UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

October 16, 2014

EA-14-005

Mr. Joseph W. Shea
Vice President, Nuclear Licensing
Tennessee Valley Authority
1101 Market Street, LP 3D-C
Chattanooga, TN 37402-2801

SUBJECT: BROWNS FERRY NUCLEAR PLANT - NRC INSPECTION PROCEDURES 95001 SUPPLEMENTAL INSPECTION AND 92702 FOLLOWUP - INSPECTION REPORT 05000259/2014012; 05000260/2014012; 05000296/2014012 AND ASSESSMENT FOLLOW-UP LETTER

Dear Mr. Shea:

From May 21, 2007, through October 30, 2013, your staff failed to follow and maintain the effectiveness of an emergency plan that met the planning standards of 10 CFR 50.47 when your staff did not ensure adequate staffing to provide initial facility accident response in key functional areas was maintained at all times.

On December 31, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Browns Ferry Units 1, 2, and 3. Based on the results of this inspection, documented in NRC Inspection Report 05000259, 260, 296/20013005 on February 14, 2014, and the final significance determination documented in NRC Inspection Report 05000259, 260, 296/20014002 on April 30, 2014, the NRC assigned a White finding Action Matrix input to the Emergency Response cornerstone in the fourth quarter of 2013. Additionally, on May 1, 2014, the NRC issued a Confirmatory Order following an alternate dispute resolution (ADR) session on April 3, 2014, to disposition two related traditional enforcement apparent violations; 1) Inaccurate Information Provided Concerning Onsite Emergency Response Organization Staffing Requirements and 2) Inappropriate Amendment of License.

On June 3, 2014, you informed the NRC that Brows Ferry was ready for the supplemental inspection.

On September 5, 2014, the NRC completed a supplemental inspection pursuant to Inspection Procedures 95001, “Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area,” and 92702, “Follow-up On Traditional Enforcement Actions Including Violations, Deviations, Confirmatory Action Letters, Confirmatory Orders, And Alternative Dispute Resolution Confirmatory Orders,” at your Browns Ferry Nuclear Plant. The NRC inspection team discussed the results of the inspection and the implementation of your corrective actions with Mr. S. Bono and other members of your staff. The inspection team documented the results of this inspection in the enclosed inspection report.

The NRC performed this supplemental inspection to determine if: 1) the root and contributing causes for the significant issues were understood; 2) the extent of condition and extent of cause for the identified issues were understood; and 3) your completed or planned corrective actions were sufficient to address and prevent repetition of the root and contributing causes.

Additionally, review of the progress of implementation of the commitments associated with the Confirmatory Order was performed to provide assurance that: 1) adequate corrective actions were being implemented for the traditional enforcement violations; 2) the root causes of this enforcement action had been identified; and 3) that generic implications have been addressed and that programs and practices have been appropriately enhanced to prevent recurrence.

The inspectors determined that the plant staff performed an adequate evaluation of the White finding. The plant's evaluation identified the root cause of the issue to be procedure revisions that diluted and then removed a review requirement that resulted in procedural changes not being properly evaluated. The inspectors found the extent of condition and extent of cause reviews were adequate, and the corrective actions implemented were adequate. The inspectors concluded that you re-established compliance. All immediate and long term corrective actions have been completed with the exception of: 1) the performance of a sampling of changes to the plant to determine if these changes have been incorporated into the licensing basis documents; and 2) the completion of an effectiveness review to verify actions following the implementation of the Licensing Compliance Review process. The inspectors also determined that progress in the implementation of commitments was appropriate and meeting the requirements of the Confirmatory Order.

The NRC has determined that completed or planned corrective actions were sufficient to address the performance that led to the White finding. Therefore, the performance issue will not be considered as an Action Matrix input after the end of the third quarter of 2014. After reviewing the performance in addressing the White finding documented in this inspection report, the NRC concluded your actions met the inspection objectives. Therefore, in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," the White finding will only be considered in assessing plant performance for a total of four quarters. As a result, the NRC determined the performance at Browns Ferry Nuclear Plant Units 1, 2, and 3, to be in the Licensee Response Column of the ROP Action Matrix as of October 1, 2014.

The NRC inspectors did not identify any findings or violations of more than minor significance.

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, “Public Inspections, Exemptions, Requests for Withholding,” of the NRC’s “Rules of Practice,” a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Website at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Jonathan H. Bartley, Chief
Reactor Projects Branch 6
Division of Reactor Projects

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

Enclosure: Inspection Report 05000259/2014012;
05000260/2014012; 05000296/2014012
w/Attachment: Supplemental Information

cc distribution via ListServ

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/RA/

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Letter to Joseph W. Shea from Jonathan H. Bartley October 16, 2014

SUBJECT: BROWNS FERRY NUCLEAR PLANT - NRC INSPECTION PROCEDURES 95001 SUPPLEMENTAL INSPECTION AND 92702 FOLLOWUP - INSPECTION REPORT 05000259/2014012; 05000260/2014012; 05000296/2014012 AND ASSESSMENT FOLLOW-UP LETTER

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.:	05000259, 05000260, 05000296
License Nos.:	DPR-33, DPR-52, DPR-68
Report No.:	05000259/2014012; 05000260/2014012; 05000296/2014012
Licensee:	Tennessee Valley Authority (TVA)
Facility:	Browns Ferry Nuclear Plant, Units 1, 2, and 3
Location:	Corner of Shaw and Nuclear Plant Road Athens, AL 35611
Dates:	September 2, 2014, through September 5, 2014
Inspectors:	C. Kontz, Senior Project Engineer S. Sanchez, Senior Emergency Preparedness Inspector
Approved by:	Jonathan H. Bartley, Chief Reactor Projects Branch 6 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000259/2014012, 05000260/2014012, 05000296/2014012; 09/2/2014 – 09/5/2014; Browns Ferry Nuclear Plant; Supplemental Inspection – Inspection Procedures (IP) 95001 and 92702.

One Senior Project Engineer and one Senior Emergency Preparedness inspector performed this inspection. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

Cornerstone: Emergency Preparedness

The NRC staff performed the supplemental inspection in accordance with IP 95001, "Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area," and IP 92702, "Follow-up On Traditional Enforcement Actions Including Violations, Deviations, Confirmatory Action Letters, Confirmatory Orders, And Alternative Dispute Resolution Confirmatory Orders," to assess the licensee's evaluation associated with a failure to maintain plant emergency response staffing levels and to follow-up on Alternate Dispute Resolution (ADR) Confirmatory Order items related to two Apparent Violations associated with main control room shift staffing. The NRC staff previously characterized this issue as having low to moderate safety significance (White), as documented in NRC IR 05000259/2014002; 05000260/2014002; 05000296/2014002.

During this inspection, the inspectors determined that your staff performed an adequate evaluation of the cause of the White finding. Your staff's evaluation identified the root cause to be procedure revisions that diluted and then removed a review requirement that resulted in procedural changes not being properly evaluated. The inspectors found the extent of condition and extent of cause reviews were adequate, and the corrective actions implemented were adequate. All immediate and long term corrective actions have been completed except for: 1) the performance of a sampling of changes to the plant to determine if these changes have been incorporated into the licensing basis documents; and 2) the completion of an effectiveness review to verify actions following the implementation of the Licensing Compliance Review process. The inspectors also determined that progress in the implementation of commitments was appropriate and meeting the requirements of the Confirmatory Order.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 SUPPLEMENTAL INSPECTION (95001)

.01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure (IP) 95001 to assess the licensee's evaluation of a White finding that affected the emergency preparedness cornerstone in the reactor safety strategic performance area. The inspection objectives were to provide assurance that the:

- root causes and contributing causes of risk significant performance issues were understood
- extent of condition and extent of cause of risk significant performance issues were identified
- licensee's corrective actions for risk significant performance issues were sufficient to address the root and contributing causes and prevent recurrence

The finding was characterized as having (White) safety significance as discussed in NRC IR 05000259, 05000260, 05000296/2014002 and was associated with the failure to maintain plant emergency response staffing levels in accordance with NP-REP, Tennessee Valley Authority Nuclear Power Radiological Emergency Plan. The condition was found to have existed from 2007 until 2013.

The licensee informed the NRC staff on June 3, 2014, that they were ready for the supplemental inspection. In preparation for the inspection, the licensee performed multiple root cause investigations, documented in Root Cause Analysis Report PERs 838964 and 790109, to identify weaknesses that existed in organizations and processes that resulted in the risk-significant (White) finding.

The inspectors reviewed the licensee's Root Cause Evaluations (RCE) and other assessments conducted in support of and as a result of the investigation. Corrective actions taken to address the identified root and contributing causes were also reviewed. Additionally, inspectors interviewed licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood and corrective actions were appropriate to address the causes and preclude repetition.

.02 Evaluation of Inspection Requirements

02.01 Problem Identification

a. Determine that the evaluation identifies who (i.e., licensee-identified, self-revealing, or NRC-identified) and under what conditions the issue was identified.

The licensee identified that the Shift Technical Advisor (STA) position specified in procedure OPDP-1, Conduct of Operations, was potentially in conflict with the manning specified in the Radiological Emergency Plan. As part of an extent of condition review, an assessment of Operations staffing concluded that the minimum shift staffing levels

were not sufficient to perform all the required actions in the event of a fire in the control bay. The licensee entered the issue into their corrective action program, submitted an 8-hour report to the NRC, developed immediate compensatory measures to ensure proper shift staffing levels were maintained, and initiated appropriate apparent and root cause investigations. The inspectors verified that this information was documented in the licensee's evaluation.

b. Determine that the evaluation documents how long the issue existed and prior opportunities for identification.

The licensee identified that minimum shift staffing levels were not being maintained from when Unit 1 started up in May 2007, until discovered and corrected in October 2013. The licensee identified one prior opportunity for identification in this time period when a root cause analysis was performed from an NRC Appendix R inspection finding back in February 2010.

The inspectors determined that the licensee's evaluation and assessments were adequate with respect to identifying how long the issue existed and the prior opportunities for identification. The inspectors did not identify other missed opportunities.

c. Determine that the evaluation documents the plant-specific risk consequences, as applicable, and compliance concerns associated with the issue.

The NRC determined this issue was a White finding, as documented in NRC IR 05000259, 260, 296/2014002 dated April 30, 2014. The licensee's root cause evaluation documented the consequences of the issue, including the potential to reduce the defense in depth to nuclear safety, because had a design basis event or transient occurred, the Operations staff would not have had either an STA to provide the STA functions, or an Incident Commander (IC) to respond with the fire brigade to a fire. Upon discovery, the licensee took action to implement corrective actions to ensure appropriate control room shift staffing levels.

The inspectors concluded that the licensee appropriately documented the risk consequences and compliance concerns associated with the finding.

d. Findings

No findings were identified.

02.02 Root Cause and Extent of Condition Evaluation

a. Determine that the problem was evaluated using a systematic methodology to identify the root and contributing causes.

The licensee investigation was performed by a diverse, qualified team of nine members using licensee procedure NPG-SPP-22.306, Root Cause Analysis. The following systematic methods and tools were used to perform the root cause evaluation:

- Event and Causal Factor Charting
- Human Performance Barrier Analysis
- Interviews
- Extent of Condition and Extent of Cause Evaluations
- Safety Consequences Evaluation
- Performance Analyses
- Safety Culture Evaluation
- Organizational and Programmatic Contributors Analysis

The licensee used an independent team to perform a mock inspection in May 2014, to determine their readiness for inspection and the need for additional corrective actions.

The inspectors determined that the licensee adequately evaluated the issue using systematic methodologies to identify root and contributing causes.

b. Determine that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.

The Root Cause Evaluations were detailed in the scope of investigation and performed the following activities in support of the evaluation:

- Conducted interviews with key personnel involved with the issue
- Performed searches and reviews of the corrective action database for Emergency Preparedness identified items, Training department lesson plans, and supporting documents to include Emergency Preparedness, Work Control, and Operations procedures
- Performed reviews of industry operating experience, internal operating experience, and emergency preparedness internal change documentation.

The following represent a synopsis of the root cause, direct cause, and contributing cause:

- The root cause of this issue was determined to be procedure revisions that diluted and then removed a review requirement that resulted in procedural changes not being properly evaluated. During the Browns Ferry Unit 1 restart back in 2007, the requirement for staffing of the Shift Technical Advisor (STA) position was changed to allow an on-shift Unit Supervisor (US) to also fulfill the STA duties. This change was not evaluated in accordance with the applicable licensing change processes because there was no formal process available that provided the necessary detail to ensure all appropriate source documents were considered when revising procedure OPDP-1, Conduct of Operations.

- A direct cause to this issue was a failure to conduct an adequate licensing and regulatory review of staffing requirements related to a procedure change to OPDP-1, Conduct of Operations, that did not identify the change should have been processed in accordance with 10 CFR 50.54(q).

- A contributing cause to this issue was the procedural revision review process relied on a single barrier to review a change, resulting in changes to procedures that did not address all regulatory requirements.

Based on a review of the root cause evaluation and supporting documentation, the inspectors concluded that the evaluation was conducted to a level of detail commensurate with the significance of the problem.

c. Determine that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

The root cause evaluations included a review of plant corrective action program (CAP) databases and industry databases. The licensee identified several corrective action program items related to Operations shift staffing/inadequate staffing, but determined that the Operations minimum shift staffing was not Operating Experience (OE) preventable. However, the number of CAP items generated in the 2009/2010 timeframe clearly indicated a negative trend that should have resulted in additional site and management attention. The licensee identified several industry issues associated with shift staffing issues; however, the timeframe and specific issues identified in these items show that use of this operating experience likely would not have prevented Browns Ferry's shift staffing issue.

Based on the licensee's detailed evaluation and conclusions, the inspectors determined that the licensee's root cause investigations included adequate consideration of prior occurrences of the problem and knowledge of prior operational experience.

d. Determine that the root cause evaluation addressed the extent of condition and the extent of cause of the problem.

The licensee's evaluation limited the extent of condition review to a review of the Operations staffing requirements, as well as other Departments' staffing requirements to support Appendix A of the Radiological Emergency Plan. The extent of cause was limited to changes to procedures that contained 10 CFR 50.54q and 10CFR50.59 applicability. The inspectors recognized that certain aspects associated with the extent of cause and condition for this issue were addressed during the disposition of the two associated traditional enforcement violations. These aspects will be reviewed/assessed as part of the Order issued following alternate dispute resolution.

The inspectors concluded that the licensee's root cause investigations adequately addressed the extent of condition and the extent of cause of the issue.

e. Determine that the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components as described in IMC 0305.

The licensee found weaknesses in the following cross-cutting aspects:

- HU component of Resources [H.2(c)]: This related to the dilution and eventual removal of review requirements that would ensure adequate and proper procedural revisions occurs.

The inspectors determined that the licensee's root cause investigations included proper consideration of whether weaknesses in any safety culture component were root or significant contributing causes of the issue.

f. Findings

No findings were identified.

02.03 Corrective Actions

a. Determine that appropriate corrective actions are specified for each root and contributing cause or that the licensee has an adequate evaluation for why no corrective actions are necessary.

The licensee identified the following root cause and implemented the corresponding corrective action:

- The licensee identified the root cause to be procedure revisions that diluted and then removed a review requirement that resulted in procedural changes not being properly evaluated. Corrective actions included the development and issuance of an Interim Licensing Compliance Review Checklist for use by the procedure writing organizations and document reviewers, to provide them with a tool to ensure the correct licensing basis documents are referenced when revising procedures; the development and issuance of a procedure to establish a Licensing Compliance Review process addressing administrative and technical procedures not covered under the 10 CFR 50.59 review process; all commitment changes will receive a documented peer review by a second site licensing engineer; and conduct a 10 percent sampling of changes to the facility processed within the last three years to determine if the appropriate regulatory change process has been used.

The licensee developed corrective actions to address direct and contributing causes as summarized below:

- Following implementation of the Interim Licensing Compliance Review Checklist, the licensee will review procedures previously revised by the Procedure Upgrade Project to ensure those procedures identify the appropriate licensing basis information.

- Revise OPDP-1, Conduct of Operations, to ensure the appropriate Operations minimum shift staffing levels are consistent with the licensing basis documents.

The inspectors determined that the corrective actions were appropriate and addressed the root and contributing causes in the licensee's detailed evaluation and conclusions.

b. Determine that corrective actions have been prioritized with consideration of risk significance and regulatory compliance.

The licensee implemented an immediate action in the form of a Standing Order to ensure the appropriate Operations shift staffing levels were consistent with current licensing basis documents. The licensee completed apparent cause and root cause evaluations and a subsequent independent assessment to determine root/contributing causes and developed appropriate corrective actions with consideration of risk significance.

The inspectors determined that the immediate and follow-on corrective actions were adequately prioritized with consideration of the risk significance and regulatory compliance.

c. Determine that a schedule has been established for implementing and completing the corrective actions.

The licensee established due dates for the corrective actions in accordance with their corrective action program. The inspectors reviewed the status of each corrective assignment and determined that an appropriate schedule had been established for implementing the corrective actions with the only remaining actions being: 1) the performance of a sampling of changes to the plant to determine if these changes have been incorporated into the licensing basis documents; and 2) the completion of an effectiveness review to verify actions following the implementation of the Licensing Compliance Review process.

d. Determine that quantitative or qualitative measures of success have been developed for determining the effectiveness of the corrective actions to prevent recurrence.

The licensee established an effectiveness review plan. Final effectiveness reviews are scheduled to be completed by mid-year 2015.

The inspectors determined that the effectiveness review plan actions would adequately test and/or measure corrective actions to ensure that regulatory change processes have been adequately and properly utilized.

e. Determine that the corrective actions planned or taken adequately address a Notice of Violation (NOV) that was the basis for the supplemental inspection, if applicable.

The NRC issued the NOV to the licensee on April 30, 2014, as described in NRC Inspection Report 05000259, 260, 296/20014002. The licensee provided the NRC with the reasons for the violation, corrective actions that have been taken and results achieved, corrective actions that will be taken, and date when full compliance was

restored in a written reply to the NOV dated May 30, 2014 (ML14153A665). During this inspection, the inspectors confirmed that the licensee's root cause analysis (RCA) and planned and taken corrective actions addressed the NOV.

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f. Findings

No findings were identified.

4OA5 Other Activities

Follow-up On Alternative Dispute Resolution Confirmatory Orders (IP 92702)

a. Inspection Scope

The NRC staff performed this follow up inspection in accordance with IP 92702 for selected commitments in Confirmatory Order (ML14121A551) issued on May 1, 2014, following an alternate dispute resolution (ADR) session on April 3, 2014, to disposition two related traditional enforcement apparent violations; 1) Inaccurate Information Provided Concerning Onsite Emergency Response Organization Staffing Requirements and 2) Inappropriate Amendment of License.

The inspection objectives were to verify the licensee's implementation of commitments contained in the Order to provide assurance that (as appropriate):

- adequate corrective actions have been implemented for the traditional enforcement violations;
- the root causes of these enforcement actions have been identified;
- that generic implications have been addressed;
- that the licensee's programs and practices have been appropriately enhanced to prevent recurrence.

The following commitments were reviewed and closed:

- *a.i.1 TVA will revise and issue a fleet-wide procedure governing the preparation of information intended to support licensing submittals to the NRC. The procedure shall contain requirements for the preparation (including specifications for draft information), verification, and management oversight of this information, and will delineate acceptable validation documents. The procedure will include an overt discussion of the roles and responsibilities for individuals involved. BFN will provide training in accordance with the procedure change process*

- *a.ii.1 TVA will design, develop, and implement a BFN Integrated Completeness and Accuracy Review Evaluation Board (ICAREB). The ICAREB will be chartered to provide pre-submittal reviews of correspondence and supporting documentation for BFN licensing submittals to the NRC, including those prepared by BFN staff and Corporate Nuclear. Specific criteria for dissolution*

of the ICAREB will be established, but it will remain active, at a minimum, until a fleet-wide procedure governing the preparation of information intended to support licensing submittals to the NRC is active.

- *a.ii.2 BFN Licensing will prepare a benchmarking report identifying industry best practices in the area of 10 CFR 50.9 compliance in the preparation and validation of inputs to NRC submittals. This report will be made available to the NRC for review. BFN will consider benchmarking results, as appropriate, for implementation.*

- *b.i.1 TVA will benchmark nuclear industry methodologies used to maintain Licensing Bases Documents. A report on this activity will be made available to the NRC for review. BFN will consider benchmarking results for implementation.*

- *b.i.2 TVA will develop and issue a fleet-wide Licensing Compliance Review Procedure to establish the process for verifying that changes to NPG administrative and technical procedures not covered under the 10 CFR 50.59 review process are reviewed for conformance to the current licensing basis. BFN will provide training in accordance with the procedure change process.*

- *b.i.3 TVA will revise NPG-SPP-01.1 and NPG-SPP-01.2 to incorporate the Licensing Compliance Review process, including verification of compliance.*

- *b.i.4 TVA will convert NLDP-5 "FSAR Management" to an NPG Standard Programs and Processes (SPP) procedure. BFN will provide training in accordance with the procedure change process*

- *b.i.5 TVA will implement, via an independent entity, a review of the 10 CFR 50.9 and 10 CFR 50.90 Root Cause Analysis reports to assess the completeness and adequacy of the identified root/contributing causes, extent of cause, extent of condition and CAPRs/CAs. The deliverable from this review will be a report with documented recommendations. TVA will consider these recommendations for implementation.*

- *b.ii.1 TVA will benchmark nuclear industry methodologies used to maintain Licensing Bases Documents*

- *b.ii.2 TVA acknowledges that there have been previous instances where repetitive PERs were submitted on the issue of adequate staffing and the issue was ineffectively resolved. BFN commits to close the CAP Fundamental Problem that was identified under the 95003 that resulted in significant programmatic and organizational changes in TVA's CAP by no later than April 9, 2014. In addition, the NRC recently closed the 95003 Tier 1 CAL Commitment in the BFN CAP.*

- *b.ii.3 TVA will develop and implement an Interim Licensing Compliance Review Checklist for use by procedure writing organizations and document reviewers to ensure the correct licensing basis documents are referenced when revising procedures. This Interim Licensing Compliance Review Checklist will be used until issuance of a revised Licensing Compliance Review Procedure. (b.i.2 Fleet-wide action above).*

- *c TVA will perform, via an independent entity, a reevaluation of Operations minimum shift staffing. The results of that staffing evaluation will be documented as a reference to OPDP-1, "Conduct of Operations."*

The inspectors reviewed the licensee's RCAs associated with the violations in addition to other evaluations conducted in support of and as a result of the RCA. The inspectors reviewed corrective actions that were taken and implemented to address the identified causes. The inspectors verified that corrective actions planned and implemented were appropriate to address the causes and prevent recurrence and were consistent with the requirements of the Order.

b. Findings and Observations

No findings were identified.

4OA6 Exit Meeting

On September 4, 2014, the inspectors presented the inspection results to Mr. Bono and other members of the staff who acknowledged the results. The inspectors asked the licensee if any of the material examined during the inspection should be considered proprietary. The licensee did not identify any proprietary information.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee
A. Bergeron, Training Director
S. Bono, General Plant Manager
J. Browder, Performance Improvement Manager
D. Campbell, Operations Superintendent
T. Cole, Radiation Protection Manager
G. Doyle, 95003 Director
D. Green, Licensing Engineer
L. Hughes, Manager Operations
S. Hunnewell, Engineering Director
J. Kulisek, EP Manager
P. Parker, Security Manager
J. Paul, Nuclear Site Licensing Manager
K. Polson, Site Vice President
D. Robinson, Chemistry Manager
T. Scott, Quality Assurance Manager
J. Stone, Licensing
P. Summers, Plant Support Director
P. Wilson, Corporate Licensing
A. Yarborough, Strategic Engineering Manager

LIST OF ITEMS OPENED AND CLOSED

Opened

None

Closed

05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action a.i.1 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action a.ii.1 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action a.ii.2 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.i.1 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.i.2 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.i.3 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.i.4 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.i.5 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.ii.1 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.ii.2 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action b.ii.3 (4OA5)
05000259, 260, 296- 00	ORD	05/01/2014 Confirmatory Order Action c (4OA5)

DOCUMENTS REVIEWED

Plans and Procedures

OPDP-1, Conduct of Operations, Rev. 33
NPG-SPP-22.300, Corrective Action Program, Rev. 1
NPG-SPP-22.303, PER Analysis, Actions, Closures and Approvals, Rev. 4
NPG-SPP-22.304, PER Trending, Rev. 1
NPG-SPP-22.304, PER Trending, Rev. 2
NPG-SPP-22.306, Root Cause Analysis, Rev. 3
NPG-SPP-01.2 R11 Administration of Site Technical Procedures
NPG-SPP-01.1 R5 Administration of Standard Programs & Process; Standard Department Procedures; and Business Practices.
NPG-SPP-03.14 R0 Licensing Compliance Review
NPG-SPP-03.15 R0 FSAR Management

Corrective Action Documents – Problem Evaluation Report (PER)
PER 792140, 838964, 855259, 907411, 838977, 838972, 929935, 820585, 749576,
RCA for PER 838977
RCA for PER 838972
SR 8544570, 862641

Miscellaneous Documents
Root Cause Analysis Report PER 838964, Failure to Adequately Maintain Staffing of the Shift Technical Advisor and Incident Commander Positions in Accordance With Appendix A of the Radiological Emergency plan, Rev. 0, dated 3/24/14
Root Cause Analysis Report PER 790109, Inadequate Shift Staffing to Support Implementation of Safe Shutdown Instructions, Rev. 2, dated 5/30/14
Standing Order OS-0191 R2, Operations Staffing During Safe Shutdown Events, dated 11/1/13
BFN-NOER-13-094, TVA Nuclear Operating Event Report, Inadequate Shift Staffing to Support Implementation of Safe Shutdown, dated 12/3/13
BFN-NOER-14-016, Failure to Adequately Maintain Staffing in Accordance With the Radiological Emergency Plan, dated 3/31/14
Licensing Basis Hierarchy and Change Process Training Slides
Talisman Independent Assessment of Readiness for IP 95001 Inspection, dated 5/5/14
Self Assessment BFN-LIC-S-14-003 Accuracy of commitment Implementation
BFN On-Shift Staffing Analysis Report R1
Benchmarking CRP-LIS-F-14-BM03
Expectations and Guidance for Licensing Department Activities R7Licensing Basis Hierarchy and Change Process Training Lesson Plan Number 50001123
BFN-NOER-13-094
Operations TNA for LAR CA 838977
Licensing TNA for LAR CA 838977
Engineering TNA for LAR CA 838977
Effectiveness Review Action 838977-025
TNA for CA 838972-005