

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401

400 Chestnut Street Tower II

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April 24, 1985

U.S. Nuclear Regulatory Commission
Region II
ATTN: Dr. J. Nelson Grace, Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Dear Dr. Grace:

BROWNS FERRY, SEQUOYAH, WATTS BAR, AND BELLEFONTE NUCLEAR PLANTS - NRC-OIE
REGION II INSPECTION REPORT NOS. 50-259/85-03, -260/85-03, -296/85-03,
-327/85-04, -328/85-04, -390/85-06, -391/85-06, -438/85-03, -439/85-03 -
RESPONSE TO VIOLATION

Enclosed is our response to your March 25, 1985 letter to
H. G. Parris which forwarded the subject inspection report for Browns Ferry,
Sequoyah, Watts Bar, and Bellefonte Nuclear Plants. The subject report cited
TVA with two Severity Level IV violations.

Your March 25, 1985 letter stated that NRC is concerned regarding the
implementation of TVA's quality assurance program and requested that we
describe those actions taken or planned to improve the effectiveness of the
program. TVA believes that the corrective actions described in the response
to Item 1 of the Notice of Violation will provide an effective resolution to
this lingering programmatic deficiency. In addition to those corrective
actions, the additional actions taken or planned to improve the effectiveness
of the quality assurance program are as follows.

- a. The recent reorganization of TVA's nuclear program will improve control and accountability for the achievement of quality in the workplace as an integral part of line management's responsibility. It provides a direct focus on the responsibilities of line management for timely and effective corrective actions as well as for prompt responses to quality assurance audit report findings.
- b. The establishment of the Division of Quality Assurance in TVA's Office of Nuclear Power will contribute to an improvement in quality performance and interactions with line management. Similar benefits will accrue from the activities of the Quality Management Staff in the Office of Engineering and the Quality Assurance Branch in the Office of Construction.
- c. The assignment of plant quality assurance staffs at each site under the functional direction of the site directors further emphasizes the concept of line management's responsibility for quality.

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Dr. J. Nelson Grace

April 21, 1985

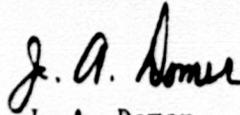
- d. The Office of Nuclear Power is also taking steps to ensure that quality assurance experience is considered a highly desirable qualification for selection to middle-level and higher technically oriented management positions and that demonstrated quality commitment is included as a goal in management appraisals.

If you have any questions, please get in touch with R. E. Alsup at FTS 858-2725.

To the best of my knowledge, I declare the statements contained herein are complete and true.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



J. A. Domer
Nuclear Engineer

Enclosure

cc (Enclosure):

Mr. James Taylor, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Records Center
Institute of Nuclear Power Operations
1100 Circle 75 Parkway, Suite 1500
Atlanta, Georgia 30339

ENCLOSURE
RESPONSE TO IE INSPECTION REPORT NOS.
50-259/85-03, -260/85-03, -296/85-03
50-327/85-04, -328/85-04
50-390/85-06, -391/85-06
50-438/85-03, -439/85-03
BROWNS FERRY, SEQUOYAH, WATTS BAR, AND BELLEFONTE
NUCLEAR PLANTS

RESPONSE TO ITEM NO. 1 OF NRC NOTICE OF VIOLATION

10 CFR 50, Appendix B, Criterion I, and the accepted QA Program (TVA-TR75-1A) collectively state that the licensee shall be responsible for the establishment and execution of the quality assurance program. TVA-TR75-1A, section 17.0.1, states that the Manager of Power and Engineering is responsible for establishing and ensuring effective execution of an overall, integrated program of plans and actions to assure that quality is achieved. 10 CFR 50, Appendix B, Criterion XVI, and TVA-TR75-1A collectively state that measures shall be established to assure that conditions adverse to quality are promptly corrected. TVA-TR75-1A, section 17.2.16, also states that adverse conditions are evaluated, reported to supervision, and corrected in a manner consistent with their safety.

Contrary to the above, an integrated program of plans and actions to assure that quality is achieved has not been effectively executed for certain conditions adverse to quality previously identified during various QA audits. (As indicated in the NRC inspection report, certain audit findings have been outstanding for several years without resolution of the identified problem. Also, the line organizations continue to have difficulty responding to QA audit findings within 30 days as stated in the accepted QA program description.)

This is a Severity Level IV violation (Supplement I). This programmatic problem applicable to the operating reactors is cited against Browns Ferry Docket Nos. 50-259, -260, and -296 and Sequoyah Docket Nos. 50-327 and -328.

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

TVA admits the violation occurred as stated.

2. REASONS FOR THE VIOLATION IF ADMITTED

The root cause of the violation is lack of management attention and action directed toward prompt correction of conditions adverse to quality. Specific causes that have contributed to the ongoing nature of the problem are:

- a. Failure of management to emphasize and establish priorities that are necessary to ensure prompt and effective correction of conditions adverse to quality.

- b. Failure of management to assign responsibility and establish accountability for prompt response to audit deviation reports and correction of the conditions adverse to quality identified therein.
- c. Failure to escalate problems to higher levels of management when conditions adverse to quality are not resolved in a timely manner.

3. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Information concerning the average age of audit deviations and other conditions adverse to quality as well as trends on corrective action timeliness are now reported and discussed monthly at the TVA Power and Engineering monthly top management meetings. Those meetings involve the Manager of Power and Engineering; the Managers of the Offices of Nuclear Power (MUC PR), Engineering (OE), and Construction (OC); the Director, Division of Quality Assurance (DQA); and other Power and Engineering managers.

An ongoing series of quarterly corrective action review meetings has been initiated between DQA management and each site director and key members of the respective plant staff. Corrective action plans and schedules are reviewed and agreements are reached on the need for improvements in plans and schedules and changes in corrective actions. The initial meeting with each site director as well as a meeting with the Division of Nuclear Services has been completed and the results have been productive in terms of improved commitment and performance.

The Division of Quality Assurance is continuing an aggressive audit deviation follow-up emphasis. As of mid-December 1984, this follow-up and the cooperation of key people at the plant sites had resulted in a significant reduction in the backlog of unverified and incomplete corrective actions. This resulted in closure of 252 deviations since mid-February 1984 when special follow-up emphasis was initially begun. At that time, there were 212 open deviations, 99 of which were more than one year old. At the end of 1984, the net number of open deviations was 148 and 64 of these were very recent deviations that were opened since October 1; the number that was more than one year old had been reduced to 39.

Since January 1985, the number of audit deviations that were more than one year old has been reduced from 39 to 27, and several of the remaining 27 are currently being evaluated and the effectiveness of corrective actions that have been completed are being verified.

The importance of timely responses to audit deviations within 30 days has been stressed at the DQA/site director meetings where line management has been briefed on TVA's needed improvement in meeting the 30-day requirement for responding to audit reports.

The Division of Quality Assurance has revised and issued a Division of Quality Assurance Instruction (DQAI-313) to establish definitive criteria for escalating problems to the attention of successively higher levels of management to ensure that corrective action issues are promptly and effectively resolved. Also Quality Bulletin 85-02, which was issued to all site- and division-level management within NUC PR, provided an analysis of the corrective action problem and recommended actions for resolution.

4. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The Manager, NUC PR, has supplemented his quality assurance policy statement to further emphasize corrective action performance and eliminate the root causes that were identified in section 2 above. The Manager, NUC PR, will continue to review the monthly top management reports and participate in monthly top management meetings that include a status of corrective action performance and trends. Management attention, priorities, and resources will be applied as necessary to resolve lingering problems.

NUC PR site directors and division directors have established fiscal year performance goals related to quality problem resolution and audit response timeliness.

The Director, Division of Quality Assurance, will ensure the continuation of regular corrective action status review meetings with each major program participant and that conditions adverse to quality are escalated to successively higher levels of management when necessary to cause prompt and effective resolution of problems. The new revision of DQAI-313 establishes the criteria needed for such escalation.

5. THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The actions described in sections 3 and 4 above have all been initiated and are either completed or, by their nature, ongoing. Some improvement in corrective action activities has already been achieved and further significant progress will occur as a result of the actions taken. Also by June 1, 1985, line organizations will have the necessary management controls in place to assure that responses to QA audit findings are completed no later than 30 days from the date of receipt.

RESPONSE TO ITEM NO. 2 OF NRC NOTICE OF VIOLATION

10 CFR 50, Appendix B, Criterion XVIII, and the accepted QA program (TVA-TR75-1A), section 17.1.18, collectively require a comprehensive system of planned and periodic audits to verify compliance with all aspects of the QA program. Table 17D-2 of the QA program endorses Regulatory Guide 1.144 and ANSI N45.2.12-1977, Requirements for Auditing of Quality Assurance Program for Nuclear Power Plants. Position C.3.a(2) of this guide requires auditing applicable design elements of an organization's QA program at least annually or at least once within the life of the activity, whichever is shorter.

Contrary to the above, annual audits of all applicable design elements of TVA's QA program were not conducted during 1984 nor were all applicable design elements scheduled for auditing during 1985. Elements which were not included in the design audit program were onsite design groups and all Engineering Project disciplines.

This is a Severity Level IV violation (Supplement II). This programmatic problem applicable to design activities is cited against Watts Bar Docket Nos. 50-390 and -391 and Bellefonte Docket Nos. 50-438 and -439.

1. ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

TVA admits the violation.

2. REASONS FOR THE VIOLATION IF ADMITTED

The Office of Engineering's (OE) interpretation of applicable design elements of TVA's quality assurance program for design was to the branch/project organizational levels. Audits that were originally scheduled for 1985 were based upon the OE interpretation that design branches/projects were the applicable design elements. Under the original FY 1985 audit schedule the audit of each discipline branch was to consist of audits of the branch central staff and one or two of the discipline project engineer groups assigned to a particular nuclear project. The violation is based on requiring a further breakdown of these organizational elements (branch/project) into their respective group/staff/project engineer levels and requiring an audit of each central staff and every discipline project engineer staff.

3. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The following corrective actions have been taken:

- a. An audit plan was issued on March 8, 1985, to address the applicable design elements as stated in the violation. The audit program now covers each OE organizational element to the group/staff/project engineer level and will provide audits on a fiscal year basis. There are a total of 47 organizational elements at this level.

Audit schedules are now being issued quarterly and the second quarter schedule was issued concurrently with the audit plan on March 8. The third quarter fiscal 1985 schedule was issued on March 28, 1985, and contains 15 audits. The fourth quarter audit schedule will cover the remaining organizational elements for fiscal year 1985. By September 30, 1985, all OE organizational elements down to the group/staff/project engineer level will have been audited.

- b. Conducted audit of the two Civil Engineering Branch pipe analysis and pipe support sections located onsite at Watts Bar and Bellefonte Nuclear Plants. Audit completed and report issued on March 28, 1985.

4. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The corrective action taken in step 3 will avoid further violations.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The program was in full compliance on April 1, 1985. The full audit cycle for fiscal year 1985 will be complete September 30, 1985.

6. ADDITIONAL INFORMATION FOR CLARIFICATION OF REPORT DETAILS

Section 6, paragraph 4, page 6, states: "The QPG is essentially responsible for OE methodology and issues and controls procedures." It should read, "The QPG is essentially responsible for the inprocess review/audit of OE methodology and the review of procedures, issued and controlled by the Engineering and Computer Methods Branch (ECB) of OE."