

Exelon Generation Company, LLC  
Byron Station  
4450 North German Church Road  
Byron, IL 61010-9794

www.exeloncorp.com

September 16, 2005

United States Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, D.C. 20555

Byron Station Units 1 and 2  
Facility Operating License Nos. NPF-37 and NPF-66  
NRC Docket Nos. STN 50-454 and 50-455

Subject: Byron Station's Response to Two Apparent Violations, EA-05-159

References: (1) Letter from M. A. Satorius, (U. S. NRC), to C. M. Crane, (Exelon Generation Company, LLC), "Byron Station, Units 1 and 2, NRC Office of Investigations Report (OIT Case No. 3-2005-008)," dated August 18, 2005

(2) Byron Station Licensee Event Report 2005-001, "Failed Technical Specification Ventilation Surveillance Requirements During Surveillance Requirement 3.0.3 Delay Period"

Enclosed is the Exelon Generation Company, LLC, (EGC), response to two apparent violations, EA-05-159. EGC acknowledges that a system engineer willfully failed to perform Technical Specification ventilation surveillance tests. The enclosure contains our response including the reason for the apparent violations, the corrective actions that have been taken and the results achieved, the corrective actions that will be taken to avoid further violations and the date when full compliance will be achieved.

Should you have any questions concerning this letter, please contact Mr. William Grundmann at (815) 406-2800.

Respectfully,

*Stephen E. Kuczynski*

Stephen E. Kuczynski  
Site Vice President  
Byron Station

Enclosure

cc: Regional Administrator – NRC Region III  
NRC Senior Resident Inspection – Byron Station

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## ENCLOSURE

### RESPONSE TO TWO APPARENT VIOLATIONS, EA-05-159

#### APPARENT VIOLATIONS

On January 13, 2005, it was discovered that a ventilation system engineer had taken 17 ventilation surveillance tests to a completed status in the work management system without the surveillance tests being performed. The investigation identified that there was a total of 61 instances involving the same engineer where a work activity was taken to a completed status without documentation supporting the performance of the activity. Additionally, it was identified that the individual had forged signatures on 27 surveillance test procedures. These forgeries impacted 11 Technical Specification surveillance tests and 16 Non-Technical Specification surveillance tests. The actions of the ventilation system engineer had placed Exelon Generation Company, LLC in violation of Byron Station Technical Specification 5.5.11, "Ventilation Filter Testing Program," and 10CFR50.9, "Completeness and Accuracy of Information." The NRC's Office of Investigation determined that an individual "deliberately falsified surveillance procedures by forging signatures to work orders, and deliberately failed to provide complete and accurate information to the licensee."

#### REASON FOR APPARENT VIOLATIONS

The reason for the apparent violations was a willful violation of company procedures and policies by a non-licensed, non-supervisor management individual in the Plant Engineering Department.

#### CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

Upon discovery, an immediate extent of condition review was conducted which was followed promptly by a more comprehensive and systematic site level extent of condition investigation. This site wide extent of condition investigation included the Engineering, Maintenance, Operations, Chemistry, and Radiation Protection Departments. This extent of condition effort reviewed work activities within these departments from July 2004 through January 2005. A random selection process chose a statistically significant sample of the work activities within this period of time and reviewed those selected for possible falsification issues. This review consisted of 1262 work activity documents. No other instances of willful violations of procedures or policies were discovered. These investigations resulted in the conclusion that this issue was isolated to the one individual.

At the time of discovery, the individual was placed on administrative leave and his unescorted access status was immediately revoked pending a root cause investigation. Following an investigation of the circumstances, the individual's employment was terminated.

A review of all Technical Specification and non-Technical Specification surveillance tests performed by this individual was conducted and a Ventilation Surveillance Recovery Plan developed for those surveillance tests that were falsified or suspect. All Technical Specification Surveillance tests in this plan were re-performed by February 28, 2005. Those surveillance tests that failed this re-performance were reported in Licensee Event Report (LER) 454-2005-001, dated March 28, 2005.

As reported in the LER, the failures were not safety significant. All other non-technical specification surveillance tests have been completed except for those that require outage conditions. These are scheduled to be performed in the upcoming fall 2005 Unit 2 refuel outage.

In addition, a review of all work documents completed by this individual during his assignment to Plant Engineering was conducted. This included surveillance tests, post maintenance tests, system walkdowns, and corrective action tracking completion documents. All discrepancies identified in this review were entered into the corrective action program.

Considering the thorough extent of condition review, the termination of the individual, and the comprehensive recovery plan, we are confident that there are no additional 10CFR50.9 related concerns and that Byron Station is in compliance with the Technical Specification 5.5.11, "Ventilation Filter Testing Program."

### **CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS**

The contributing causes and associated corrective actions identified in the root cause evaluation for the missed surveillance testing will avoid further violations. These causes are associated with supervisory oversight, management and process controls, resource management, training and qualification and issue reporting. Corrective actions were identified and implemented to address these causes and are summarized below.

To improve supervisory oversight, the Site Engineering Director provided expectations for performing and documenting quality field observations to the Plant Engineering Department supervisors in a letter dated February 28, 2005. The Plant Engineering Manager monitors performance through routine management review meetings. The Engineering Director conducted leadership assessments on the Engineering Department supervisors and managers to identify gaps in performance and develop individual actions to improve leadership performance.

Additional management and process controls were established to monitor performance of surveillance tests. A site level policy was revised that requires First Line Supervisors to review completed surveillance test procedures. The policy addresses the requirements for the delegation of this responsibility in the event a supervisor is absent. The policy also established the requirement that completed work order tasks be reviewed and completed within five business days. The status of completed work order tasks are reviewed during weekly work management meetings as well as the daily Station Plan of the Day meetings.

To address resource management, the Site Engineering Director, in a February 28, 2005 letter, provided expectations to Plant Engineering Department Supervisors that improves alignment with their duties listed in the Conduct of Plant Engineering (COPE) Manual to allow for enhanced supervision. The Site Engineering Director has developed a change management strategy for planned personnel changes within the Engineering Department to allow continuity of knowledge and skills when there are new system assignments. The strategy is documented in a Byron Engineering Policy Memorandum. Engineering conducted an evaluation of existing knowledge and skill gaps due to personnel changes (e.g., transfers, retirements, insufficient turnover). Strategies have been developed to address these gaps.

All current system managers that did not have a completed task and position specific certification guide, or did not receive a turnover per the COPE Manual were evaluated to determine whether they have obtained the necessary system specific skills, knowledge and qualifications. A remedial plan was implemented for any gaps discovered during the evaluation.

The Engineering Director provided expectations in a letter dated February 28, 2005, relating to training and qualifications. These expectations included the following items:

- Specific training needs for individuals identified in the COPE Manual turnover checklist must be documented by the Supervisor;
- No individual shall be assigned work on independent activities without first being qualified, including having the appropriate training documentation completed; and
- The change management procedure (HU-AA-1101) must be utilized for personnel changes in the organization.

Appropriate disciplinary actions were taken with the individuals relating to poor issue reporting. This included individuals associated with the monitoring of the work order backlog to assure documentation of completed surveillances was conducted in a timely fashion.

The root cause evaluation contains other corrective actions associated with the event. These corrective actions are being tracked through the corrective action process as well.

#### **DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED**

Full compliance for actions associated with the root cause was achieved on February 11, 2005, when the individual's employment was terminated.

Full compliance with the Technical Specification surveillance testing as required by the Filter Testing Program was achieved on February 28, 2005.