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SEP 04 1992

Docket Nos. 50-259, 50-260, 50-296
License Nos. DPR-33, DPR-52, DPR-68

Tennessee Valley Authority
ATTN: Dr. Mark O. Medford, Vice President
Nuclear Assurance, Licensing & Fuels
3B Lookout Place
1101 Market Street
Chattanooga, TN 37402-2801

Gentlemen:

SUBJECT: MEETING SUMMARY - BROWNS FERRY NUCLEAR PLANT SALP COMMENTS

This refers to the meeting conducted at your request at your Browns Ferry Nuclear Plant August 24, 1992. The purpose of the meeting was to discuss the Browns Ferry SALP.

It is our opinion that this meeting was beneficial to us in aiding our understanding of your comments.

In accordance with section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

Should you have any questions concerning this matter, please contact us.

Sincerely,

**Original Signed By
BRUCE A. WILSON**

Bruce A. Wilson, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Enclosures:

- 1. Meeting Attendees
- 2. Licensee Handout

cc w/encls: (See page 2)

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Tennessee Valley Authority

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ENCLOSURE 1

Meeting Attendees

NRC

F. J. Hebdon, Director, Project Directorate II-4, Office of Nuclear Reactor Regulation (NRR)
P. J. Kellogg, Chief, Reactor Projects Section 4A, Division of Reactor Projects (DRP), Region II
C. Patterson, Senior Resident Inspector, Browns Ferry
T. M. Ross, Senior Licensing Project Manager, NRR

IVA

O. J. Zeringue, Vice President, Browns Ferry Operations
J. A. Scalice, Plant Manager
R. R. Baron, Manager of Site Licensing
J. R. Rupert, Manager, Engineering and Modifications
G. D. Pierce, Licensing Engineer

Tennessee Valley Authority (TVA)

Browns Ferry Nuclear Plant (BFN)

Recommended Changes to SALP Report

Inspection Report

50-259, 260 and 296/92-18

I. PLANT OPERATIONS

- A. On page 5, beginning on line 4 of the fourth paragraph, the report states that labeling problems resulted in two violations, one of which involved an auxiliary plant operator pulling the wrong fuses during a routine tagout.

TVA's December 23, 1991, response to these violation stated that this event was caused by inadequate training. Additionally, neither the inspection report nor the notice of violation that document this incident raises plant labeling as a causal or contributing factor; rather, the subject of the violation is failure to follow procedures.

With respect to the pulling of fuses, as discussed in TVA's response to this violation, in this incident at no time were fuses physically pulled or removed from their fuse holders. Instead, the equipment actuations occurred when the compartment door was opened. This is due to the configuration of the door (opening the door electrically disconnects the fuses).

TVA suggests that this latter example be deleted, and suggests the report be revised as follows:

"Labeling problems resulted in one violation. A drywell blower breaker was found labeled on two different electrical boards. One of the locations was a spare. [Delete next sentence.]"

- B. On page 6, beginning on line 11 of the first paragraph, the report discusses a fire watch that was not maintained after fire wrap was removed from operable residual heat removal service water pump power cables in the intake structure. The report states that although this activity was performed by Unit 3 personnel, "a contributing factor to this problem was separate operations work control centers for Unit 3 and Unit 2."

NRC Inspection Report 91-26, dated September 11, 1991, documented this event and cited it as a violation. TVA's October 9, 1991, response to the violation TVA stated that this event was caused by management's failure to ensure that Unit 3 planning and implementation of work was in full compliance with site procedures. TVA's response also identified inadequate verbal communications and management's failure to ensure the existence of a complete training matrix for certain personnel that identified training needed to adequately perform a particular function as contributing factors. Additionally, neither the inspection report nor the notice of violation discuss separate operations work control centers as a contributing factor.

TVA suggests that discussion of the separate operations work control centers be deleted from the report.

II. RADIOLOGICAL CONTROLS

TVA has no comments in this area.

III. MAINTENANCE/SURVEILLANCE

On page 10, beginning on line 1 of the third full paragraph, the report states that actions taken to correct equipment and procedural deficiencies were not always effective. As an example, the report cites trouble shooting activities to correct excessive fluctuation in recirculation flow. The NRC concludes that TVA's troubleshooting activities were not always effective because the majority of these activities were directed at the electrical/electronic control system, even though the probable cause was mechanical misalignment. The report further states that the excessive fluctuations were discovered only after six months and numerous problems when the scoop tube positioning arm bolt sheared off, and resultant "proper mechanical alignments" fortuitously corrected the problems.

In this event, TVA determined that the flow fluctuation problems at issue were caused by malfunctioning electrical equipment, not mechanical misalignment. This determination was based on troubleshooting efforts, which included use of recirculation control monitoring instrumentation. Following identification of the malfunctioning equipment, TVA replaced this equipment, which corrected the flow fluctuation problems. Subsequently, 12 days following replacement of the malfunctioning component, the scoop tube arm bolt sheared off following an unplanned automatic reactor scram. However, this event was not related to the recirculation flow fluctuations.

TVA suggests that this discussion be deleted from the report.

IV. EMERGENCY PREPAREDNESS

TVA has no comments in this area.

V. SECURITY

On page 15, beginning on line 1 of the second paragraph, the report states that during the assessment period TVA identified access control problems. The report states that these problems involved permitting terminated contract employees to enter the plant and a vital portal that was unalarmed and unattended in excess of one hour.

On May 22, 1991, TVA determined that these two terminated employees had previously entered the plant. TVA acknowledges that this event represents an access control weakness. However, the problem occurred and was discovered prior to the assessment period.

TVA believes that discussion of this event should be removed from the report and suggests the paragraph be revised as follows:

"During the assessment period, TVA identified an access control weakness. A vital portal was unalarmed and unattended in excess of one hour."

VI. ENGINEERING/TECHNICAL SUPPORT

- A. On page 17, beginning on line 5 of the third paragraph, the report states that "[o]ne area where the design control process was not fully successful was licensee control of contractor activities." The report continues by stating that "[s]everal violations, one deviation and a licensee issued stop work order had occurred in this area since August 1991 concerning contractor performance of design work without authorization, failure to update a primary drawing, and failure to observe Unit 2/Unit 3 separation and access control requirements. Although these items were related to Unit 3 design activities, they affected Unit 2 support systems."

The report states that "several violations" were issued in this area since August 1991. As TVA noted in the July 27, 1992, SALP meeting, this information is contrary to the statement on page 20 (i.e., "[o]ne violation was issued during the assessment period"), and the number of violations listed in the table on page 27 of the report.

With respect to the examples cited to support the alleged inadequacy in the design control program, TVA recognizes that on one occasion a contractor performed work without authorization. However, this isolated incident does not indicate a weakness in the design control process.

Furthermore, TVA disagrees that the remaining examples cited affected Unit 2 support systems. Specifically, the failure to update a primary drawing involved modifications to the 4160V loop line. As TVA stated in its May 18, 1992, reply to a violation cited in NRC Inspection Report 92-12, dated April 17, 1992, the 4160V loop line is an industrial nonsafety-related power source that supplies power to equipment outside the power block. This line does not supply power to equipment required for Unit 2 safe shutdown. In the remaining example, the incident involving Unit 2 and Unit 3 separation and access control did not affect Unit 2 support systems.

TVA maintains that the section of the existing paragraph which states that the design control process was not fully successful should be deleted.

- B. On page 18, beginning on line 11 of the first full paragraph, the report states that an engineering problem not resolved in a timely manner involved the control room emergency ventilation system. The report states that "TVA has considered the problem but the corrective action commitment date has been extended."

First, TVA has expended considerable man-hours evaluating the control room emergency ventilation system problem, which is a very detailed, complex issue. Stating that TVA has only "considered the problem" does not accurately reflect the effort expended.

In addition, during the assessment period the corrective action commitment date has not been extended. By letter dated September 18, 1989, from S. Black to O. D. Kingsley, TVA, NRC issued amendments to BFN Technical Specifications which extended completion of control room emergency ventilation modifications to prior to startup following the Unit 2, Cycle 6 refueling outage.

TVA suggests that this portion of the paragraph (i.e., that portion beginning with "One engineering problem ...") be deleted.

VII. SAFETY ASSESSMENT/QUALITY VERIFICATION

- A. On page 21, beginning on line 12 of the fourth paragraph, the report discusses an incident involving failure to update a primary drawing following closure of a design change.

TVA acknowledges that in this event a primary drawing was not updated; however, the design change was never closed. Therefore, the portion of the statement discussing closure of a design change should be deleted, and the statement reworded as follows:

"Another example included an incident investigation associated with failure to update primary drawings for the 4160V loop resulting in configuration problems and ..."

- B. On page 22, beginning on line 2 of the first paragraph, the report states that an example of missing information in an LER was discovered during the assessment period.

TVA acknowledges that the NRC may have discovered this condition during the assessment period. However, the LER that was cited (LER 260/91009, Revision 0) was actually submitted to the NRC prior to the assessment period (on May 11, 1991)

Accordingly, TVA suggests that this statement be deleted.

- C. On page 22, beginning on line 1 of the second full paragraph, the report states that the Quality Assurance (QA) organization was not always proactive in identifying problems. The report states that several problems were not identified by TVA prior to NRC inspections, including the "control of contractor activities involving the removal of fire wrap from operating equipment and configuration control problems."

With respect to the removal of fire wrap, this work was performed by TVA personnel, not contractors. Therefore, stating that this event involved control of contractors is inaccurate. Additionally, this was an isolated event that was identified by NRC ^{as it occurred}. TVA's Quality Assurance organization cannot reasonably be expected to identify isolated instances, particularly at the time they are occurring.

With respect to the configuration control problems, the report appears to be addressing the telecommunications work that was cited as a violation in NRC Inspection Report 91-41, and the incident involving the 4160V loop line. TVA acknowledges that the event involving the telecommunications work was caused by inadequate contractor control. However, this event was identified by TVA, not NRC. In the second event involving the 4160V loop line, this work was performed by TVA personnel, not contractors. Therefore, stating that this example involved control of contractors is also inaccurate.

Furthermore, TVA considers that the QA organization has been proactive in identifying quality-related problems. For example, the event involving contractors performing work without authorization, which is discussed on page 13 of the SALP report, was identified by the QA organization. An additional example is found on page 8, where the report states that TVA "had a good quality assurance program for inplant radiological analyses ..."

TVA suggests that this entire paragraph be deleted from the report.

- D. On page 22, beginning on line 4 of the third full paragraph, the report states that twice during the SALP period TVA failed to provide a timely response, and references the two examples as TVA's response to NRC Generic Letter (GL) 91-11 and "10 CFR 54(w) (sic)." Additionally, the report states that once during the assessment period TVA provided incorrect information in a submittal.

With respect to GL 91-11, TVA responded to this generic letter by the required due date. Subsequent to this response, TVA provided additional information to the NRC. In the second instance cited, TVA assumes the SALP report is actually referring to a submittal required by 10 CFR 50.54(w). In this case TVA recognizes that a timely response was not provided. However, since the information TVA was required to submit was due to NRC prior to the beginning of the assessment period (i.e., due April 1, 1991), TVA considers it inappropriate to include this example in this SALP report. Finally, with respect to the submittal that allegedly contained incorrect information, TVA recognizes that a difference of opinion may exist between TVA and NRC regarding the language contained in this submittal. However, TVA submits that characterizing the information as incorrect based on this difference of opinion is inappropriate.

TVA suggests that the portion of the paragraph discussing untimely responses and submittals containing incorrect information be deleted from the report.

- E. On page 22, beginning on line 1 the fourth full paragraph, the report states that TVA continued to exhibit instances of poor planning in the pursuit of high priority plant specific licensing actions needed to support plant operations or anticipated outage work. The report cited examples where this alleged inadequate planning by TVA "resulted in unnecessarily exigent evaluations by NRC, includ[ing]: ASME Code Case N-491, HVAC Seismic Criteria, certain Technical Specifications (TS) amendments (TS-299 and TS-295), and an exemption from 10 CFR 50 Appendix J."

TVA acknowledges that "TS-295" involved inadequate planning by TVA. However, stating that the remaining examples involve poor planning by TVA is inaccurate.

Specifically, in the "ASME Code Case N-491" example TVA requested that NRC include this code case in TVA's inservice inspection program. TVA considered this to be a responsible, proactive approach. The "HVAC Seismic Criteria" submittal was identified by the NRC in NUREG-1232, Supplement 2, dated January 23, 1991, as a post-restart open item. In the "TS-299" example, TVA originally intended to perform these logic system functional tests at power. However, TVA subsequently reevaluated performance of these tests with a more conservative operational philosophy. TVA determined that performance of these tests at power would have created a potential for inadvertent scrams, actuations of equipment and resultant transients which place unnecessary demands on safety systems. Finally, in the exemption from Appendix J, this type of exemption request is standard industry practice. In this example, as previously explained to NRC, this exemption was necessitated by an extended startup and better than expected unit performance following restart. In this case, TVA notified the NRC at the earliest possible time of the need for this exemption.

Consequently, while TVA recognizes that inadequate planning existed in one instance, TVA maintains that this isolated incident does not indicate continuing planning problems. TVA considers this paragraph unnecessary and suggests that it be deleted in its entirety.

- F. On page 23, beginning on line 1 of the first paragraph, the report states that in a limited number of cases "the technical content of TVA's submittal (sic) was incomplete or ambiguous" and cites as examples TVA's submittals regarding the status of post-restart commitments and drywell steel seismic criteria.

TVA recognizes that some ambiguity may have existed in the post-restart commitments submittal. Regarding the submittal which forwarded the drywell steel seismic criteria, TVA acknowledges that a difference of opinion may exist between TVA and the NRC on the content of this submittal. However, characterizing the submittal as incomplete or ambiguous due to this difference of opinion is inaccurate.

TVA suggests that this sentence be revised as follows:

"In one instance TVA submitted ambiguous information (Status of Post-Restart Commitments)." On this occasion, and other occasions where further clarification and/or additional information ..."

- G. On page 23, beginning on line 1 of the second full paragraph, the report stated that TVA continued to experience difficulty in meeting established schedules, and TVA failed to achieve many of its own scheduled commitment dates for supporting important licensing activities. The report further states that a negative trend in the timely completion of commitments and resolution of potential Part 21 issues was identified during the SALP period. The report cited examples, including delays in resolving concerns associated with safety relief valve acoustic monitor cards and Rosemount transmitters, and extending the resolution of the Control Room Emergency Ventilation System design. TVA considers that these statements are unnecessary and mischaracterize TVA's performance in this area.

During the assessment period, TVA successfully completed over 95 percent of commitments (91 of 95) on time without the need for extensions. The remaining 4 were completed within the schedule negotiated with the NRC. This data clearly indicates that TVA rarely failed to achieve scheduled commitment dates.

With respect to the acoustic monitor issue and the Rosemount transmitter problems, TVA promptly evaluated these components and determined that neither condition was reportable under Part 21 based on plant configuration. TVA subsequently shipped the failed components to the respective vendors for additional evaluation. While delays were experienced in the shipments of these components, TVA considers that the Part 21 determinations were completed in a timely manner.

Furthermore, TVA considers that the isolated examples cited do not provide the necessary indications to conclude that a negative trend exists.

TVA suggests that this paragraph be deleted in its entirety.

- H. On page 23, beginning on line 1 of the third full paragraph, the report states that Unit 3 interface activities and control of contractor activities "was a weaknesses (sic)." The report further states that although a unit separation program existed, examples were identified that indicated contractors did not understand personnel access requirements. The report also cites inadequately controlled and supervised subcontractors, and licensee management failure to ensure that these activities were properly authorized prior to beginning work.

TVA considers that the Board has placed adequate emphasis on contractor control and unit interface activities through previous discussion in this report and in the recommendation provided in the Engineering/Technical Support functional area. For example, control of contractors is discussed in the first paragraph on page 3, the third paragraph on page 17, the Board recommendation on page 20, and the above instance.

TVA considers that restatement of these concerns within this functional area is redundant. Accordingly, TVA suggests that this paragraph be deleted.