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ZERINGUE,O.J. Tennessee Valley Authority
RECIP.NAME RECIPIENT AFFILIATION
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SUBJECT: Responds to NRC 920501 ltr re violations noted in Insp Repts 50-259/92-11,50-260/92-11 & 50-296/92-11 on 920314-0417. Corrective actions:plan developed to relocate independent verification steps & unapproved chart papers removed.

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

O. J. "Ike" Zeringue
Vice President, Browns Ferry Operations

JUN 01 1992

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

Gentlemen:

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

BROWNS FERRY NUCLEAR PLANT (BFN) - NRC INSPECTION REPORT 50-259, 260, 296/92-11 - REPLY TO NOTICE OF VIOLATION (NOV)

This letter provides TVA's reply to the NOV transmitted by letter from B. A. Wilson to M. O. Medford dated May 1, 1992. In this letter, NRC cited TVA with two violations. The first violation involving two examples for failure to perform independent verification. The second violation involves one example for ineffective corrective action on a previous violation involving a radiation monitor recorder.

Enclosure 1 to this letter is TVA's "Reply to the Notice of Violation" (10 CFR 2.201). A listing of commitments made in this letter is provided by Enclosure 2.

If you have any questions regarding this response, please telephone Raul R. Baron at (205) 729-7566.

Sincerely,

O. J. Zeringue

Enclosures
cc: See page 2

IE01
1/1

U.S. Nuclear Regulatory Commission

JUN 01 1992

Enclosures
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ENCLOSURE 1

TENNESSEE VALLEY AUTHORITY

Browns Ferry Nuclear Plant (BFN)

Reply to Notice of Violation (NOV)

Inspection Report Number

50-259, 260, 296/92-11

VIOLATION A

During the Nuclear Regulatory Commission (NRC) inspection conducted on March 14-April 17, 1992, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1991), the violations are listed below:

A. Technical Specification (TS) Section 6.8.1, Procedures, requires that written procedures shall be established, implemented and maintained covering surveillance and test activities of safety-related equipment.

Site Standard Practice 12.6, Independent Verification, designates the minimum requirements for independent verification as all valves, breakers, and other components in safety related systems where an inappropriate positioning could adversely affect system operation. Included is fire protection systems including water supply necessary for the system to function and supply the extinguishing media to the fire.

Site Standard Practice 12.1, Conduct of Operations, requires that procedures which are not routine, frequently performed (once per shift), and easily accomplished be performed "step by step."

Contrary to the above, these requirements were not met for the following two examples:

1. On April 15, 1992, an NRC inspector identified during the performance of surveillance O-S1-4.11.B.2.a, Diesel Driven Fire Pump Operability Test, that independent verification steps in the body of the instruction were not performed "step by step," as required by SSP-12.1. The verification steps were performed after completion of the test although steps such as checking that the engine air breather was properly installed prior to operating the engine were in the body of the procedure.

2. On February 25, 1992, the requirements were not met in that during the performance of surveillance instruction 2-SI-4.2.C-8FT, independent verification was not performed as required by SSP-12.6 for steps 7.13, 7.14, and 7.23. This resulted in a pressure transmitter isolation valve for turbine first stage pressure, remaining closed for six days following completion of the surveillance testing. This problem was identified when the rod sequence control system required by T.S.3.3.B.3.a below 20 percent power was still active after increasing power above 30 percent.

This is a repeat Severity Level IV Violation (Supplement 1) applicable to all three units.

VIOLATION B

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires that measures shall be established to assure that conditions adverse to quality are properly identified and corrected.

Contrary to the above, on April 9, 1992, an NRC inspector identified incorrect chart paper in two control room recorders for high range containment radiation levels required by Technical Specification Table 3.2.F. The same finding of incorrect chart paper had been identified by an NRC inspector on May 24, 1991, as part of Violation 260/91-24-01. This problem was identified after the licensee presented the previous violation for closure.

This is a Severity Level IV Violation (Supplement 1) applicable to Unit 2.

TVA'S REPLY TO VIOLATION A

1. Reason for the Violation

   a. Failure to Perform Independent Verification During Diesel Driven Fire Pump Operability Test

      The reason for this example is inconsistent performance of independent verification. Specifically, inconsistencies have been identified relating to what point in a procedure independent verification is required to be performed. Questions raised by NRC through this example have lead TVA to revaluate how independent verification is conducted at BFN.

The requirements for independent verification are established in Site Standard Practice (SSP)-12.6 Independent Verification. Paragraph 2.2 of SSP-12.6 states that independent verification is an act of checking a condition at a different time and physically separate from an independent work activity by a qualified individual not involved in that work activity. The independent verification confirms that the activity has been implemented in conformance with specified requirements and that the affected system has been returned to standby. Paragraph 3.1.8.A, requires that the Independent Verification be conducted physically separate and at a different time from the activity/manipulation initially performed. SSP-12.1, Conduct of Operations, which provides requirements, guidelines, and instructions for the conduct of operations, states that procedures which are not routine, frequently performed (once per shift) and easily accomplished, be performed "step by step."

In this example, Surveillance Instruction (SI), 0-SI-4.11.B.2.a, Diesel Driven Fire Pump Operability Test, all of the procedural steps (Section 7.0) were completed in the order written without performing the required independent verifications. Then, after the procedural steps were completed, a different qualified individual was dispatched to perform the independent verification steps contained within the body of the procedure.

It is TVA's position that even though the independent verifications were not performed during the performance of Section 7.0 of the SI, the physical manipulations required to complete the instruction were performed in the order written as required by SSP-12.1 Furthermore, performing the independent verifications after completion of Section 7.0 was within the scope of SSP-12.6, that is, physically separate and at a different time from the activity/manipulation.

b. Failure to Open a Valve and Perform Independent Verification

This example was a result of an inappropriate personnel action. The individual charged with the task of performing an independent verification failed to do so.

The requirements for independent verification as established in SSP-12.6 state, to ensure the integrity of the independent verification process, the person performing the independent verification shall not rely on the observed actions of the individual performing the initial alignment, installation, position, or condition. The verifier shall be a qualified person not involved in the work activity.

On February 25, 1992, during performance of 2-SI-4.2.8.2.cFT, Instrumentation that Initiates Rod Block Rod Sequence Control System Restraint Functional Test, an individual performing an independent verification failed to follow the procedural requirements. As noted in the NRC Inspection Report the individual that signed the independent verification observed the action of an individual located within the contamination zone and did not physically verify the action. Furthermore, the individual responsible for the independent verification was a member of the crew performing the work activity.

2. Corrective Steps Taken and Results Achieved

a. Failure to Perform Independent Verification During Diesel Driven Fire Pump Operability Test

TVA has revaluated its program for independent verification and found that procedures do not meet the intent of SSP-12.6. That is, procedures with the independent verification steps located within Section 7 cannot be performed at a different time and physically separate from an independent work activity by personnel not involved in its activity without impacting performance of the procedures. TVA has developed a plan to relocate independent verification steps that are not necessary to prevent detrimental equipment operation to a data sheet. The data sheet will be completed by a qualified individual not involved in the work activity as required by SSP-12.6.

b. Failure to Open a Valve and Perform Independent Verification

The individuals involved in this violation of procedures received personnel corrective action in accordance with TVA personnel policy.

3. Corrective Steps That [Have Been or] Will be Taken to Avoid Further Violations

a. Failure to Perform Independent Verification During Diesel Driven Fire Pump Test

TVA will perform a review of SIs and those that do not meet the intent of SSP-12.6 will be revised.

b. Failure to Open a Valve and Perform Independent Verification

No additional corrective actions are required.

4. Date When Full Compliance Will Be Achieved

a. Failure to Perform Independent Verification During Diesel Driven Fire Pump Test

TVA will implement corrective actions by September 30, 1992.

b. Failure to Open a Valve and Perform Independent Verification

No additional corrective actions are required.

TVA'S REPLY TO VIOLATION B

1. Reason for the Violation

This violation was a result of an inappropriate personnel action. A Unit Operator (UO) was inattentive to details when obtaining replacement chart paper for the Unit 2 Primary Containment Radiation Monitor Recorder.

Contributing to this event was the labeling of the chart paper bin. In response to NRC Inspection Report 91-24, TVA revised the chart paper operator aid, the label on the recorder was corrected, and controlled drawing was issued. These corrective actions were implemented by January 15, 1992. However, the label on the chart paper bin was not revised. This allowed storage of both the approved and unapproved chart papers in the same bin. In this event, the UO that changed the chart paper, withdrew the incorrect chart paper from the bin and installed it in the recorder.

2. Corrective Steps Taken and Results Achieved

TVA has removed the unapproved chart papers from the chart paper bin in the control room. Furthermore, since the unapproved papers are no longer required at BFN, they have been removed from the warehouse. Finally, the chart paper bin label was revised to reflect only the chart paper referenced on the operator aid and the controlled drawing.

3. Corrective Steps That [have been or] Will be Taken to Avoid Further Violations

TVA considers that full compliance has been achieved for this example.

4. Date When Full Compliance Will be Achieved

No additional corrective actions are required.

ENCLOSURE 2

Listing of Commitments for Violation A

1. TVA will perform a review of SIs, and those that do not meet the intent of SSP-12.6 will be revised. This will be completed by September 30, 1992.