UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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July 12, 2010

David J. Bannister, Vice President
and Chief Nuclear Officer
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Subject: ERRATA FOR FORT CALHOUN STATION NRC INTEGRATED INSPECTION REPORT 05000285/2009004 and 072000054/2009001

Dear Mr. Bannister:

It was identified that an inconsistency exists in REPORT 05000285/2009004 and 072000054/2009001, dated November 13, 2009, between the description of the crosscutting aspect of the first GREEN finding under the “Barrier Integrity” cornerstone located in the “Summary of Findings,” and the description of the finding in Section 1R15, “Operability Evaluations.” Specifically, the correct crosscutting aspect for the described finding was in problem identification and resolution because of the failure to take appropriate corrective actions to address safety issues [P.1 (d)]. This is consistent with the information that was provided during the exit meeting held on October 7, 2009. As a result of this correction, please replace page 3 of the report with the enclosed page 3 (Summary of Findings).

In addition, it was also found that an inspection activity was inadvertently omitted from the same NRC Inspection Report 05000285/200904 and 072000054/2009001, dated November 13, 2009. The inspection activity in question was the in-office review of Revision 14 to the Fort Calhoun Station Radiological Emergency response Plan Section L, “Medical and Public Health Support,” and Section F, “Emergency Communications.” Please add page 34 to NRC Inspection Report 05000285/200904 and 072000054/2009001.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and its enclosure, will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records 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).

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Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

Jeffrey A. Clark, P.E.
Chief, Project Branch E
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Docket: 50-285
License: DPR-40

Enclosure:
Errata Pages 3 and 34 for NRC Inspection Report 05000285/200904 and 072000054/2009001

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SUNSI Rev Compl.	☒ Yes ☐ No	ADAMS	☒ Yes ☐ No	Reviewer Initials	JAC
Publicly Avail	☒ Yes ☐ No	Sensitive	☐ Yes ☒ No	Sens. Type Initials	JAC

SRI:DRP/E	SPE:DRP/E	C:DRS/PSB1	C:DRP/E	
JKirkland	RAzua	MPShannon	JAClark	
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07/08/10	07/08/10	0709/10	07/12/10	

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either installed in the plant or stored in the warehouse. Additionally, the procedure failed to adequately evaluate defects in components, which have never been installed or used in the nuclear plant.

The inspectors determined that the failure to adopt appropriate procedures to evaluate deviations and failures to comply associated with substantial safety hazards was a performance deficiency. This finding was more than minor because if the procedure were left uncorrected it could become a more serious safety concern. Specifically, failure to notify the vendor upon discovery of a deviation does not allow for adequate evaluation of other components that could be subject to the deviation. Additionally, components with deviations could be located in the licensee's warehouse and subsequently installed in the plant without the licensee's knowledge, potentially creating a substantial safety hazard. Because this issue affected a potential reporting requirement and NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. Consistent with the guidance in Section IV.A.3 and Supplement VII paragraph D.4 of the NRC Enforcement Policy, this violation was categorized at Severity Level IV noncited violation. There is no crosscutting aspect associated with this finding because it is not indicative of current performance in that the procedure is many years old. (Section 4OA3)

Cornerstone: Barrier Integrity

- Green. The inspectors identified a finding of having very low safety significance (Green) for failure to perform checks at the beginning of each shift on the main hoist limit switches of the refueling area crane (HE – 2) in the spent fuel pool area as specified in ANSI B30.2 – 1976, "Overhead and Gantry Cranes", Section 2-2.1.2 Frequent Inspections a.2, prior to using the crane to perform dry fuel storage activities on June 29, 2009.

  The failure to perform checks on the main hoist limit switches at the beginning of each work shift is a performance deficiency because the dry cask personnel used the crane to perform dry cask storage operations to lift items over the spent fuel pool without performing the required checks per shift change. The inspectors determined that the performance deficiency was more than minor in accordance with Inspection Manual Chapter 0612, Appendix B, "Issue Screening", minor question 2 because if left uncorrected the performance deficiency could lead to a more significant safety issue. Specifically, the main hoist limit switches are installed to limit the main hoist travel and to prevent a two blocking event. Preventing two blocking events ensures safe load handling of heavy loads over the spent fuel pool. Using the NRC Manual Chapter 0609, Phase 1 screening worksheet under the Barrier Cornerstone for spent fuel pool issues, the finding screened as having very low safety significance because it did not result in loss of cooling to the spent fuel pool, did not cause damage to the fuel cladding or result in dropped fuel assembly or result in a loss of spent fuel pool volume of greater than 10 percent. The finding had a crosscutting aspect in problem identification and resolution because the licensee failed to take appropriate corrective actions to address safety issues [P.1 (d)]. (Section 1R15)

1EP4 Emergency Action Level and Emergency Plan Changes (71114.04)

a. Inspection Scope

The inspector performed an in-office review of Revision 14 to Fort Calhoun Station Radiological Emergency Response Plan Section L, “Medical and Public Health Support,” submitted August 5, 2009, and Section F, “Emergency Communications,” submitted September 24, 2009. These revisions designated the Operations Support Center as having responsibility for medical response while the facility is activated, relocated the First Aid Room from the Technical Support Center to the Maintenance Building, expanded the number of stations on the Conference Operations Network hotline, and added additional communications capability at the Scenario Development Room.

These revisions were compared to their previous revisions, to the criteria of NUREG-0654, “Criteria for Preparation and Evaluation of Radiological Emergency Response Plans and Preparedness in Support of Nuclear Power Plants,” Revision 1, and to the standards in 10 CFR 50.47(b) to determine if the revisions adequately implemented the requirements of 10 CFR 50.54(q). These reviews were not documented in safety evaluation reports and did not constitute approval of licensee-generated changes; therefore, these revisions are subject to future inspection.

These activities constitute completion of two samples as defined in Inspection Procedure 71114.04-05. **Note that combined with the results documented on page 18 of this report for Section 1EP4 these activities constitute a total completion of six samples in this report as defined in Inspection Procedure 71114.04-05.**

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA6 Meetings

Exit Meeting Summary

On September 29, 2009, the inspector conducted a telephonic exit meeting with Mr. S. Gebers, Manager, Emergency Preparedness and Health Physics, to present the results of the in-office inspection of licensee changes to their emergency plan. The licensee acknowledged the issues presented. The inspector asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.