VISTRA ENERGY

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TXX-18075

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

11/14/2018

SUBJECT: Comanche Peak Nuclear Power Plant (CPNPP) Units 1 and 2
Docket Nos. 50-445 and 50-446
Response to Apparent Violation in NRC Inspection Report 05000445/2018011; 050004462018011; EA-18-064

Reference Letter dated October 4, 2018 from Anton Vegel, Director Division of Reactor Projects, NRC to Ken J. Peters, Senior Vice President and Chief Nuclear Officer, Vistra Operations Company LLC, "Comanche Peak Nuclear Power Plant, Units 1 and 2 – NRC Inspection Report 05000445/2018011; 05000446/2018011 and NRC Investigation Report 4-2017-030

Dear Sir or Madam:

This letter provides the Vistra Operations Company LLC ("Vistra OpCo") response to the apparent violation contained in the above referenced letter. The referenced letter provided the option to respond in writing to the apparent violation, request a predecisional enforcement conference (PEC), or request alternate dispute resolution (ADR). The attachment provides Vistra OpCo's response to the apparent violation. Additional information relative to the application of the Enforcement Policy is provided at the end of the attachment for your consideration.

Corrective actions identified in the attachment will be tracked and implemented in accordance with the Comanche Peak Corrective Action Program. On November 1, 2018, approval was obtained from the NRC staff to extend the response deadline until November 15, 2018.

IE01

There are no new commitments in this letter.

Should you have any questions, please contact Jack C. Hicks at (254) 897-6725 or jack.hicks@luminant.com.

RGN-IV

Sincerely,

Thomas P. McCool

Attachment Response to Apparent Violation Regarding Failure to Maintain a Quality Record Complete and Accurate in All Material Respects

c - Kriss Kennedy, Region IV
Mark Haire, Region IV
Margaret Watford O'Banion, NRR
Resident Inspectors, Comanche Peak

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Restatement of Violation:

The inspectors identified an apparent violation of 10 CFR 50.9, in that the licensee appears to have failed to maintain information required by the Commission's regulations that was complete and accurate in all material respects. Specifically, following equipment manipulation and an unanticipated loss of inventory in a portion of the reactor coolant system, the licensee appears to have failed to maintain complete and accurate information in condition report CR-2017-005788 relative to the cause of the loss of inventory event and the identified condition adverse to quality in the corrective action program.

Reason for the Apparent Violation:

On April 28, 2017, following an attempt to fill the refueling water storage tank (RWST) that resulted in a lowering level in the volume control tank (VCT), a licensed reactor operator (RO) admitted that he provided incomplete or inaccurate information to licensee personnel on a number of occasions. Specifically, the RO stated that after he realized that valve 2-FCV-110B, reactor coolant system makeup to charging pump suction isolation valve, was not aligned properly he repositioned the valve control switch and did not alert the control room, and when others assumed the valve must be leaking by he did not correct them. After some troubleshooting by Operations and continued questions related to plant conditions, the RO admitted that he knowingly submitted a written statement where he indicated inaccurately that the valve had been closed and reported the same in Condition Report CR-2017-005788 that he drafted, which was not accurate.

Corrective Steps That Have Been Taken and Results Achieved:

1. The following actions were taken after the falsification of the condition report was discovered:
    - The individual's plant access was restricted.
    - The NRC Resident Inspector was notified.
    - The individual was subsequently terminated and PADS appropriately updated.

2. May 16th, 2017 - Communication from the Plant Manager was disseminated to the Operations Department regarding the event and subsequent termination including:
    - Vistra OpCo is committed to upholding its Code of Conduct.
    - Violations of the Code may result in disciplinary action up to and including termination.
    - Employees participating in a Company investigation must provide full and accurate disclosure of relevant information at the outset. The failure to do so may result in disciplinary action up to and including termination.
    - All employees must be trustworthy and reliable in order to work at Comanche Peak.

3. May 17-20, 2017 – Conducted Operations Departmental and Shift crew discussions about the event on both DAYS and NIGHTS led by Director of Operations, Shift Operations Manager and all Shift managers, with an emphasis on procedure adherence and trustworthiness.

4. June 26, 2017 (Personal Choices and Actions/Safety Culture) & November 13, 2017 (Code of Conduct) – Presented Leadership and Alignment presentation on Personal Choices and Actions to CPNPP Leaders. This communicated the efforts that should be taken by Leaders and personnel on site to ensure Behaviors, Performance and Safety remain at the forefront. This included a focus on communications and challenging the organization in addressing low-level errors with the ultimate goal of preventing events.

5. August 2017: Completed a Human Performance training session during Operator Training cycle 17-3, which included Licensed and non-Licensed operators. The Instructor and Shift Managers reemphasized the importance of procedure adherence and ensuring that event facts are documented accurately when issues occur to assist in recreation if necessary and accurate problem identification can be completed.

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6. Multiple Operations Shift Orders (ex. Feb 2018, Apr 2018, and May 2018) contain examples of Operating Experience (OE) from other sites being assessed by the NRC as violations concerning falsification of logs and rounds. The Shift Order is an Operations Department weekly communication that is covered during shift turnover and crew meetings.

7. March 2018 - The 2018 Nuclear Safety Culture Survey was completed; the survey identified the following observations of CPNPP personnel:
   - Personal Accountability: PA.1 & PA.2
     Adherence to Nuclear Standards is prevalent across site
     Individuals take personal responsibility for safety
     Individuals hold themselves accountable to standards
     Individuals stop and collaborate with peers or leaders when questions arise
   - Decision Making: DM.1, DM.2, & DM.3
     Individuals stated supervisors consistently reinforce the expectations for conservative bias
     Employees are willing to stop when unsure
     Employees work with others to understand risks before proceeding

8. October 15,2018: Site Memo from Ken Peters, Senior Vice President & Chief Nuclear Officer, to all CPNPP Luminant Employees concerning the Proposed NRC Violation stated:
   - Disciplinary action was taken against the individual specifically related to the inaccurate portrayal of the error, not the error itself.
   - Integrity is a core principle of Vistra...the foundation of all that we do (Vistra Code of Conduct)
   - Employees are expected to...maintain books and records...accurately, fairly and completely (Vistra Code of Conduct)
   - Information provided...or...maintained shall be complete and accurate in all material respects (Code of Federal Regulations 10 CFR 50.9)
   - The Code of Conduct provides some specific examples of where failure to comply may be subject to discipline, up to and including termination. One such example stated is: Failure to fully cooperate in an investigation, including withholding information or giving misleading information.
   - A key human performance tool is the "stop when unsure" or if you're feeling overwhelmed by the situation – this is not only our expectation, but your right as a conscientious worker. No one will ever be penalized for this behavior exercised in good faith.

9. All CPNPP Luminant employees are required to complete Vistra Code of Conduct training annually, typically in the September-November timeframe.

10. October 15-25, 2018: An Organizational Effectiveness Investigation was conducted. Twenty three (23) licensed operators were interviewed including at least one person from each crew. No organizational or cultural drivers were identified that in 2017 or today would lead an individual to falsify a record and make false statements to the control room staff. In addition, the following insights were revealed:
    - Senior Reactor Operator oversight of Reactor Operator activities during a refueling outage is not considered less than at steady-state power operation and work activities scheduled during outages are not considered excessive for available staffing.
    - Work activities on April 27, 2017 were not considered excessive based on review of the control room logs and interviews with the control room staff present on that day.
    - Requests for help or peer checks are and would have been readily accepted and if necessary work would be or would have been halted until the help or peer check could be made available.

11. Condition Report CR-2017-005788 was updated on October 30, 2018 with the condition description section clarified as follows: "Additional Information: Valve misalignment was the cause of the lowering VCT level. Reference CR-2018-006118."

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Corrective Steps That Will Be Taken:

1. Brief the following items with current licensed operators by **December 7, 2018**:
   - Using the actual copy of a "Part 55 license" (letter to individual), include discussion about what is meant by condition of license.
   - Vistra Code of Conduct for individual integrity
   - 50.5 and 50.9 Regulations and discuss the meaning
   - CNO letter to describe the 50.9 event including expectation to stop when uncertain

2. Develop training package for 10CFR50.5, Deliberate Misconduct, and 10CFR50.9, Completeness and Accuracy of Information, training for licensed operators (initial and continuing).

3. Develop training on falsification issue, using a case study. The training will focus on the importance of self-reporting errors, the importance of stopping when uncertain, following procedures, and deterring individuals from concealing mistakes. We will provide this training to the licensed and non-licensed operators.

4. Discuss 10CFR50.5 and 10CFR50.9 during the 2019 SOER 10-2, "Engaged, Thinking Organization", training to the management team.

5. Add a requirement to the Qualification Card for licensed Reactor Operators and Senior Reactor Operators to review the Roles and Responsibilities of their individual Licenses with the Site Vice President.

Date When Full Compliance with be Achieved:

Full compliance was achieved by Vistra OpCo on October 30, 2018.
The additional corrective actions identified above will be completed by July 31, 2019.

Additional Information for Consideration:

With appropriate consideration of the Enforcement Policy, this issue should not be treated as an escalated enforcement item for the following reasons:

NRC Enforcement Policy-Section 2.3.2.a.4 states "The violation must not be willful. Notwithstanding willfulness, an NCV may still be appropriate in the following circumstances:

(a) The licensee identified the violation and promptly provided the information concerning the violation, to appropriate personnel.
   - The actions of this Reactor Operator were identified by Vistra OpCo Operations personnel during post event investigation by the Shifts and Operations Staff; Vistra OpCo promptly informed the NRC of both the event and the causes when identified.

(b) The violation involves the acts of an individual in a low-level position within the licensee's organization (and not a licensee official).
   - The Reactor Operator involved in this issue was a member of the bargaining unit under the supervision of a Unit Supervisor and Shift Manager and did not have supervisory responsibilities warranting escalation of the violation in this case. The definition of a licensee official applied in the Enforcement Policy is extremely broad, extending to the Site Vice President, and would not appear appropriate to this factual situation.

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(c) The violation appears to be the isolated action of the employee without management oversight.

- The issue was isolated to the individual reactor operator and his personal actions. He knowingly obscured his actions from Vistra OpCo management during the Company's investigation. The individual had no prior history of deliberate misconduct putting management on notice of this possible event.
- The actions of the Reactor Operator (initial and subsequent) though unacceptable, were of very low significance from a nuclear safety perspective. Operations personnel acted promptly to control and restore VCT level control.

(d) The licensee took significant remedial action.

- As stated above in the "Corrective Steps That Have Been Taken and Results Achieved", significant corrective steps related to completeness and accuracy of Company records already have been taken for this action. These include not only individual-related disciplinary and PADS actions, but also prompt communications on related standards to the operating crews followed by communications to the site leaders.

Even if the NRC concludes that escalated enforcement is warranted under the Enforcement Policy, no civil penalty is appropriate for the following reasons:

NRC Enforcement Policy-Section 2.3.4, civil penalty assessment process consideration;

(a) Did the licensee have any previous escalated enforcement action within the previous 2 years?

- CPNPP has had no Severity Level I II, or III violations since 1996 as documented on the NRC website under "Escalated Enforcement Actions Issued to Reactor Licensees".

(b) Should the licensee be given credit for actions related to identification of the violation?

- The inaccurate condition report, CR-2017-005788, while initiated on 04-27-17, did not go through the complete review process until 05-04-17. It was recognized on 04-29-17 as an HU (human performance) error, and no further action was taken with respect to plant equipment. Vistra OpCo's comprehensive investigation actions prevented reliance on inaccurate information. Personnel disciplinary actions were conducted appropriately outside of the Corrective Action Program.
- The actions of this reactor operator were identified by Vistra OpCo and promptly communicated to the NRC.

(c) Were the licensee's corrective actions prompt and comprehensive?

- The corrective actions taken both to the event and to the failure to disclose, including the inaccurate CR, were prompt and comprehensive.
- Extensive ongoing corrective actions, which include items to address any potential cultural issues, are being taken to prevent recurrence. This included actions based on additional insights gained on this event from the NRC Inspection Report.