies in the program that led to the identification and investigation of the full scope of the problem.

NRC's letter of July 27, 2000, states that the situation involving the M&TE Program Administrator occurred over an extended period, and that although TVA had indications of personnel performance problems in this area, indicating that management oversight of this process failed to detect this situation earlier. TVA believes that while the M&TE Program Administrator had experienced some performance difficulties in the past, they were not of the nature or degree of those he exhibited during this violation. After examining the M&TE Program Administrator's work history and BFN's management of his work performance over several years, we found no prior indications of the M&TE Program Administrator's behavior that could have reasonably led management to believe that he would cease performing his duties altogether and create false reports to cover up that fact. In short, we do not believe that the facts of this

case warrant a finding that TVA had missed opportunities to identify or prevent the violation. A detailed discussion is contained in Enclosure 2.

Finally, upon discovery of the problem, TVA took prompt and comprehensive corrective action to ensure that there was no safety impact and to restore compliance with procedures. In accordance with TVA's Corrective Action Program, a PER was initiated to examine the problem, perform an extent of condition, and develop appropriate corrective actions as described fully above.

As part of its extent of condition analysis, TVA examined M&TE for a two-year period to ensure that there was ample overlap of possible M&TE applications. TVA evaluated all OOTRs that were issued by the CLS facility during this period and found that in all cases there was no indication of affected or degraded safety-related equipment. Therefore, there was no safety significance associated with this event.

The M&TE program processes were evaluated and found to be effective. M&TE issues receive greater review in regular management meetings which provide for early identification of adverse trends.

#### **SEVERITY LEVEL ASSESSMENT**

TVA believes this violation should be classified as Level IV. This is based on consideration of TVA identification of the violation, prompt and comprehensive corrective action, lack of safety significance as described above, and the following additional information.

The violation was committed by an employee who filled a union-represented position. While he had considerable program responsibilities, he was not a first line supervisor and did not directly supervise any employees. As a result, he cannot reasonably be classified as a licensee official as described in the Enforcement Policy.

The violation, an isolated action of the employee, was committed without management involvement and was not a result of lack of management oversight. There was no history of willful violations by the employee, nor was there any lack of oversight or supervision of the employee. The circumstances surrounding this violation, including employment history and management oversight, are fully described in Enclosure 2 of this letter.

The employee who committed the violation resigned before disciplinary actions could be taken by TVA. Given the circumstances, it is reasonable to conclude that he expected to be terminated. Based on his actions, it is evident that the employee understood the seriousness of this behavior and expected that TVA would take strong disciplinary action. While TVA did not have the opportunity to take strong action and create a deterrent effect among other employees, the employee's response to immediately resign effectively sent the same message to other site employees.