



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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ARLINGTON, TEXAS 76011-8064

DEC 27 1999

S. K. Gambhir, Division Manager
Nuclear Operations
Omaha Public Power District
Fort Calhoun Station FC-2-4 Adm.
P.O. Box 399
Hwy. 75 - North of Fort Calhoun
Fort Calhoun, Nebraska 68023-0399

SUBJECT: INSPECTION PLAN - FORT CALHOUN STATION

Dear Mr. Gambhir:

On December 7, 1999, the NRC staff reviewed the performance of Fort Calhoun Station as reflected in the performance indicators and inspection results in order to integrate performance information and to plan for inspection activities at your facility from December 1, 1999, through July 31, 2000. The purpose of this letter is to inform you of our plans for future inspections at your facility so that you will have an opportunity to prepare for these inspections and to inform us of any planned inspections which may conflict with your plant activities.

Our review of Fort Calhoun Station identified that you have crossed the green (licensee response band) to white (increased regulatory response band) threshold for the Emergency Preparedness Drill & Exercise Performance indicator on two occasions, based on monthly reporting. We have conducted additional inspections of your investigation into these events in accordance with the action matrix and we are satisfied with your review and proposed corrective actions. We also noted that when calculated on a quarterly basis, as the performance indicator currently reflects, you would not have transitioned from green to white. Therefore, no additional inspections are planned in the emergency preparedness cornerstone.

This letter advises you of our planned inspection effort resulting from the Fort Calhoun Station midcycle review. Enclosure 1 details the scheduled inspections that will occur from December 1, 1999, to July 31, 2000. The inspection plan is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Routine resident inspections are not listed due to their ongoing and continuous nature. The last 4 months of the inspection plan are tentative and will be revised at the end-of-cycle review meeting.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room (PDR).

If circumstances arise which cause us to change this inspection plan, we will contact you to discuss the change as soon as possible. Please contact me at 817/860-8185 with any questions you may have regarding this letter or the inspection plan.

Sincerely,



Charles S. Marschall, Chief
Project Branch C
Division of Reactor Projects

Docket No.: 50-285
License No.: DPR-40

Enclosures:

1. Fort Calhoun Station Inspection/Activity Plan
2. Plant Issues Matrix

cc w/enclosures:

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Omaha Public Power District

-4-

DEC 27 1999

E-Mail all documents to Jim Isom for Pilot Plant Program (JAI)

E-Mail all documents to Sampath Malur for Pilot Plant Program (SKM)

E-Mail notification of issuance of all documents to Nancy Holbrook (NBH).

bcc to DCD (IE01)

bcc distrib. by RIV:

Regional Administrator

DRP Director

DRS Director

Branch Chief (DRP/C)

Project Engineer (DRP/C)

Chief, NRR/DIPM/IIPB

RIV File

RITS Coordinator

Resident Inspector

Branch Chief (DRP/TSS)

DOCUMENT NAME: R\PILOT INSPECTION PROGRAM\INSPECTION PLANS\FCS
MIDCYCLE INSP PLAN LETTER

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RIV:C:DRP/C		RSLO		PAO					
CSMarschall;df <i>SM</i>		CAHackney <i>CA</i>		BHenderson <i>BH</i>					
12/23/99		12/23/99		12/23/99					

OFFICIAL RECORD COPY

FORT CALHOUN
Inspection / Activity Plan
12/01/1999 - 07/31/2000

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates Start	Planned Dates End	Inspection Type
	EMB	- TRIENNIAL FIRE PROTECTION TEAM INSPECTIO	3				
1	IP 71111.05	Fire Protection (I,M)		3	01/24/2000	01/28/2000	Other Routine
	PSB-01	- ACCESS AUTH/ACCESS CONTROL & PIV	1				
1	IP 71130.01	Access Authorization		1	04/03/2000	04/07/2000	Other Routine
1	IP 71130.02	Access Control		1	04/03/2000	04/07/2000	Other Routine
1	IP 71151	Performance Indicator Verification		1	04/03/2000	04/07/2000	Other Routine
	OB-PIR	- PIR INSPECT	6				
1	IP 71152	Identification and Resolution of Problems		2	05/15/2000	05/19/2000	Other Routine
	PSB-02	- RAD MAT PROCESSING & SHIPPING	1				
1	IP 71122.02	Radioactive Material Processing and Shipping		1	06/05/2000	06/09/2000	Other Routine

United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region IV
 05000285 - FORT CALHOUN 1

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
10/26/1999	1999013	NRC	FIN	Initiating Events	Green	<p>LOSS OF VITAL AC WHILE SHUT DOWN</p> <p>Green. During the refueling outage, the vital buses lost power for 2 minutes as operators transferred station lighting from 4160 volt Vital Bus 1A3 to Vital Bus 1A4.</p> <p>The NRC staff determined that this event had low risk significance because, using conservative assumptions, operators had a recovery time in excess of 10 hours before boiling around the core would occur. This gave operators sufficient time to start the emergency diesel generators and place shutdown cooling in service. In addition, the actual loss of power lasted 2 minutes, and reactor coolant and spent fuel pool temperatures remained unchanged during this period.</p>
10/27/1999	1999013-01	NRC	NCV	Mitigating Systems	Green	<p>FAILURE TO INDEPENDENTLY VERIFY VALVE POSITION OF THE UPPER SPENT FUEL POOL SUCTION V</p> <p>Green. An operator failed to properly align the upper spent fuel pool cooling suction valve. The resultant loss of cooling had only minor consequences.</p> <p>The issue was characterized as having low safety significance. The failure to provide a suction source for cooling of the spent fuel pool had the potential to result in a release of radioactivity due to loss of cooling to the spent fuel. Due to operator attentiveness and prompt action, however, no increase in radiation and only a slight increase in spent fuel pool temperature (4 F) resulted. Failure to independently verify the valve position is being treated as a noncited violation of Technical Specification 5.8.1, consistent with the interim enforcement policy for pilot plants.</p>
11/04/1999	1999014-01	NRC	NCV	Occupational Radiation Safety	Green	<p>VIOLATION OF TECHNICAL SPECIFICATION 5.11.1/FAILURE TO PERFORM ALARA REVIEWS</p> <p>Green. Two examples of failures to perform ALARA reviews were identified. The first example was identified after the NRC observed inconsistencies in the use of engineering controls and respiratory protection equipment. The first example involved the failure of ALARA planners to review the need for engineering controls or respiratory protection equipment during certain quality control inspections. The second example involved the failure of ALARA planners to review dose reduction methods associated with outage activities that exceeded their estimated dose totals. These findings were examples of a violation of Technical Specification 5.11.1, which requires that procedures for personnel radiation protection be prepared consistent with the requirements of 10 CFR Part 20 and be approved, maintained, and adhered to for all operations involving personnel radiation exposure.</p> <p>The failure to perform ALARA reviews could result in unplanned personnel radiation dose, if appropriate dose saving measures were not identified and implemented. However, because the incidents did not result in overexposures or have a significant potential to cause overexposures in these examples, the Occupational Radiation Safety Significance Determination Process indicated that both violation examples had a very low risk significance. This violation is being treated as non-cited violations, consistent with the Interim Enforcement Policy for pilot plants. This violation is in the licensee's corrective action program as Condition Reports 199902241 and 199902258.</p>

United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region IV
 05000285 - FORT CALHOUN 1

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
11/04/1999	1999014-02	NRC	NCV	Occupational Radiation Safety	Green	<p>VIOLATION OF 10 CFR 20.1703(a)(3)(iv)/INADEQUATE SELF-CONTAINED BREATHING APPARATUS TRAINING</p> <p>Green. A violation of 10 CFR 20.1703(a)(3)(iv) was identified because the licensee's self-contained breathing apparatus training program was incomplete and, therefore, inadequate. Specifically, the procedure used to train non-fire brigade personnel in the use of self-contained breathing apparatuses was inadequate because it did not inform individuals as to the correct method of changing air supply bottles during use. This resulted in some individuals receiving incomplete training in the use of respiratory protection equipment.</p> <p>The violation could result in personnel injury if individuals were inadequately trained and unable to change air supply bottles while in an atmosphere that was immediately dangerous to life or health. However, through use of the Emergency Preparedness Significance Determination Process, the NRC determined the violation had a very low risk significance because it did not involve the failure to implement or meet an emergency preparedness planning standard and there had been no actual event. This violation is being treated as a non-cited violation, consistent with the Interim Enforcement Policy for pilot plants. This violation is in the licensee's corrective action program as Condition Report 199700559.</p>
10/22/1999	1999012-01	NRC	NCV	Occupational Radiation Safety	Green	<p>FAILURE TO MEET THE REQUIREMENTS OF TECHNICAL SPECIFICATION 5.3.1</p> <p>Green. The inspector identified a violation for the failure of a contractor radiation protection technician to meet the minimum qualifications of Technical Specification 5.3.1. Using radiation protection personnel that do not meet the minimum qualifications of Technical Specification 5.3.1 could ultimately result in improper radiation worker job coverage and/or inaccurate radiological assessments of work areas and conditions. In utilizing the significance determination process, this issue was determined to have very low risk significance, because there were no instances of an overexposure event. This violation is being treated as a noncited violation, consistent with Appendix F of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report 199902232.</p>
10/20/1999	1999012-02	NRC	NCV	Occupational Radiation Safety	Green	<p>FAILURE TO INFORM RADIATION WORKERS OF THE RADIOLOGICAL CONDITIONS IN THEIR WORK AREA</p> <p>Green. The inspector identified two examples of a violation of 10 CFR 19.12(a) for the failure to inform radiation workers of the radiological conditions in their work area prior to the start of work. The failure to inform workers of the radiological conditions in their work area could cause the workers to receive unnecessary radiation exposure or become contaminated. In utilizing the significance determination process, these examples were determined to have very low risk significance, because there were no instances of an overexposure event and general area radiation levels were approximately 600 millirems per hour. This violation is being treated as a noncited violation, consistent with Appendix F of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report 199902241.</p>
10/11/1999	1999012-03	Licensee	NCV	Occupational Radiation Safety	Green	<p>FAILURE TO LOCK A RESTRICTED HIGH RADIATION AREA TO PREVENT UNAUTHORIZED ENTRY</p> <p>Green. The licensee identified a violation of Technical Specification 5.11.2 for the failure to lock a restricted high radiation area to prevent an unauthorized entry. The failure to lock a restricted high radiation area could cause a worker to receive an unplanned radiation exposure. In utilizing the significance determination process, this issue was determined to have very low risk significance, because there were no instances of an overexposure event and general area radiation levels were approximately 1500 millirems per hour. This violation is being treated as a noncited violation, consistent with Appendix F of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Report 199902076.</p>

United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

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Region IV
 05000285 - FORT CALHOUN 1

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
10/08/1999	1999012-04	Licensee	NCV	Occupational Radiation Safety	Green	<p>FAILURE TO POST A RADIATION AND HIGH RADIATION AREA</p> <p>Green. The licensee identified two examples of a violation of 10 CFR 20.1902 for the failure to post a radiation and high radiation area. Not posting radiation and high radiation areas could cause a worker to receive an unplanned radiation exposure. In utilizing the significance determination process, this issue was determined to have very low risk significance, because there was not a substantial potential for an overexposure event and general area radiation levels were approximately 200 millirems per hour. This violation is being treated as a noncited violation, consistent with Appendix F of the NRC Enforcement Policy. These examples of a violation are in the licensee's corrective action program as Condition Reports 199902046 and 199902099 (Section 4OA1).</p>
08/23/1999	1999011-01	NRC	NCV	Occupational Radiation Safety	Green	<p>RADIATION WORKERS FAILED TO IMMEDIATELY LEAVE THE CHARGING PUMP ROOM, DURING PERFO</p> <p>Green. Radiation workers failed to immediately leave the charging pump room, during performance of work in the room, when a noble gas area radiation monitor was alarming.</p> <p>This issue was characterized as having low safety significance based on the significance determination process review for occupational radiation safety. The failure to leave the charging pump room when a noble gas radiation monitor was in alarm could have resulted in an unintended personnel exposure. No overexposure occurred; however, and no significant exposure could have resulted from this event due to the highest sampled airborne radioactive concentration of approximately .1 DAC being well below the required posting of an airborne radiation area of .3 DAC. In addition, the ability to monitor and determine personnel dose was not lost as evidenced by the functioning air monitoring system and whole body counts performed on the workers who failed to exit the charging pump room. The licensee's review of this issue was consistent with the inspector's determination. The inspectors concluded that the workers failed to adhere to the requirement in Section 5.6.1 (c) of Standing Order SO-G-101, "Radiation Worker Practices," Revision 12, to immediately leave the area and notify the control room if an area radiation monitor or continuous air monitor alarms. We are treating this violation as a noncited violation, consistent with the Interim Enforcement Policy for pilot plants. The licensee documented this in their corrective action program as Condition Report 199901594.</p>
07/23/1999	1999007	NRC	FIN	Occupational Radiation Safety	Green	<p>Occupational Radiation Safety-Green; failure to Source Check instrument prior to use.</p> <p>A radiation protection technician failed to response check a neutron survey meter prior to use during an at power entry into the reactor containment building. Using a survey instrument that was not response checked prior to use could have provided inaccurate information needed to assess radiological conditions. This finding was viewed as an issue which had the potential as an overexposure event. The ability to monitor and assess the workers' dose was never lost. Using the SDP, this issue was determined to have minimal impact on safety. (Section 4OA1).</p>

United States Nuclear Regulatory Commission

Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Legend

Type Codes:

AV	Apparent Violation
FIN	Finding
NCV	NonCited Violation
URI	Unresolved item
VIO	Violation

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

AVs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the AVs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

E-Mail all documents to Jim Isom for Pilot Plant Program (JAI)

E-Mail all documents to Sampath Malur for Pilot Plant Program (SKM)

E-Mail notification of issuance of all documents to Nancy Holbrook (NBH).

bcc to DCD (IE01)

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DRS Director

Branch Chief (DRP/C)

Project Engineer (DRP/C)

Chief, NRR/DIPM/IIPB

RIV File

RITS Coordinator

Resident Inspector

Branch Chief (DRP/TSS)

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