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May 20, 2014 Presentation to NRC & TVA
NRC Browns Ferry Public Meeting
By Garry Morgan

POWER SUPPLY FAILURES

Antiquated parts - repetitive power supply failures: Antiquated Power Supply's causing failures, references http://www.nucpros.com/content/browns-ferry-nuclear-plant-unit-3-ler-annunciator-panel-power-supply-fire-unit-3-control-roo Quote from Nuc-Pros: "This same failure has occurred three times with similar response. On January 26, 2012, at 1908 hours Central Standard Time (CST) Browns Ferry Nuclear Plant (BFN), Unit 3, was in Mode 1 at 100 percent power. Operations personnel in the BFN, Unit 3 Control Room, smelled smoke and observed a flame coming from the bottom of a power supply located in an annunciator panel."

NRC Event Notification Report for May 12, 2014 Event Number 50090, Unit 3. A Core and Containment Cooling Systems Analog Trip Unit Functional Test was in progress, the reactor scrammed due to a failed power supply.

INPO JULY 2010 PEER REVIEW REPORT SUMMARY

The Browns Ferry 2010 INFO Report identified 25 serious problems at TVA's Browns Ferry Nuclear Power Plant. INPO, Institute for Nuclear Power Operations, was established by the nuclear power industry in December 1979. The Institute of Nuclear Power Operations is a not-for-profit organization headquartered in Atlanta.

INPO Browns Ferry Disclosures, July 2010:

[Note: Item 1, pages 30-31 from Field notes]

1. The TVA and the NRC knew of several valve failures, not just one. Valve failures had been an ongoing serious issue in all three Browns Ferry Nuclear Plants since 2006.

[Note: Items 2-25 pages 1-17, Executive Summary]

2. Notable gaps in operator fundamentals remain.
3. Weaknesses in the review and recognition of risks associated with some work activities have negatively impacted plant operations.
4. The conduct of maintenance has improved, however, behavior gaps continue to adversely affect safety system performance and cause reworks and injuries.
5. Management is not holding key personnel accountable.
6. On-line risk continues to be adversely affected.

7. Chemistry performance has declined, performance gaps are not fully understood. Several unplanned and unmonitored radioactive releases have occurred.
8. Significant gaps in equipment health and component reliability have not been resolved.
9. High-Pressure core injection systems have experienced multiple failures and are not meeting industry goals.
10. Reactor core cooling system failures are attributed to age related degradation.
11. Multiple safety system failures in the emergency system cooling water and residual heat removal service water.
12. Multiple scrams and transients were the results of long standing equipment problems not corrected, industry goals are not being met.
13. Source of increasing unidentified dry well leakage not identified.
14. Several long standing emergency generator problems have not been resolved.
15. Equipment reliability programs and processes are not being implemented in a manner that will result in a timely resolution of problems, equipment failures or the prevention of new problems.
16. Initiatives to improve equipment reliability are inhibited by supervisors and management.
17. Preventive maintenance is not being implemented to prevent equipment failures.
18. Inadequate consideration of design inputs for plant modifications resulted in multiple scrams.
19. A significant vulnerability remains with the lack of testing for safety related cables.
20. Industry standards for radiological protection are not being met.
21. A number of organizational and human performance issues exist because personnel were not effective at identifying, properly characterizing, and resolving issues with appropriate corrective actions.
22. Gaps in operational risk assessment, equipment reliability, and human performance remain. As a result, the station is vulnerable in its ability to sustain event-free operations.
23. Workforce behaviors and cultural norms are not aligned with a strong nuclear safety culture.
24. Management's acceptance of degraded conditions challenges safety system reliability.
25. Station is adversely impacted by weaknesses in supervisory and individual behaviors which have the potential to impact future station performance. Workers in several work groups tend to deviate from station standards and station supervisors often do not correct these behaviors.

WANO REPORT REQUEST

A later Peer Review report on Browns Ferry by the World Association of Nuclear Operators (WANO), published in 2013, would verify progress on the issues reported by 2010 INPO report. TVA claims that the inspection of this report by me would harm TVA's future participation in WANO. I did not request a copy of the report, I requested permission to inspect the report.

TVA's denial of my request to inspect also states that the WANO report contains proprietary methodology and would harm WANO's competitive financial position in the nuclear power industry. WANO is a non-profit organization.

Neither the TVA nor the NRC should keep secret work practice issues which could create a danger to the public at large.

Proprietary information, restricted commercial/financial information and copyright restrictions are bogus red-herring arguments which are unsupportable excuses to not inform the public about serious management and safety culture failures at the Browns Ferry nuclear power facility.

We are not speaking about the failure of a valve in one safety system, as the NRC and TVA would like the public to believe. We are speaking about the intentional cover-up of multiple unsafe operations as a result of failed management and a failed safety culture at a nuclear power plant. How does the public know the serious deficiencies described in the INPO report have been corrected?

The recent NRC 95003 Red Finding at Browns Ferry involved a valve problem, not the complete breakdown of TVA management at Browns Ferry, which the INPO report vividly describes.

Maybe the NRC, TVA, INPO, WANO and others should 'practice what they preach' as it applies to law and policy. NRC Safety Culture Policy Statement – "The Safety Culture Policy Statement (76 FR 34773; June 14, 2011) describes the Commission's expectation that individuals and organizations performing regulated activities establish and maintain a positive safety culture that recognizes the safety and security significance of their activities and the nature and complexity of their organizations and functions." http://www.nrc.gov/about-nrc/safety-culture/sc-policy-statement.html

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