



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

July 26, 2012

EA-12-133

Mr. Joseph Shea
Manager, Corporate Nuclear Licensing
Tennessee Valley Authority
4B Lookout Place
1101 Market Street
Chattanooga, TN 37402-2801

SUBJECT: PUBLIC MEETING SUMMARY - REGULATORY CONFERENCE FOR
BROWNS FERRY NUCLEAR PLANT, DOCKET NO. 50-259, 260, 296

Dear Mr. Shea:

This refers to the meeting conducted on July 25, 2012, in Atlanta, GA. The purpose of this meeting, was to allow representatives of Tennessee Valley Authority (TVA), the licensee for Browns Ferry Nuclear Plant, to meet with U. S. Nuclear Regulatory Commission (NRC) personnel to discuss one preliminary White finding associated with one Apparent Violation that was documented in NRC Inspection Report 05000259/2012007, 05000260/2012007, and 05000296/2012007 (ML12150A219). The finding involved the failure to adequately accomplish the requirements contained in procedure NPG-SPP-09.3 "Plant Modifications and Engineering Change Control" which required that an evaluation of training needs be completed to support implementation of Design Change Notice (DCN) 69957. The licensee stated, during the meeting, that they agreed with the Apparent Violation and the significance determination for the violation. The licensee discussed the immediate corrective actions they implemented and the actions that will be taken based on the licensee's root cause analysis.

A list of attendees and a copy of the presentation handouts are enclosed.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

J. Shea

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Should you have any questions concerning this meeting, please contact me at (404) 997-4662.

Sincerely,

/RA/

Eugene F. Guthrie, Chief
Special Project, Browns Ferry
Division of Reactor Projects

Docket Nos.: 50-259, 50-260 and 50-296

License Nos.: DPR-33, DPR-52, DPR-68

Enclosures: 1. List of Attendees
2. Presentation Handouts

cc w/encls: (See page 2)

J. Shea

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☒ PUBLICLY AVAILABLE

☐ NON-PUBLICLY AVAILABLE

☐ SENSITIVE

☒ NON-SENSITIVE

ADAMS: ☐ Yes

ACCESSION NUMBER: _____

☒ SUNSI REVIEW COMPLETE

OFFICE	RII:DRP	RII:DRP						
SIGNATURE	CRK /RA/	EFG /RA/						
NAME	CKontz	EGuthrie						
DATE	07/26/2012	07/26/2012						
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

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J. Shea

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cc w/encl:
K. J. Polson
Site Vice President
Browns Ferry Nuclear Plant
Tennessee Valley Authority
Electronic Mail Distribution

James L. McNees, CHP
Director
Office of Radiation Control
Alabama Dept. of Public Health
P. O. Box 303017
Montgomery, AL 36130-3017

C.J. Gannon
General Manager
Browns Ferry Nuclear Plant
Tennessee Valley Authority
Electronic Mail Distribution

James E. Emens
Manager, Licensing
Browns Ferry Nuclear Plant
Tennessee Valley Authority
Electronic Mail Distribution

Manager, Corporate Nuclear Licensing -
BFN
Tennessee Valley Authority
Electronic Mail Distribution

Edward J. Vigluicci
Assistant General Counsel
Tennessee Valley Authority
Electronic Mail Distribution

T. A. Hess
Tennessee Valley Authority
Electronic Mail Distribution

Chairman
Limestone County Commission
310 West Washington Street
Athens, AL 35611

Donald E. Williamson
State Health Officer
Alabama Dept. of Public Health
RSA Tower - Administration
Suite 1552
P.O. Box 30317
Montgomery, AL 36130-3017

J. Shea

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Letter to J. Shea from Eugene F. Guthrie dated July 26, 2012.

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BROWNS FERRY NUCLEAR PLANT, DOCKET NO. 50-259, 260, 296

Distribution w/encl:

C. Evans, RII

L. Douglas, RII

OE Mail

RIDSNRRDIRS

PUBLIC

RidsNrrPMBrownsFerry Resource

NRC ATTENDEES

L. Wert, Deputy Regional Administrator, RII
E. Guthrie, Chief, Special Project, Browns Ferry, DRP, RII
C. Kontz, Senior Project Engineer, Special Project, Browns Ferry, DRP, RII
G. Hopper, Chief, Branch 7, DRP, RII
C. Evans, Regional Counsel, ORA, RII
S. Sparks, Senior Enforcement Specialist, ORA, RII
R. Bernhard, Senior Reactor Analyst, DRP, RII
M. Franke, Chief OLB2, DRS, RII
E. Brown, Senior Project Manager, DORL, NRR, HQ
S. Vaughn, Reactor Operations Engineer, DIRS, NRR, HQ
J. Circle, Senior Reliability and Risk Engineer, DRA, NRR, HQ
L. Casey, Enforcement Specialist, EB, OE, HQ
E. Powell, General Engineer, DRA, NRR, HQ

**BROWNS FERRY
REGULATORY CONFERENCE
PUBLIC MEETING**

NRC RII Office
Atlanta, Ga.

July 25, 2012

Attendees (Via Phone)

<u>Name (Print)</u>	<u>Title and Organization</u>
<u>Lou Zeller</u>	<u>Executive Director – Blue Ridge</u>
	<u>Environmental Defense League (BREDL)</u>
<u>Joe Shea</u>	<u>Corporate Licensing Manager – TVA</u>
<u>Stewart Horn</u>	<u>Public</u>
<u>Gary Morgan</u>	<u>BREDL</u>
<u>Don Safer</u>	<u>Tennessee Environmental Council</u>
<u>Gretta Johnston</u>	<u>MATRR</u>
<u>Pam Sohn</u>	<u>Chattanooga Times Free Press</u>
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**BROWNS FERRY
REGULATORY CONFERENCE
PUBLIC MEETING**

NRC RII Office
Atlanta, Ga.

July 25, 2012

Attendees

<u>Name (Print)</u>	<u>Title and Organization</u>
GERARD J DOYLE	TEAM MGR - 15003 / TVA
ROBERT J. WATSON	VP NUCLEAR ENGINEERING / TVA
DANIEL L. HIGGINS	SR MANAGER OPS / BFN TVA
Preston Swafford	CNO / TVA
MICHAEL WILSON	TRAINING DIRECTOR / BFN TVA
EUGENE CORBEY	TVA - CORPORATE LICENSING
Tim Cleary	TVA / VP REG REC
Don Fleming	TVA
Jim NESBIT	TVA
Eric Steele	TVA
RAY GOLDEN	TVA
Glenn Carroll	Nuclear Watch South

Attendees

Name (Print)

Title and Organization

Keith Polson

524 / 524

Mike Lovell

BD: Work Control

JEFF DILLER

083 f. Transcribe

JAMES EMENS

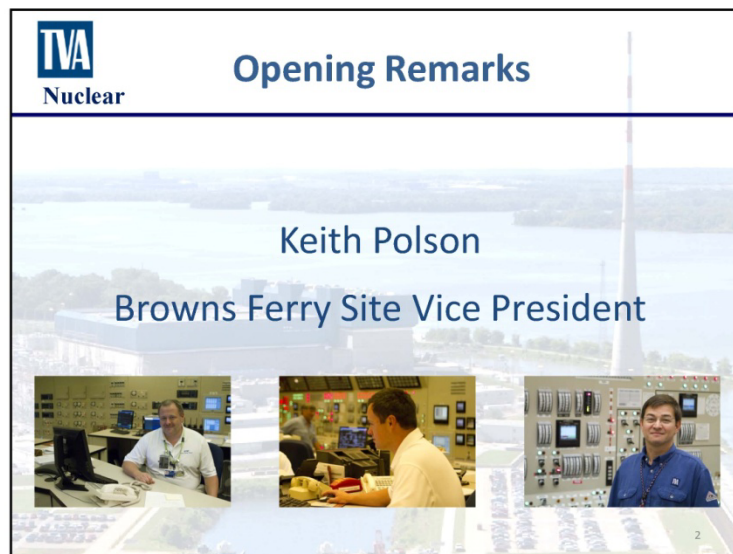
BFN LICENSING MGR

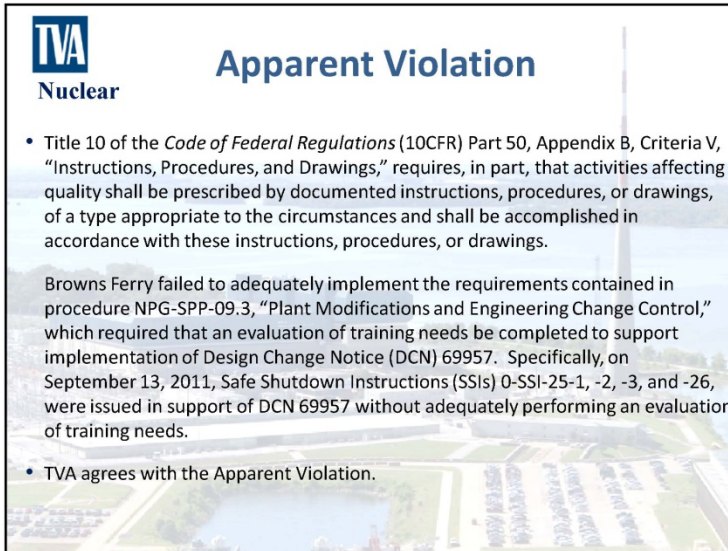


BROWNS FERRY REGULATORY CONFERENCE
July 25, 2012

REGULATORY CONFERENCE AGENDA
TENNESSEE VALLEY AUTHORITY
July 25, 2012
NRC REGION II, ATLANTA, GEORGIA

- I. OPENING REMARKS AND INTRODUCTION**
- II. NRC REGULATORY AND ENFORCEMENT POLICY**
- III. STATEMENT OF ISSUE AND APPARENT VIOLATION**
- IV. TENNESSEE VALLEY AUTHORITY**
- V. BREAK/NRC CAUCUS**
- VI. NRC FOLLOW UP QUESTIONS**
- VII. CLOSING REMARKS**
- VIII. PUBLIC QUESTIONS**





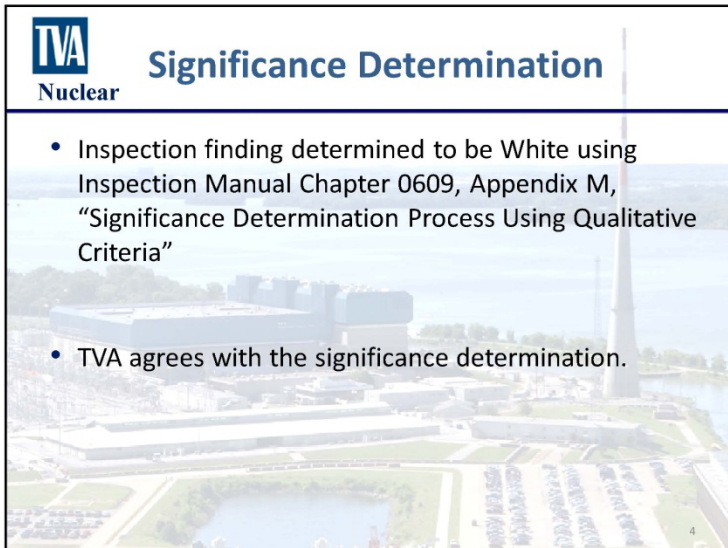
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Apparent Violation

- Title 10 of the *Code of Federal Regulations* (10CFR) Part 50, Appendix B, Criteria V, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

Browns Ferry failed to adequately implement the requirements contained in procedure NPG-SPP-09.3, "Plant Modifications and Engineering Change Control," which required that an evaluation of training needs be completed to support implementation of Design Change Notice (DCN) 69957. Specifically, on September 13, 2011, Safe Shutdown Instructions (SSIs) 0-SSI-25-1, -2, -3, and -26, were issued in support of DCN 69957 without adequately performing an evaluation of training needs.

- TVA agrees with the Apparent Violation.

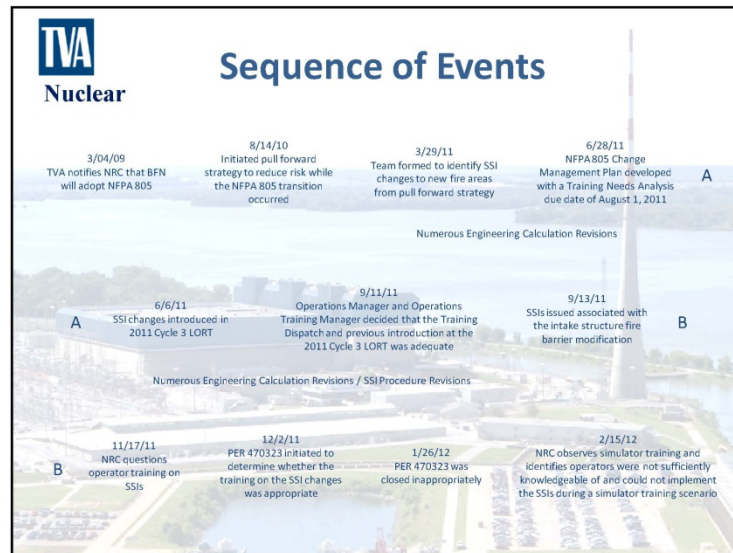


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Significance Determination

- Inspection finding determined to be White using Inspection Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria"

- TVA agrees with the significance determination.




TVA Nuclear

Immediate Corrective Actions

- Reviewed and revised SSIs.
- All licensed Operators received instruction on implementation of the revised SSIs and were evaluated in the simulator prior to assuming duties on shift.
- Established a requirement to perform a formal Training Needs Analysis for each DCN that affects or changes operator actions for any plant system or process.
- Operations Training conducted a stand-down with Operations Training Instructors to reinforce the expectations and tracking of DCN Impact Sheets.


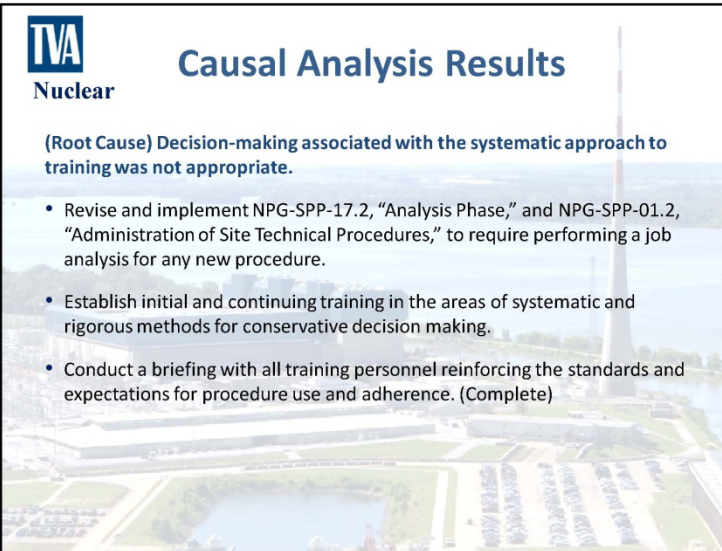
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Causal Analysis Results

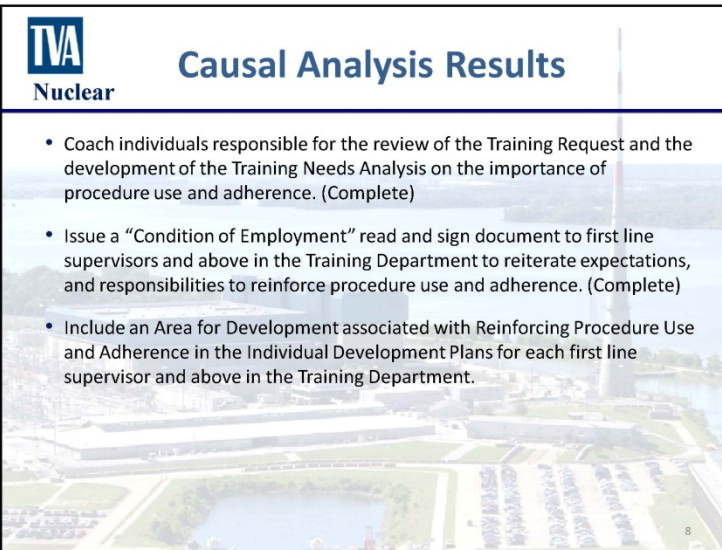
(Root Cause) Decision-making associated with the systematic approach to training was not appropriate.

- Revise and implement NPG-SPP-17.2, "Analysis Phase," and NPG-SPP-01.2, "Administration of Site Technical Procedures," to require performing a job analysis for any new procedure.
- Establish initial and continuing training in the areas of systematic and rigorous methods for conservative decision making.
- Conduct a briefing with all training personnel reinforcing the standards and expectations for procedure use and adherence. (Complete)




Causal Analysis Results

- Coach individuals responsible for the review of the Training Request and the development of the Training Needs Analysis on the importance of procedure use and adherence. (Complete)
- Issue a "Condition of Employment" read and sign document to first line supervisors and above in the Training Department to reiterate expectations, and responsibilities to reinforce procedure use and adherence. (Complete)
- Include an Area for Development associated with Reinforcing Procedure Use and Adherence in the Individual Development Plans for each first line supervisor and above in the Training Department.




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Causal Analysis Results

(Contributing Cause) Operations Manager and Operations Training Manager succumbed to time pressure when determining training needs for new and revised SSI procedures.

- Implement a Station Directive that focuses BFN leaders on standards and expectations.
- Institutionalize conservative decision making principles at BFN through the use of Excelerated Leadership Strategic Performance Management process.
- Implement mentoring for Curriculum Review Committee members to strengthen performance.

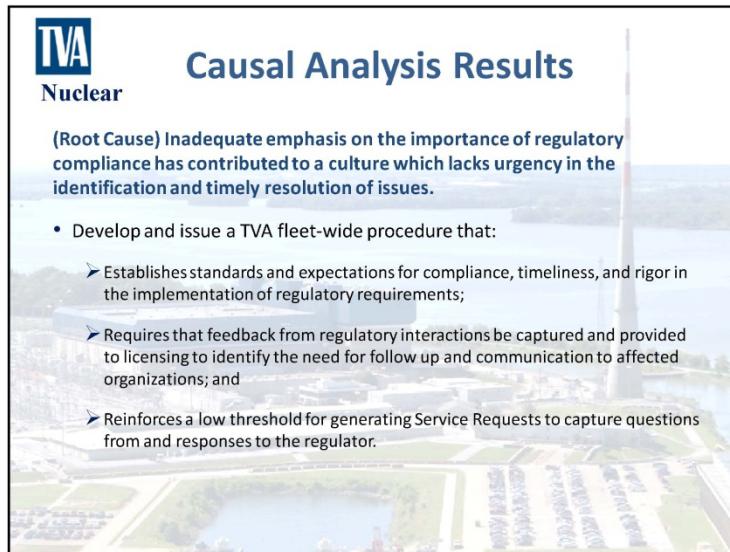


Causal Analysis Results

(Contributing Cause) Revisions to SSIs were not adequately prepared, reviewed, and validated to ensure accuracy and completeness.

- Conduct a briefing with all Operations procedure writers and independent reviewers regarding standards and expectations for SSI procedure development and revisions. (Complete)
- Coach individuals involved with the preparation, review and approval of the SSI procedures on the importance of attention to detail and technical accuracy. (Complete)
- Implement a procedure quality verification program.
- Develop and implement qualification requirements for procedure preparers, verifiers, and independent quality reviewers.

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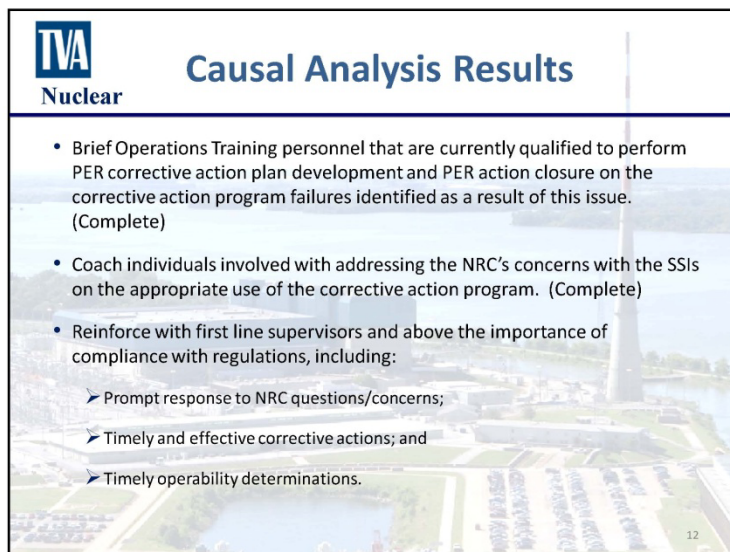


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Causal Analysis Results

(Root Cause) Inadequate emphasis on the importance of regulatory compliance has contributed to a culture which lacks urgency in the identification and timely resolution of issues.

- Develop and issue a TVA fleet-wide procedure that:
 - Establishes standards and expectations for compliance, timeliness, and rigor in the implementation of regulatory requirements;
 - Requires that feedback from regulatory interactions be captured and provided to licensing to identify the need for follow up and communication to affected organizations; and
 - Reinforces a low threshold for generating Service Requests to capture questions from and responses to the regulator.




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Causal Analysis Results

- Brief Operations Training personnel that are currently qualified to perform PER corrective action plan development and PER action closure on the corrective action program failures identified as a result of this issue. (Complete)
- Coach individuals involved with addressing the NRC's concerns with the SSIs on the appropriate use of the corrective action program. (Complete)
- Reinforce with first line supervisors and above the importance of compliance with regulations, including:
 - Prompt response to NRC questions/concerns;
 - Timely and effective corrective actions; and
 - Timely operability determinations.


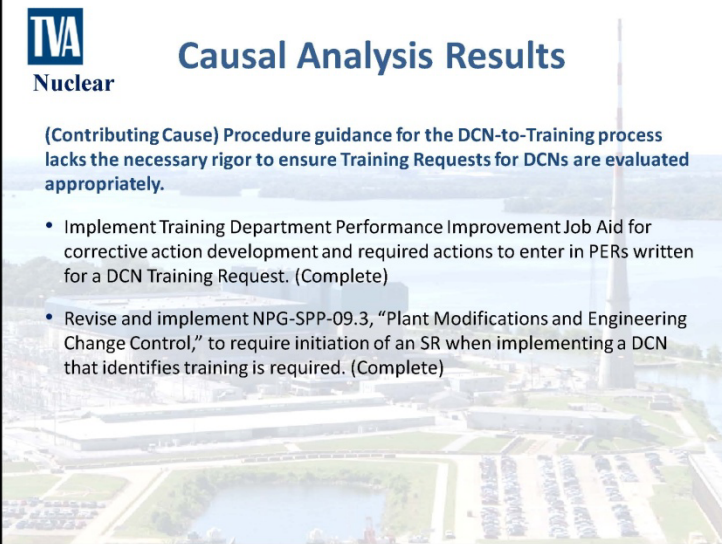
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Causal Analysis Results

(Contributing Cause) Procedure guidance for the DCN-to-Training process lacks the necessary rigor to ensure Training Requests for DCNs are evaluated appropriately.

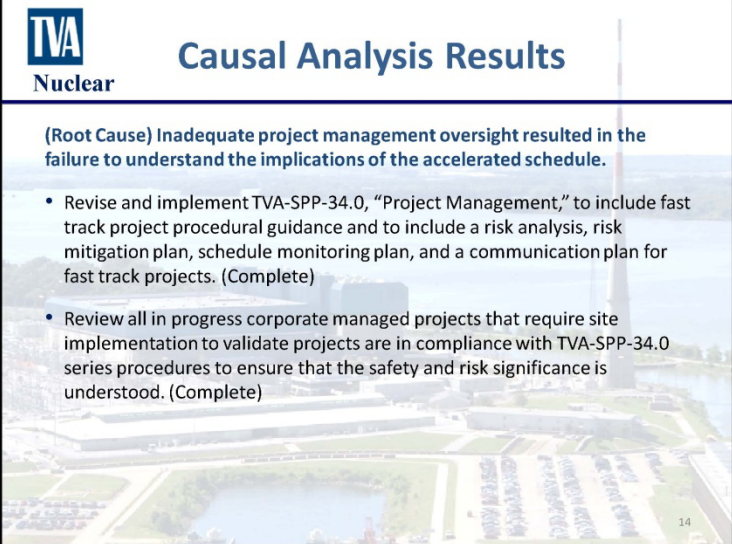
- Implement Training Department Performance Improvement Job Aid for corrective action development and required actions to enter in PERs written for a DCN Training Request. (Complete)
- Revise and implement NPG-SPP-09.3, "Plant Modifications and Engineering Change Control," to require initiation of an SR when implementing a DCN that identifies training is required. (Complete)




Causal Analysis Results

(Root Cause) Inadequate project management oversight resulted in the failure to understand the implications of the accelerated schedule.

- Revise and implement TVA-SPP-34.0, "Project Management," to include fast track project procedural guidance and to include a risk analysis, risk mitigation plan, schedule monitoring plan, and a communication plan for fast track projects. (Complete)
- Review all in progress corporate managed projects that require site implementation to validate projects are in compliance with TVA-SPP-34.0 series procedures to ensure that the safety and risk significance is understood. (Complete)




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Causal Analysis Results

- Change Management Boards (CCB) at BFN, SQN, and WBN will review new corporate managed projects that require site implementation to validate projects are in compliance with TVA-SPP-34.0 series procedures to ensure that the safety and risk significance is understood. (Complete)
- Coach the individuals involved with the project management (PM) oversight of DCN 69957 on the importance of communications within the PM team of schedule changes, understanding the safety and risk significance, and contingency planning as issues arise to ensure project quality is maintained. (Complete)
- Develop and present a case study of this event to the Browns Ferry Management Team.



Causal Analysis Results

(Contributing Cause) Procedure Use and Adherence was less than adequate.

- Coach individuals involved with the preparation, review and approval of the change management plan (CMP) on the importance of procedure use and adherence and documenting actions for a change management plan in the action tracking system. (Complete)
- Issue a "Condition of Employment" read and sign document to all first line supervisors and above to reiterate expectations, and responsibilities to reinforce procedure use and adherence.
- Include an Area for Development associated with Reinforcing Procedure Use and Adherence in the Individual Development Plans for each first line supervisor and above.

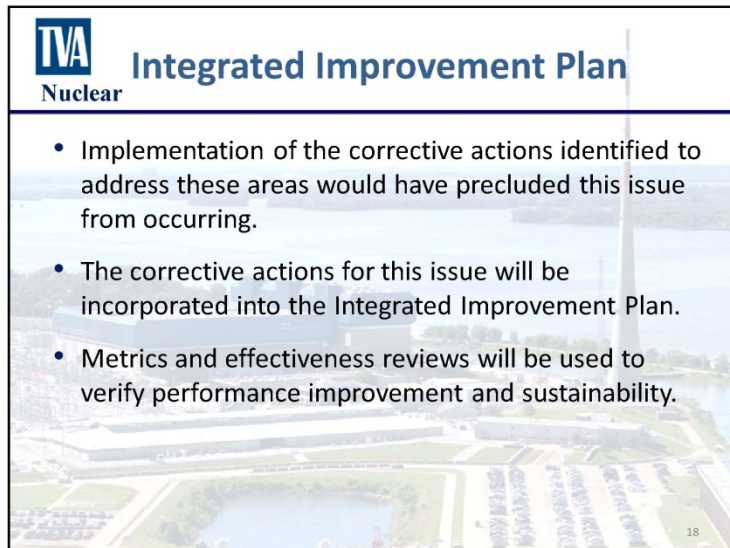
16

This slide features the TVA Nuclear logo in the top left corner. The background is a faded aerial photograph of a large industrial facility, likely a nuclear power plant, with multiple buildings and a tall containment dome. The title "Integrated Improvement Plan" is prominently displayed in the upper right. The content consists of a bulleted list starting with a general statement about SSI inspection findings, followed by a sub-bulleted list of six specific areas: Management, Leadership, and Standards; Operational Focus / Decision Making; Corrective Action Program; Procedure Use and Adherence; Procedure / Instruction Quality; and Technical Rigor.

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Integrated Improvement Plan

- The causes for the SSI inspection finding are consistent with Browns Ferry's recently completed 95003 diagnostic effort. Specifically:
 - Management, Leadership, and Standards
 - Operational Focus / Decision Making
 - Corrective Action Program
 - Procedure Use and Adherence
 - Procedure / Instruction Quality
 - Technical Rigor

This slide features the TVA Nuclear logo in the top left corner. The background is a faded aerial photograph of a large industrial facility, likely a nuclear power plant, with multiple buildings and a tall containment dome. The title "Integrated Improvement Plan" is prominently displayed in the upper right. The content consists of a bulleted list with three items: implementation of corrective actions to prevent recurrence, incorporation of corrective actions into the IIP, and the use of metrics and effectiveness reviews for verification.

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Integrated Improvement Plan

- Implementation of the corrective actions identified to address these areas would have precluded this issue from occurring.
- The corrective actions for this issue will be incorporated into the Integrated Improvement Plan.
- Metrics and effectiveness reviews will be used to verify performance improvement and sustainability.

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Closing Remarks

Preston Swafford
Chief Nuclear Officer, TVA

