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R. D. (Rick) Machon
Vice President, Browns Ferry Nuclear Plant

December 6, 1996

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

10 CFR 2.201

Gentlemen:

In the Matter of)
Tennessee Valley Authority)

Docket Nos. 50-259
50-260
50-296

BROWNS FERRY NUCLEAR PLANT (BFN) - NRC INSPECTION REPORT 50-259, 50-260, 50-296/96-10 - REPLY TO NOTICE OF VIOLATION (NOV)

This letter provides our reply to the subject NOV transmitted by letter from Mark S. Lesser, NRC to Oliver D. Kingsley, TVA, dated November 7, 1996. The NOV involved two violations: Violation A involved a failure to maintain provisions of the Commission-approved Physical Security Plan; Violation B involved a failure to provide management oversite of work performed by non-plant personnel during a maintenance activity on safety related equipment. TVA admits the violations.

Enclosures 1 and 2 provide our reply to the violations.

Enclosures
cc: See page 2

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There are no commitments made in this reply. If you have any questions regarding this reply, please contact me at (205) 729-3675.

Sincerely,

R. D. Machon

Enclosures
cc (Enclosures):
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ENCLOSURE 1

TENNESSEE VALLEY AUTHORITY
BROWNS FERRY NUCLEAR PLANT (BFN)
UNITS 1, 2 AND 3

REPLY TO NOTICE OF VIOLATION (NOV)
VIOLATION A

INSPECTION REPORT NUMBER
50-259, 260, 296/96-10

RESTATEMENT OF THE VIOLATION

"Unit 1, Unit 2 and Unit 3 Facility Operating License Conditions 2.C.(11), 2.C.(11), and 2.C.(6), respectively, state that the licensee shall fully implement and maintain in effect all provisions of the Commission-approved Physical Security Plan.

Contrary to the above, on September 18, 1996, the licensee did not maintain in effect all provisions of the Commission-approved Physical Security Plan. Two vehicles within the protected area were identified unlocked with the ignition keys inside of the vehicle.

This is a Severity Level IV violation (Supplement III)."

TVA'S REPLY TO THE VIOLATION

1. Reason For The Violation

This violation was caused by personnel error. In both events the individuals knew the procedural requirement to remove the ignition keys from the vehicle. However, in the first event the instrument mechanic decided to leave the keys in the ignition and keep visual control of the vehicle. In the second event, the contract carpenter overlooked the fact that the vehicle was within the protected area and left the keys in the vehicle.

Site Standard Practice (SSP) SSP-11.1, "Providing Access Clearance For Nuclear Plants And Safeguard Information," Section 3.22, "Control of Vehicles within the Protected Area", states that designated vehicles, when left unattended, shall be secured by ignition key removal, or, if not equipped with an ignition key, immobilized to prevent their use by unauthorized persons.

In the first event, the individual responsible to remove the keys from the ignition lost visual control while performing a job task. This action resulted in the vehicle not being secured as delineated in SSP-11.1.

In the second event, the individual removed the keys from the ignition and placed the keys over the driver's side sun visor. The placing of the keys over the sun visor was a BFN Facilities organization practice for vehicles parked outside the protected area. Consequently, the failure to remove the keys while within the protected area was a violation of SSP-11.1.

2. **Corrective Actions Taken And Results Achieved**

The keys to the two vehicles were confiscated and controlled by Site Security.

Personnel corrective actions were taken with the individuals responsible for the violations.

3. **Corrective Steps That [Have Been Or] Will Be Taken To Avoid Further Violations**

A notice was written to address the specifics of this event. Site Security distributed a copy of the notice to vehicle drivers entering the protected area.

Additionally, a Site Security memorandum directed motor patrol personnel to increase checks and searches of designated vehicles in the protected area until vehicle driver's awareness was heightened.

Training was rendered to the BFN Facilities and Instrumentation and Controls personnel on the specifics of the event to heighten their awareness of their responsibility to secure vehicles in accordance with SSP-11.1.

4. **Date When Full Compliance Will Be Achieved**

Full compliance was achieved when the two vehicles were secured by ignition key removal.

ENCLOSURE 2

TENNESSEE VALLEY AUTHORITY
BROWNS FERRY NUCLEAR PLANT (BFN)
UNITS 1, 2, and 3

REPLY TO NOTICE OF VIOLATION (NOV)
VIOLATION B

INSPECTION REPORT NUMBER
50-259, 260, 296/96-10

RESTATEMENT OF THE VIOLATION

"Technical Specification 6.8.1.1.a requires that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Paragraph 9 of Appendix A of Regulatory Guide 1.33 recommends procedures for performing maintenance that can affect safety related equipment.

Site Standard Practice (SSP) SSP-6.1, Conduct of Maintenance, Revision 5, Section 3.1.1.C.5 addresses management oversight of work performed by non-plant personnel and contractors to ensure that work is being performed in a quality manner.

Contrary to the above, between August 26, 1996 and September 12, 1996, management oversight of work performed by non-plant personnel and contractors was not adequate enough to ensure that work was being performed in a quality manner while painting was being conducted on the emergency diesel generators. This was illustrated by three examples of painting problems which affected the diesel generators.

This is a Severity Level IV violation (Supplement I), applicable to Unit 2 and 3."

TVA's REPLY TO THE VIOLATION

1. Reason For The Violation

This violation resulted from failure to meet management expectations for the oversight of a maintenance activity. Specifically, TVA underestimated the amount of management supervision required for painting of the Emergency Diesel Generators (EDG) and the EDG rooms. Site Standard Practice (SSP) SSP-6.1, "Conduct of Maintenance", Section

3.1.2.B, states in part: Maintenance management and supervisors shall be involved in daily activities associated with maintenance to include but not be limited to walking spaces, maintaining an awareness of problems, and quality of workmanship. Additionally, Section 3.1.2.B requires that Maintenance management and supervisors shall monitor work activities and initiate corrective actions to minimize repeat maintenance and personnel errors. A failure to fully implement these requirements resulted in three incidents during the painting of the EDGs which affected their performance.

On August 27, 1996, paint was identified on the governor and rod drive to a limit switch. Also, on September 10, 1996, an EDG emergency fuel shut off valve was found mispositioned (closed). Finally, on September 12, 1996, during a cleaning process, EDG 1D experienced a ground indication due to misapplication of a degreasing agent to an EDG component.

2. **Corrective Actions Taken And Results Achieved**

Following the identification of the above issues with the painting activity, TVA recognized the need for increased management attention of this activity. TVA stopped painting on the EDGs. Painting of the EDG rooms was allowed to continue.

The three incidents identified above were appropriately dispositioned. The paint identified on August 27, was removed from the governor and rod drive assembly. Other movable parts on the EDG were inspected and found free of paint. The painter supervisor cautioned workers on the application of paint on moveable parts. Also, the fuel shutoff valve found closed on September 10, was returned to the correct position. The valve was pointed out to the painters during a briefing. The September 12 incident was the result of spraying a degreasing agent directly onto an electrical component. It was determined that the degreasing agent should be first applied to a clean cloth and then cloth used to wipe down the component. This practice was immediately started. A change to Modification and Addition Instruction "Protective Coatings," added the requirement to spray the cleaning agent onto a clean cloth and then apply to the area to be cleaned.

In order to address the management oversight of the

painting, TVA developed a paper detailing lessons learned on the incidents. As part of the lessons learned, detailed discussions of each occurrence were held with those involved. Critical components were identified and illustrated to the painters. This discussion also included examples of problem areas identified with photographs of these areas.

Additionally, the system engineer and operations personnel performed a walkdown of the area to be painted with the painters' foreman/supervisor. During the walkdown, critical components and areas requiring extra precautions were identified. The foreman/supervisor then pointed out these areas to the painters in a pre-job briefing and walkdown.

At the end of each shift, operations personnel inspected the EDGs for critical components that may have been affected during the work activity. Also, the system engineer walked down the EDGs after the painting was completed to identify any problems that may have been encountered during the activity.

Following briefings on the lessons learned painting was resumed. Painting of seven EDGs was completed on September 26, 1996 without further incident.

3. **Corrective Steps That [Have Been Or] Will Be Taken To Avoid Further Violations**

TVA is in compliance with circumstances described in this violation. However, to further emphasize management expectations with regard to painting, TVA developed a guide for those supervising the performance of painting activities at BFN. The guide "Painting Expectations," has been issued as part of the maintenance night orders. Also, during shifts that painting activities are being conducted, the maintenance shift duty manager performs a walkdown the painting activity in the area to ensure that expectations are being implemented.

In addition to the guidance provided in the lessons learned, "Painting Expectations" requires that during a painting activity, the supervisor/foreman be present at the job site. In the event a component is bumped or dislodged, operations personnel are immediately notified. At the end of each shift, operations personnel and the system engineer are contacted for a review of the work

conducted during that shift.

At the completion of the activity the supervisor, the system engineer, and operations personnel conduct a walkdown of the task to identify and correct problems that may have been encountered during the activity.

4. **Date When Full Compliance Will Be Achieved**

TVA is in full compliance.