TENNESSEE VALLEY AUTHORITY
CHATTANOOGA, TENNESSEE 37401
400 Chestnut Street Tower II

July 6, 1981

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Region II - Suite 3100
101 Marietta Street
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

In R. C. Lewis' March 18, 1981 letter to H. G. Parris, which transmitted Inspection Report Nos. 50-259/81-02, -260/81-02, -296/81-02 for Browns Ferry Nuclear Plant, NRC expressed concerns regarding the implementation of our quality assurance program. We have completed our review of this program, and the results of our investigations are enclosed. If you have any questions, please call Jim Domer at FTS 857-2014.

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

Very truly yours,

TENNESSEE VALLEY AUTHORITY

L. M. Mills, Manager
Nuclear Regulation and Safety

Enclosure

ENCLOSURE
EVALUATION OF QUALITY ASSURANCE PROGRAM
OFFICE OF INSPECTION AND ENFORCEMENT INSPECTION REPORT NOS.
50-259/81-02, 50-260/81-02, 50-296/81-02
BROWNS FERRY NUCLEAR PLANT

NRC concerns in NRC Inspection Report Nos. 50-259, 260, 296/81-02 "about the implementation of quality assurance program that permitted their occurrence," and to "...describe in particular those actions taken or planned to improve the effectiveness of your quality assurance program," required detailed analysis. The analysis was conducted as follows:

1. Categorize the violations cited to determine if program deficiencies exist.

2. Review other occurrences to determine whether a substantial number could be placed into these same categories, thereby supporting or denying a program deficiency exists.

3. Determine what corrective actions could be applied to improve the effectiveness of the QA programs if deficiencies exist.

Categorization of Violations

We have identified two general categories into which several of the items from this report can be grouped. A review of other occurrences supports this categorization. Some items are random failures which will occur in any system. These two categories are identified as 1) Commitment Control and 2) Personnel Error. These are defined as follows:

Commitment Control--A lack of necessary procedures to track and close out open items; to ensure routine activities are completed in a timely manner; or to ensure that regulatory requirements and commitments are identified and met.

Personnel Error--Personnel failure to complete assignments with the attention to detail required; personnel failing to take required initiative to correct recognized problems; or failure to understand assigned responsibilities.

Our analysis of the violations and deviations from the inspection report are classified into these two categories as follows:

Commitment Control

Violations B, C.2, C.3, E.1, and E.3 along with Deviations A and B were caused by lack of commitment control.

Violation B and Deviations A and B may be attributed to the lack of a disciplined system to identify open items and commitments for tracking, completion, and closure.

Violations C.2 and C.3 may be attributed to lack of a positive means to ensure attendance at these training courses.

Violation E.1 occurred because periodic review of all instructions to ensure that new requirements and policies are incorporated into all appropriate instructions has not been a requirement.

Item E.3 regarding possible use of outdated revisions of drawings had been recognized and identified but resolution had not been given priority.

Personnel Error

Violations A, C.1, and D can be classified personnel error.

Violation A occurred because an experienced engineer, who has been responsible for the relief valve testing program for some time, overlooked an instruction requirement. The individual was aware of this requirement, as he had addressed it satisfactorily in the past.

Violation C.1 is a citation against two different organizations, operations and outage. The individual in operations responsible for the task was maintaining records in accordance with a verbal agreement with his supervisor and plant management. This system in and of itself was, and still is, adequate to document this training. The violation resulted from this agreement not being documented in the standard practice. The individual in outage responsible for documenting training is a clerk who also handles a number of other personnel activities. All training was documented and available but had not been transferred to a master training record as required by the standard practice.

Violation D occurred because the individual responsible for assembling the report was not aware of the 10 CFR 50.59 requirement until it was identified by TVA auditors.

Other Occurrences

A number of other occurrences identified by NRC or TVA auditors over the past year have been reviewed; a significant number of which can be placed in the above two categories.

Corrective Actions

We continue to ask the question, "Should the QA program have identified these problems?" We believe that, had a commitment control program been in effect, we could reasonably expect Violations A, B, C.1, C.2, C.3, and E.1 to have been identified or prevented.

The other violations in the report were either of a nature that an onsite staff would not have been investigating the area (Violations D, E.2), or inadequate guidelines to survey against would have existed (Violation E.3).

The following actions have been or are to be taken:

1. A compliance staff has been established. At this time, the staff has the responsibility to track and close out regulatory and internal TVA commitments.

2. Realign the plant QA Staff to separate the quality assurance and quality control functions, to better implement and improve each through more managerial control and attention.

4. Implement a management action tracking system to provide additional assurance that assignments are tracked and completed in a timely manner. This system has been in place for some time, although not rigidly disciplined.

5. Require plant management to spend more time in independent observation of plant activities.

6. Publish an administrative procedure describing the NRC enforcement policy and potential violation areas.

7. In no cases will the individual directly responsible for performing a task also perform a second level review.

8. Personnel errors will be taken into account in preparing service reviews and in promotional considerations.

9. Willful violations of either license requirements, NRC commitments, or plant procedures will be reviewed by supervisors to determine the need for disciplinary actions.

10. Issue periodic memorandums to all plant personnel encouraging their initiative in identifying problems. At least two avenues will be identified to follow to assure adequate attention.

11. Review and revise where necessary the scope of our General Employee and Specialized Training programs. This includes an ongoing program of position-task analysis which will identify the training necessary for various plant positions.

12. Issue a periodic memorandum to all plant employees emphasizing the need for adherence to plant procedures as written.

Conclusions

Although not all occurrences reviewed fit into these two categories, the significant number which did lead us to believe that a program deficiency did exist in commitment control.

The review of these incidents shows that primarily a lack of documentation existed to prove an activity had been performed. In the majority of cases the activity had in fact been done in a timely manner.