In Reply Refer To:
Docket: 50-285/85-07

MAY 14 1985

Omaha Public Power District
ATTN: R. L. Andrews, Division Manager -
Nuclear Production
1623 Harney Street
Omaha, Nebraska 68102

Gentlemen:

This refers to the Systematic Assessment of Licensee Performance (SALP) Board Report of the Fort Calhoun Station. The SALP Board met on April 16, 1985, to evaluate the performance of the subject facility for the period September 1, 1983, through February 28, 1985. The performance analyses and resulting evaluations are documented in the enclosed SALP Board Report.

The performance of your facility was evaluated in the selected functional areas identified in Section IV of the enclosed SALP Board Report.

The overall performance of Omaha Public Power District at the Fort Calhoun Station indicates a high level of dedication to nuclear safety as well as a high degree of technical competence in diverse areas essential to the safe operation of the facility.

It is of significant merit that the facility received Category 1 ratings in the following functional areas: plant operations, radiological controls, maintenance, fire protection, surveillance, refueling, and licensing activities. Additionally, a general trend toward a more favorable rating in quality programs and administrative controls affecting quality when compared to the previous SALP evaluation is noted. The decline in the performance category rating for security and safeguards indicates a need for aggressive management attention. The repeat Category 3 rating for training is based on the conclusion that the majority of OPPD's plans to upgrade this area are still in the developmental stage.

Unless you specifically request it, a management meeting will not be scheduled for this reporting period. Any request for a management meeting should be made, in writing, within 10 days of receipt of this report.

Any comments you may have regarding our evaluation of the performance of your facility should be submitted to this office within 30 days of issue of the SALP report. We specifically request that you advise us of actions you plan to take

RIV:RPB2/A	RPB2/A	RPB1/SPES	D/DRSS	DRSP	RA-RIV
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in response to the Category 3 ratings in the security and safeguards, and training functional areas. Your comments and our disposition of the same will be issued as appendices to the SALP Board Report.

Comments which you may submit are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, PL-96-511.

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

Sincerely,

Original signed by
Robert D. Martin

Robert. D. Martin
Regional Administrator

Enclosures:
Appendix - NRC SALP Board Report 50-285/85-07
Attachment 1 - NRR Supplement
Attachment 2 - AEOD Supplement

cc w/enclosures:

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bcc to DMB (IE40)

bcc distrib. by RIV: (Cont. on next page)

*RPB1
*RPB2
*EP&RPB
*RIV File
*Resident Inspector
*Section Chief (RPB2/A)
R. P. Denise, DRS&P
R. D. Martin, RA
*MIS System
*RSTS Operator
*D. Weiss, LFMB (AR-2015)
All RRIs (9)

M. E. Murphy, RIV
ALL RRIs
Records Center, INPO
J. M. Taylor, D/IE
Chmn. N. J. Palladino (MS: H-1144)
Comm. P. M. Roberts (MS: H-1149)
Comm. J. K. Asselstine (MS: H-1149)
Comm. F. M. Bernthal (MS: H-1149)
Comm. L. W. Zeck (MS: H-1149)

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SALP BOARD REPORT

U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

SYSTEMATIC APPRAISAL OF LICENSEE PERFORMANCE

50-285/85-07

Omaha Public Power District

Fort Calhoun Station

September 1, 1983 - February 28, 1985

I. INTRODUCTION

The Systematic Assessment of Licensee Performance (SALP) program is an integrated NRC staff effort to collect available observations and data on a periodic basis and to evaluate licensee performance based upon this information. SALP is supplemental to normal regulatory processes used to ensure compliance to NRC rules and regulations. SALP is intended to be sufficiently diagnostic to provide a rational basis for allocating NRC resources and to provide meaningful guidance to the licensee's management to promote quality and safety of plant operation.

An NRC SALP Board, composed of the staff members listed below, met on April 16, 1985, to review the collection of performance observations and data to assess the licensee performance in accordance with the guidance in NRC Manual Chapter 0516, "Systematic Assessment of Licensee Performance." A summary of the guidance and evaluation criteria is provided in Section II of this report.

This report is the SALP Board's assessment of the licensee's safety performance at Fort Calhoun Station for the period September 1, 1983, through February 28, 1985.

SALP Board for Fort Calhoun Station:

- R. P. Denise, Director, Division of Reactor Safety and Projects (Chairman)
- R. L. Bangart, Director, Division of Radiation Safety and Safeguards
- L. E. Martin, Section Chief, Project Section A, Reactor Project Branch 2
- L. A. Yandell, Senior Resident Inspector
- J. R. Miller, Chief, Operating Reactors Branch 3
- E. G. Tourigny, Project Manager

Attendees at all or part of the SALP Board Meeting were:

- R. E. Hall, Chief, Emergency Preparedness and Radiological Protection Branch
- W. C. Seidle, Technical Assistant
- J. B. Baird, Chief, Emergency Preparedness Section
- R. J. Everett, Chief, Nuclear Materials Safety Section
- R. E. Baer, Regional Inspector

II. CRITERIA

Licensee performance was assessed in 11 selected functional areas. Each functional area normally represents areas significant to nuclear safety and the environment, and are normal programmatic areas.

One or more of the following evaluation criteria were used to assess each functional area.

1. Management involvement and control in assuring quality.

2. Approach to resolution of technical issues from a safety standpoint.

3. Responsiveness to NRC initiatives.

4. Enforcement history.

5. Reporting and analysis of reportable events.

6. Staffing (including management).

7. Training effectiveness and qualification.

However, the SALP Board is not limited to these criteria and others may have been used where appropriate.

Based upon the SALP Board assessment each functional area evaluated is classified into one of three performance categories. The definition of these performance categories is:

Category 1. Reduced NRC attention may be appropriate. Licensee management attention and involvement are aggressive and oriented toward nuclear safety; licensee resources are ample and effectively used so that a high level of performance with respect to operational safety is being achieved.

Category 2. NRC attention should be maintained at normal levels. Licensee management attention and involvement are evident and are concerned with nuclear safety; licensee resources are adequate and are reasonably effective so that satisfactory performance with respect to operational safety is being achieved.

Category 3. Both NRC and licensee attention should be increased. Licensee management attention or involvement is acceptable and considers nuclear safety, but weaknesses are evident; licensee resources appear to be strained or not effectively used so that minimally satisfactory performance with respect to operational safety is being achieved.

The SALP Board has also categorized the performance trend over the course of the SALP assessment period. The trend is meant to describe the general or prevailing tendency (the performance gradient) during the SALP period. This categorization is not a comparison between the current and previous SALP ratings; rather the categorization process involves a review of performance during the current SALP period and categorization of the trend of performance during that period only. The performance trends are defined as follows:

Improved: Licensee performance has generally improved over the course of the SALP assessment period.

Same: Licensee performance has remained essentially constant over the course of the SALP assessment period.

Declined: Licensee performance has generally declined over the course of the SALP assessment period.

III. SUMMARY OF RESULTS

In summary, the licensee has exhibited significant strength in the areas of plant operations, radiological controls, maintenance, fire protection, surveillance, refueling, and licensing activities. Weak areas identified included security and safeguards, and training. The licensee's performance and trend are summarized in the table below along with the performance category from the previous SALP evaluation period:

	Functional Area	Previous Performance Category (9/1/82 to 8/31/83)	Present Performance Category (9/1/83 to 2/28/85)	Trend During Latest SALP Period
A.	Plant Operations	1	1	Declined
B.	Radiological Controls		1	Improved
	1. Radiation Protection	2	N/A	
	2. Chemistry/Radiochemistry and Confirmatory Measurements	3	N/A	
	3. Radwaste Management, Effluent Releases, and Effluent Monitoring	2	N/A	
	4. Transportation/Solid Radwaste	3	N/A	
	5. Environmental Monitoring	2	N/A	
C.	Maintenance	2	1	Improved
D.	Surveillance	1	1	Same
E.	Fire Protection	2	1	Same

F.	Emergency Preparedness	2	2	Improved
G.	Security and Safeguards	2	3	Improved
H.	Refueling	1	1	Same
I.	Quality Programs and Administrative Controls Affecting Quality*	3	2	Improved
J.	Licensing Activities	2	1	Improved
K.	Training	3	3	Improved

*This category was divided into two individual categories in the previous SALP report.

The total NRC inspection effort during this SALP evaluation period consisted of 44 inspections including resident inspector inspections and emergency exercises for a total of 3,241 direct inspection man-hours.

IV. PERFORMANCE ANALYSIS

A. Plant Operations

1. Analysis

This area was inspected on a continuing basis by the NRC resident inspector. Four violations and no deviations were identified in this functional area during the appraisal period:

- Failure to properly terminate a containment pressure reduction when the limiting X/Q was exceeded. (Severity Level IV, 8407-01)

- Failure to provide an adequate procedure requiring independent verification of tag-outs to ensure that equipment was properly isolated. (Severity Level IV, 8412-01)

- Failure of shift supervisor to document review of maintenance orders. (Severity Level IV, 8412-02)

- Failure to install the locking device on a closed valve as required by the procedure lineup. (Severity Level IV, 8429-02)

The four Licensee Event Reports (LERs) listed below involved activities in the area of plant operations:

- Inadvertent opening of breaker supplying power to a control room DC panel. (LER 84-003)

- Unplanned actuation of VIAS while shifting to the high alert/alarm setpoints. (LERs 84-014, 84-019, and 84-024)

Fort Calhoun Station maintains an experienced group of senior operators and reactor operators. The plant manager, three of the five technical area supervisors, three training supervisors, and the plant engineer all hold and maintain senior reactor operator licenses and provide support and technical expertise to the operations department. Operating personnel exhibit a strong commitment to procedural compliance and a good understanding of technical issues associated with plant operations. These strengths have been observed by NRC inspectors during emergency preparedness drills, routine operations, and abnormal plant situations. The Fort Calhoun Station completed 302 days of continuous operation (the longest in the plant's history) during this evaluation period which is indicative of the high caliber of onshift personnel. The plant experienced only one reactor trip this SALP period, the first since December 1982.

The operations department has experienced a net loss of licensed personnel during this appraisal period. Attrition due to resignations, retirement, and one transfer to another department prevents the licensee from manning a full six-shift rotation as they did on January 1, 1984, when the new manning regulations went into effect. Additional burden was placed on the licensed operators due to long term disabilities, hospitalizations, and the removal of one senior operator from the shift rotation for training following his failure of the annual requalification examination. A review of licensee statistics for the last quarter of this appraisal period indicated that overtime work hours are increasing.

The licensee continued their program of upgrading the Fort Calhoun Station annunciator system to eliminate nuisance alarms and to have no annunciators lit during power operation. Significant progress was made during the last refueling outage with work continuing in this area as part of the overall control room design review being done in accordance with Supplement 1 to NUREG-0737 (Generic Letter 82-33), Item 1.D.1. Portions of the safety parameter display system were energized this report period and are available for use by the operators.

2. Conclusions

The overall performance level of the operations department has been excellent during this appraisal period. The net loss of licensed personnel and the lack of qualified replacements are a concern to the NRC.

The licensee is considered to be in Performance Category 1 in this area.

Trend: Declined

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area could be reduced.

b. Recommended Licensee Actions

Licensee management should give priority to reversing the declining trend related to staffing and staff qualifications to ensure that the licensee meets Fort Calhoun Station staffing objectives. Efforts to improve the control room annunciator system and to implement the recommendations of the control room design review should be continued.

B. Radiological Controls

1. Analysis

Eight inspections were conducted during the assessment period by region-based inspectors concerning radiological controls. These eight inspections covered the following areas: radiation protection-normal operations; radiation protection-refueling outage; radwaste management, effluent releases, and effluent monitoring; chemistry/radiochemistry and confirmatory measurements; and transportation/solid radwaste. One violation and no deviations were identified:

. Failure to Follow Procedures. (Severity Level V, 83-31)

a. Radiation Protection

This area was inspected twice during normal plant operations and once during a refueling outage.

The person-rem for 1983 was 433 as compared to the PWR national average of 592. In 1984, 544 person-rem was expended. The 1984 national averages have not been tabulated, but the 1984 values are expected to be near the 1983 levels. The licensee's person-rem average between 1978 and 1983 was 385 which is below the PWR national average of 556 for the same time period.

The radiation protection staff was stable during the assessment period. All members of the radiation protection staff met the ANSI N18.1-1971 qualification requirements as senior radiation protection technicians. The radiation protection staff consisted of 12 technicians, 2 supervisors, and 2 ALARA coordinators. The licensee had decreased reliance on contractor technicians; only one contractor technician was included in the radiation protection staff.

The lack of a full-time ALARA coordinator was noted as a concern in the previous assessment. In this assessment period, the licensee established and filled an ALARA coordinator and an assistant ALARA coordinator position. The implementation of an extensive decontamination program in the auxiliary building corridors, that allowed access into these areas without the need for protective clothing, was noted as a program improvement in the previous assessment. The licensee had continued to expand this decontamination effort to include additional areas and rooms in the auxiliary building. The lack of timely action to resolve open items was identified as a major concern in the previous assessment. In this assessment period, good progress had been made toward the resolution of outstanding open items.

A comprehensive training program has not been implemented for the radiation protection staff.

b. <u>Chemistry/Radiochemistry and Confirmatory Measurements</u>

This area was inspected once during the assessment period which included onsite confirmatory measurements with the Region IV mobile laboratory. The following LERs concerning this area were submitted:

- Boron concentrations in the Safety Injection and Refueling Water Tank below Technical Specification limits. (LERs 84-012 and 84-021)

An overall improvement was noted in the percent agreement between the NRC's and the licensee's measurements in this assessment period. Considerable improvement was made in the percent agreement concerning the comparative analyses of gaseous samples. The percent agreement for gaseous samples in this assessment was about 70 percent as compared to less than 50 percent in the previous assessment period. The licensee had implemented a quality control cross-check program with an offsite independent laboratory.

An approximate 60 percent turnover rate was noted among the chemistry/radiochemistry staff in the assessment period.

A comprehensive training program had not been implemented for radiochemistry personnel.

c. Radwaste Management, Effluent Releases, and Effluent Monitoring

This area was inspected once in the assessment period. The following LERs concerning this area were submitted:

- Exceeded Technical Specification Limits for I-131 Dose Equivalent in Reactor Coolant. (LER 84-004)
- Unplanned actuation of Ventilation Isolation Actuation Signal (VIAS) due to instrument error. (LERs 84-005, 006, 007, 010, 017, 018, and 023)
- Disconnection of sample line from auxiliary building ventilation duct to gaseous effluent monitor. (LER 84-011)
- Gaseous leak in the waste gas vent header caused stack iodine monitor to initiate VIAS. (LER 84-025)

The licensee had a well established program for sampling and analyses of liquid and gaseous samples to assure compliance with Technical Specification requirements. Improvements noted in this area included: installation of low-background steam generator blowdown radiation monitors; in-place calibration of liquid and gaseous effluent monitors with liquid and gas standards; and an in-place testing program for the auxiliary building HEPA filters.

Approximately 20 unplanned actuations of the VIAS related to instrument error were reported in LERs during the assessment period.

d. Transportation/Solid Radwaste

This area was inspected twice during the assessment period. The licensee had updated their program to include the revisions to Department of Transportation regulations effective July 1, 1983, and revisions to 10 CFR Part 20.311, 10 CFR Part 61.55, and 10 CFR Part 61.56 effective December 27, 1983. Improvements noted in this area included: assignment of a full-time radwaste coordinator; development of detailed shipping procedures and records; implementation of a QA/QC program concerning the packaging of radioactive materials; and establishing a procedure to evaluate the amount of radwaste generated.

A comprehensive training program had not been established for personnel involved with transportation/solid radwaste activities.

e. Environmental Monitoring

The radiological environmental monitoring program was inspected once during the assessment period. No significant problems were identified. There had been no turnover in the onsite staff responsible for the program during the past several years. Improvements noted in this area included the use of persons with expertise in environmental monitoring on the team responsible for auditing the radiological environmental monitoring program and implementation of comprehensive procedures for identification, collection, and shipping of environmental samples.

A formal training program had not been established for persons involved with the radiological environmental monitoring program.

2. Conclusions

Improvements were noted in the area of radiological controls in this assessment period as compared to the previous assessment and these improvements reflect strong management attention to weaknesses previously identified. The licensee had made good progress toward resolution of outstanding open items. During the assessment period, 31 open items were resolved and only one new open item was identified. A high turnover rate was noted among the chemistry/radiochemistry staff. Comprehensive training programs had not been established that included

schedules, goals and objectives, full-time instructors, lesson plans, and training aids.

No problems were noted concerning enforcement history, resolution of technical issues, management involvement, and responsiveness to NRC initiatives.

The licensee is considered to be in Performance Category 1 in this area.

Trend: Improved

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area could be reduced.

b. Recommended Licensee Actions

Management attention is needed to ensure that comprehensive training programs are established. Management should investigate the cause of the high turnover rate in the chemistry/radiochemistry staff and establish any appropriate remedial actions.

C. Maintenance

1. Analysis

This area was inspected by region-based NRC inspectors and on a continuing basis by the NRC resident inspector. Four violations and no deviations were identified in this functional area during the appraisal period:

- Failure to have proper receipt inspection of material performed prior to installation by maintenance personnel. (Severity Level V, 8415-01)

- Failure by maintenance craftsman to properly verify and use the correct revision of a surveillance test. (Severity Level IV, 8418-02)

- Failure to provide adequate procedures:

  a. to identify and resolve nonconformances associated with plant process instrumentation, surveillance test

instrumentation, and pressure gauges when found to be out-of-tolerance at calibration; and

b. to implement the cleaning requirements for fluid systems and associated components in accordance with ANSI N45.2.1-1973. (Severity Level V, 8421-01)

- Failure to follow procedures:

  a. by failing to perform investigation to determine the effect of secondary standards being out-of-tolerance; and

  b. by failing to provide minimum calibration schedules for oscilloscopes and electrical current measuring standards. (Severity Level IV, 8421-02)

The twelve LERs listed below involved activities in the area of maintenance:

- Diesel generator field failed to flash during surveillance test. (LERs 83-008 and 83-011)

- Reactor Coolant Loop RC-2A flow indicator loop failed high. (LER 83-009)

- Low pressure safety injection pump sequencer timer failed during monthly ESF surveillance test. (LER 83-010)

- Failed power supply fuse in RPS channels. (LER 83-012)

- Containment pressure switches were found out-of-tolerance during surveillance test. (LER 83-013)

- Main steam safety valves failed to lift within setpoint values during surveillance test. (LER 84-002)

- Steam Generator RC-2L tube failure. (LER 84-008)

- Electrical penetration assemblies failed under environmental qualification testing being conducted by the test laboratory to fulfill the requirements of 10 CFR Part 50.49. (LER 84-009)

- Noise spikes caused tripping of the "A" and "C" Thermal Margin Low Pressure reactor protective system trip circuits which resulted in a reactor trip. (LER 84-013)

- High alarm setpoint for stack noble gas monitor was found out-of-tolerance during surveillance test. (LER 84-016)

- Hydrogen analyzers failed to indicate proper concentration during calibration. (LER 84-020)

The major maintenance efforts accomplished this appraisal period occurred during the refueling outage March 5 to July 8, 1984. Maintenance activities accomplished included eddy current testing of both steam generators, sludge lancing of the secondary side of both steam generators, repair of the reactor coolant pump gaskets, work on the Quality Safety Parameters Display System (QSPDS), and replacement of the high pressure turbine rotor. Extensive management involvement at the planning level and expanded use of the computerized tracking system enabled these activities to be accomplished essentially on schedule.

Three additional, events caused an extension to the originally planned outage. The first was the removal of the drilled tube support plate rim in both steam generators to reduce the potential for tube "denting" caused by stresses in the support plate. This "rim cut" was accomplished by contract boilermakers under the direct supervision of OPPD personnel and completed within two weeks. The licensee utilized mockup training for all craftsmen, and this contributed to the timely completion of the job and to the less than anticipated overall man-rem exposure. The second event was the steam generator tube failure in RC-2B that occurred on May 16, 1984, during the reactor coolant system leak test. The licensee had identified a small tube leak prior to shutdown, and had expended considerable effort to identify the cause prior to startup. This effort included an extensive eddy current test program, helium leak checks before and after sludge lancing, and dye leak tests, but no positive indication of a leak was identified prior to the reactor coolant system leak test. Following the tube failure, the licensee removed the failed tube from RC-2B, performed eddy current testing on all accessible tubes on both steam generators, performed a lab analyses on the failed tube, initiated more restrictive limits on the primary to secondary leak rate, and instituted vendor recommended chemistry control procedures. The third event was precipitated when a testing laboratory informed OPPD that containment penetration lead wire insulation could fail under the harsh environment of a Large Break Loss of Coolant Accident (LBLOCA). To correct this problem, the licensee developed a cable splice using qualified sleeves that shielded the lead wire insulation from the harsh environment. A total of 638 splices

involving 48 cables were reworked during this 2-week extension of the outage. With regard to all three of these events, the licensee management responded quickly to address these matters and to provide the necessary resources and support to these activities.

Another major maintenance effort undertaken by Fort Calhoun during this appraisal period was the installation of new spent fuel storage racks by an outside contractor. While removing the old racks, there were instances where plant QC personnel stopped work because of the improper way the job was being performed and controlled. During the removal of one spent fuel rack, the wire rope sling broke and the rack became wedged in the pool. OPPD failed initially to exercise appropriate management control by providing adequately trained people to direct this work and sufficient QC coverage to monitor contractor activities.

The licensee's system for tracing measuring and test equipment (M&TE) usage was found to be weak and lacked adequate procedures to identify all items inspected, tested, or measured to specific M&TE. Adequate procedures were not established to make disposition of possible nonconformances of those items when M&TE was found to be out-of-tolerance. The licensee revised plant procedures and expanded the M&TE program during this SALP period to address those concerns identified in NRC Inspection Reports 50-285/84-12 and 50-285/84-21.

The previous SALP identified that several long term electrical jumpers dating back to 1973 were still outstanding. The licensee made significant progress during this SALP period at closing out these items and incorporating them as permanent design changes in accordance with the plant standing order.

The tracking of maintenance orders (MOs) was another item of concern discussed in the previous SALP. A computerized MO system is now in effect that works in conjunction with a computerized tracking system to provide current status information.

The tracking and closeout of design changes was a third item of concern discussed in the previous SALP report. The efforts of the update team were completed this SALP period, and all modifications through December 31, 1980, have been reviewed. A computerized listing of all outstanding Design Change Requests and Engineering Evaluation and Assistance Requests was established and licensee management now has the capability of assessing the status of the design change program.

The licensee implemented a Qualified Life Program (QLP) during this appraisal period to "establish and maintain the qualified life of safety-related equipment installed in a harsh environment." Although the QLP was established in April 1984, the licensee was slow in fully implementing the program and delegating appropriate responsibility to the various crafts. A full-time coordinator was assigned to this effort in order to: (1) review Electrical Equipment Qualification (EEQ) documentation since the QLP started, (2) review QLP entries for accuracy in the computer data base used in the maintenance program, and (3) provide comprehensive training of the QLP/EEQ program.

2. Conclusions

The licensee has initiated additional management control programs to strengthen the maintenance area, and has established a better working interface between the plant and design groups at the Jones Street office. The resolution of items mentioned in previous SALP reports indicates OPPD's commitment in maintenance, but poor control of the new spent fuel rack installation and delays in full implementation of the EEQ program suggest areas that require additional management attention.

The plant has a stable, well-qualified maintenance staff that has seen little turnover the past three SALP periods.

The licensee is considered to be in Performance Category 1 in this area.

Trend: Improved

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area could be reduced.

b. Recommended Licensee Actions

The licensee should continue the increased management attention being given to the EEQ program in preparation for a site verification inspection by the NRC in 1985.

D. Surveillance

1. Analysis

This area was inspected on a continuing basis by the NRC resident inspector. No violations or deviations were identified in this area.

Fort Calhoun maintains a well-developed and effectively managed surveillance test program. A monthly surveillance testing schedule is published to ensure that all required tests are assigned as to due date and responsible department. The program is set up to verify that the current revision to the test is being used, that QC verification is obtained where required, and that calibrated test equipment is used and identified on the procedure. During the last refueling outage, the master schedule was updated and the applicable surveillance tests were written or modified to reflect new Technical Specification requirements.

2. Conclusions

The licensee maintains a well-developed and effectively managed surveillance test program.

The licensee is considered to be in Performance Category 1 in this area.

Trend: Same

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area should remain at the reduced level.

b. Recommended Licensee Actions

The Board recommends that the licensee continue to exercise strong management control of the surveillance program.

E. Fire Protection

1. Analysis

This area was inspected on a continuing basis by the NRC resident inspector. No violations or deviations were identified in this area. The one LER listed below involved activities in the functional area of fire protection:

- Temporary fire barrier failed to meet design criteria. (LER 84-022)

A major activity in this area by OPPD during this appraisal period was the resolution of items identified by the NRC special inspection team and documented in NRC Inspection Report 50-285/83-12 dated July 1, 1983.

Another major effort by the licensee this report period was the upgrading of temporary fire barriers into permanent barriers and to grout conduit penetrations. This 3-month effort utilized a qualified outside contractor and resulted in approximately 350 fire barriers being upgraded. The licensee is presently developing a program to enable OPPD personnel to install new fire barrier penetrations and perform maintenance on permanent fire barriers.

2. Conclusions

The licensee has made significant progress at resolving the items identified in the fire protection audit report and is working toward compliance with the requirements of 10 CFR Part 50, Appendix R, Sections III.G and III.L.

The licensee is considered to be in Performance Category 1 in this area.

Trend: Same

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area should remain at the present level.The NRC should complete the review and processing of OPPD's exemption requests.

b. Recommended Licensee Actions

The licensee management should continue their efforts to resolve all identified items pertaining to compliance with Appendix R.

F. Emergency Preparedness

1. Analysis

During the assessment period, five routine emergency preparedness inspections were conducted. Three of the inspections were routine reviews of the implementation status for various elements of the emergency preparedness program.

Two emergency exercise inspections were also conducted during the assessment period in conjunction with the licensee's annual emergency exercises held December 6-7, 1983, and October 24, 1984. No violations or deviations were observed by the NRC inspectors.

Most of the open items identified during inspections in the previous assessment periods were closed during this assessment period based on timely licensee actions. For concerns identified during the reporting period, corrective action was noted for most items during the next review of that item.

During the October 24, 1984, emergency exercise, the Federal Emergency Management Agency (FEMA) evaluated offsite emergency preparedness of states and local agencies. As a result of this evaluation, FEMA identified a Category A deficiency in regard to agreements for ambulance services in two counties of the state of Iowa side of the 10-mile emergency planning zone. Plans for resolution of this deficiency included agreements between Iowa and the ambulance services, training for ambulance personnel, and a drill to demonstrate this capability. The licensee has been active in this matter and is cooperating with state and local authorities to achieve resolution of this offsite preparedness concern.

Management involvement and control of the emergency preparedness program during the period appeared to be adequate for implementation of an effective program.

Staffing of the emergency preparedness program was also considered to be adequate during this reporting period. No reportable events in the emergency preparedness area were received during this reporting period.

2. Conclusions

The licensee has maintained an acceptable level of emergency preparedness during the period and demonstrated adequate capability to protect the health and safety of the public by conducting two successful emergency exercises. Management involvement and control has been adequate for implementation of an effective program. Responses to NRC concerns have been timely, thorough, and acceptable in most cases. Overall, the licensee's program appeared to have increased in effectiveness since the previous assessment period.

The licensee is considered to be in Performance Category 2 in this area.

Trend: Improved

3. Board Recommendations

a. Recommended NRC Action

The NRC inspection effort in this functional area should continue at a normal level.

b. Recommended Licensee Action

A more aggressive level of management attention to implementation of the emergency preparedness program should be pursued. Additional management attention should be given to resolution of each of the NRC identified concerns in a timely manner.

G. Security and Safeguards

1. Analysis

The physical security staff performed five inspections during this SALP period.

Twelve violations were identified in this functional area during the appraisal period.

- Failure to demonstrate that the microwave system is tested quarterly against the manufacturer's design specifications. (Severity Level IV, 8417-02)
- Failure to take proper compensatory action when the perimeter intrusion detection system coverage was discovered to be ineffective. (Severity Level IV, 8417-03)
- Failure to provide authorized escort. (Severity Level IV, 8418-01)
- Failure to report facility modification. (Severity Level *, 8420-01)
- Inadequate key control. (Severity Level *, 8420-02)
- Failure to provide an adequate barrier for part of one vital area. (Severity Level IV, 8420-03)
- Inadequate compensatory measures. (Severity Level *, 8420-04)
- Inadequate surveillance television coverage. (Severity Level *, 8420-05)
- Failure to provide adequate access control for a vital area. (Severity Level IV, 8420-06)
- Insufficient search at access control point. (Severity Level *, 8420-07)

- Failure to maintain operable assessment aids. (Severity Level *, 8420-08)

- Inadequate compensatory measures following failure of search equipment. (Severity Level *, 8420-09)

*Violations 8420-01, 02, 04, 05, 07, 08, and 09 were categorized individually at Severity Level IV or V, but were considered in the aggregate as a Severity Level III Violation.

Three deviations were identified in this functional area during the appraisal period.

- Failure to revise security plan according to commitment made to NRC. (8326-04)

- Failure to provide continuous monitoring. (8420-10)

- Failure to perform effectiveness test. (8420-11)

Forty-nine licensee event reports (LER) of physical security events were submitted in accordance with 10 CFR Part 73.71:

- Loss of primary (CPU1) and secondary (CPU2) security computers. (LER's Nos. 83-07 through 12, 84-02 through 27, 84-29 through 34, and 85-01 through 09)

- Loss of AC power and failure of uninterruptible power source to operate the security computers. (LER No. 84-01)

- Reduction in offsite communications to local law enforcement agencies. (LER No. 84-28)

The licensee lost use of his primary (CPU1) and secondary (CPU2) security computers 47 times during this SALP period. On one occasion, the licensee lost AC power and his backup source of uninterruptible power failed to operate automatically. In LER 84-28, the licensee lost "normal" offsite communications to the local area due to an accidental slicing of the underground cable by an offsite nonutility construction crew.

The licensee was issued a Confirmatory Action Letter (CAL) on August 16, 1984. The CAL was issued as a result of a Region IV inspection in July 1984. An enforcement conference was held October 11, 1984, and documented in NRC Inspection Report 50-285/84-27. The enforcement conference was called to discuss

the apparent violations from the special security inspection (NRC Inspection Report 50-285/84-20) conducted during the period August 20-24, 1984. The importance of management involvement in establishing an effective security program was emphasized by the NRC participants. The need to develop and implement an effective testing and maintenance program for security-related equipment was discussed. As a consequence of the August special security inspection, a Notice of Violation and Proposed Imposition of Civil Penalty (CP) dated February 14, 1985, was issued to the licensee. The CP was reduced by 50 percent to $25,000 because of prior good performance in the area of concern; specifically, no previous escalated enforcement actions and repeated ratings of Category 2 in their (SALP) evaluations.

Subsequent to the August 20-24, 1984, inspection, OPPD initiated an extensive security improvement program. OPPD management approved a Fort Calhoun Station security organizational change providing for a dedicated security supervisor reporting to the Supervisor-Administrative Services and Security at Fort Calhoun Station, a review of the maintenance and testing program relating to security equipment, and a review of the entire physical security plan by a qualified security consultant. In addition, Fort Calhoun Station made a commitment to submit a revised physical security plan to the NRC by May 1, 1985.

2. Conclusions

The licensee had not placed emphasis and dedication on maintaining an effective security program and management involvement with security matters has been marginal. The result of management's lack of commitment to security was evidenced by insufficient training and maintenance, and by improper compensatory actions resulting in violations.

The licensee is considered to be in Performance Category 3 in this area

Trend: Improved

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area should be increased. An evaluation of the licensee's corrective actions and their impact on the security program should be performed by August 31, 1985.

b. Recommended Licensee Action

The level of licensee management attention evidenced during the last quarter of this SALP period should be continued.

The licensee should increase audit activity of security training, maintenance, and requirements of the security plan. Licensee management should ensure that security resources and organization are adequate to implement the security plan.

H. Refueling

1. Analysis

This area was inspected on a continuing basis by the NRC resident inspector during the period of refueling April 1-8, 1984. Fort Calhoun Station was in a refueling outage from March 5 to July 8, 1984, for Cycle 9 refueling. A total of 40 new bundles were inserted into the core.

No violations or deviations were identified during this evaluation period.

The licensee continued to utilize a fuel load/shuffle scheme designed to reduce neutron flux to the reactor vessel as part of OPPD's efforts to address the pressurized thermal shock issue. The fuel movement was completed without incident and the NRC inspector verified that Technical Specification requirements were satisfied.

2. Conclusions

The licensee management demonstrated excellent prior planning and effective control of refueling activities. The licensee is considered to be in Performance Category 1 in this area.

Trend: Same

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area should remain at reduced levels.

b. Recommended Licensee Actions

Licensee management should continue its involvement in the planning of refueling outages, the observation of refueling activities, and adherence to procedures.

I. Quality Programs and Administrative Controls Affecting Quality

1. Analysis

This functional area was inspected on a continuing basis by the NRC resident inspector and by region-based NRC inspectors. Six

violations and no deviations were identified in this area during the appraisal period:

- Failure to audit security procedures every 12 months. (Severity Level IV, 8326-01)

- Failure to adequately perform the review and approval steps of a CQE piping isometric as part of the post-installation modification review process. (Severity Level IV, 8335-01)

- Failure to provide procedures to assure that appropriate Fort Calhoun Station personnel were provided with current lists of CQE equipment. (Severity Level V, 8410-03)

- Failure to properly review OPPD's response to IE Bulletin 82-02 resulting in a material false statement being made that was contrary to actual practice at the Fort Calhoun Station. (Severity Level III, 8412-03)

- Failure to take prompt corrective action on the resolution of QA deficiency/quality reports within the required response period. (Severity Level IV, 8429-01)

- Failure to properly establish, monitor, and closeout temporary CQE storage areas. (Severity Level IV, 8501-01)

The two LERs listed below involved activities in the area of administrative controls:

- Auxiliary building crane interlocks were left in the bypass position without the crane supervisor being present. (84-001)

- A load of approximately 250 pounds was carried by the polar crane over the reactor coolant system when the fluid in the pressurizer was greater than 225 degrees F. (84-015)

The licensee submitted the revised OPPD QA Plan to the NRC for review on August 31, 1984. The program is fully implemented and the complete set of QA department procedures has been issued. These items were addressed in the last SALP period and the delay in implementing the new program was considered a weakness in the OPPD program.

It was determined during routine inspections by regional inspectors in the radiological controls area that there were no QA auditors on the licensee's onsite staff that had any training or background experience in radiation protection except for instrument calibration. The NRC determined during another

inspection that the licensee did not have a program established to audit vendors that are contracted to perform radiochemical analyses on samples of Fort Calhoun Station radwaste for the requirements of 10 CFR Part 61.55. In the area of security and safeguards the NRC determined that the licensee had failed to perform an audit of security procedures and practices every 12 months as required by the Fort Calhoun Station Physical Security Plan.

During this appraisal period, major management changes were implemented at the OPPD corporate level and at the Fort Calhoun Station. A Nuclear Production Division was formed and a separate division manager for nuclear matters was established directly under the assistant general manager. The reorganization provided increased management attention to the operation of the Fort Calhoun Station. The NRC resident inspector observed that the manager of the Nuclear Production Division initiated weekly staff meetings at the site, made routine tours of the plant, and attended all NRC exit interviews at the site.

The licensee reorganized the site management structure to have the Quality Control (QC) section report to the Supervisor-Technical, instead of the Supervisor-Maintenance. Observations by the resident inspector indicated that this move provided a greater degree of independence for the QC section from the Maintenance Department and enhanced their effectiveness onsite. A Supervisor-Station Training position reporting directly to the plant manager was established this appraisal period and filled in February 1985. This reflects the licensee's commitment to provide increased management attention to plant training activities.

An area of continued long standing concern to the NRC is the matter of the Fort Calhoun Station construction QA records. An enforcement conference between OPPD and NRC personnel was held in the Region IV offices on September 9, 1983, to address this matter and identify the licensee's corrective actions. OPPD agreed to review "all commitments to the NRC for retention of design, procurement, manufacturing, installation and construction records, and all applicable involved codes, standards, and specifications." The licensee has examined the available records and identified those which were missing, along with an evaluation of their significance. A recent inspection by the NRC indicates that this review and evaluation was not done to the depth and detail necessary to resolve this matter.

In addition to those specific items discussed in the various functional areas, other items that indicated a lack of sufficient administrative controls and management attention during this assessment period include:

- The inadequate review of OPPD's response to IE Bulletin 82-02 and the subsequent escalated enforcement, as discussed in Section IV.C of this report, indicated a weakness in the licensee's technical evaluation and review process. Although the specific incident occurred before this SALP evaluation period, the investigation during this SALP period revealed that weaknesses still existed. The licensee exerted significant effort during the past nine months to correct these problems.

- The failure to followup on identified deficiencies in a QA audit of the plant security program, and the lengthy times involved in closing out other deficiency reports/quality reports indicated that management failed to achieve appropriate and timely corrective actions.

2. Conclusions

The licensee has demonstrated improvement in the QA area with regard to program implementation. OPPD's administrative controls and management attention had weaknesses in the specific areas outlined above and in the other analyses sections. The establishment of a separate Nuclear Production Division is a positive step towards bringing management controls to bear on those areas that need attention.

The licensee is considered to be in Performance Category 2 in this area.

Trend: Improved

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area should be maintained at normal levels.

b. Recommended Licensee Actions

The licensee management needs to work toward a timely resolution of the NRC concerns regarding construction records and to address the other weaknesses identified.

J. Licensing Activities

1. Analysis

The NRC Office of Nuclear Reactor Regulation has performed an assessment of licensee performance in the functional area of licensing activities. Refer to Attachment 1 for details of this assessment.

2. Conclusions

As discussed in Attachment 1, the licensee is considered to be in Performance Category 1 in this area.

Trend: Improved

3. Board Recommendations

a. Recommended NRC Actions

Continue to perform licensing activities as required.

b. Recommended Licensee Actions

The licensee should continue its high level of management involvement in this area.

K. Training

1. Analysis

This functional area was inspected by region-based NRC inspectors and on a periodic basis by the NRC resident inspector. Three violations and no deviations were identified in this functional area during the appraisal period:

- Failure to follow approved training and qualification plan as it pertains to firearms qualification program. (Severity Level IV, 8326-02)

- Failure to complete security training program in accordance with commitment made to NRC. (Severity Level IV, 8326-03)

- Failure to provide training as required by the Fort Calhoun Station Security Plan. (Severity Level IV, 8417-01)

The licensee has devoted much attention to this functional area since receiving a Category 3 rating in the previous SALP report. An outside consultant was brought in for evaluation and

consultation during the winter of 1983/84, and in May 1984, a working group was in place preparing training materials. This group started with about five persons and has grown to 15 during the past nine months. Following the failure of all three license candidates in June 1984, OPPD initiated an evaluation to identify and correct the specific causes of these failures. Part of this evaluation included an independent task force assessment of the existing operator training program. The results of this assessment formed the bases for short term and long term corrective actions to be implemented to ensure that future license candidates are prepared to pass the NRC examination and safely operate the plant. OPPD and NRC personnel met in September 1984, to discuss the licensee's operator licensing program and the results of this independent task force assessment. OPPD established the position of Supervisor-Training Services in July 1984, to head the newly established offsite Training Services Department. The NRC resident inspector reviewed the independent assessment report and concluded that the observations made represented an accurate picture of the training program at that time, and that the three groups of recommendations set forth would correct the problems if implemented. Some results from the efforts described above that occurred during this evaluation period included: (1) improved and expanded lesson plans and training packages, (2) the successful licensing of two reactor operator license candidates, (3) the addition of instructors from an inter-plant transfer and outside contractors, and (4) the appointment of the new Supervisor-Station Training. The NRC resident inspector reviewed portions of the revised student handout material and instructor lesson plans and found them to be comprehensive, well organized, and clearly written.

Three operator licensing examinations were administered during this evaluation period as tabulated below:

	SRO Candidates			RO Candidates		
	Total	Pass	Fail	Total	Pass	Fail
November 29-December 1, 1983	6	3	3	1	1	0
June 5-7, 1984	0	-	-	3	0	3
November 7-8, 1984	0	-	-	2	2	0

One requalification examination was administered as tabulated below:

	SRO Candidates			RO Candidates		
	Total	Pass	Fail	Total	Pass	Fail
November 7, 1984	5	2	3	2	2	0

The first two examination results continued a downtrend that was identified in the previous SALP period. These results were below the industry norm and reflected a weakness in the licensee's training department to adequately screen and prepare candidates for licenses. The intensive training effort focused on the November 1984, candidates and the successful licensing of both examinees indicated that this trend may have been reversed.

License requalification training continued to be a problem area during this evaluation period. Interviews by the NRC resident inspector and a region based NRC inspector with licensed operators indicated that actual in-class lecture time was being cut short and that the quality of training was suffering because of the limited availability of experienced licensed instructors. In addition, the high failure rate for new license candidates and NRC requalification candidates during this appraisal period seemed to confirm that the overall quality of training at the licensed operator level remained marginal. The NRC resident inspector attended selected training lectures during this appraisal period and observed a wide variation in quality of handout material and instructor capabilities.

As part of the overall restructuring of the training program, a new "performance based" training program for newly hired auxiliary operator trainees has been developed and will be implemented during the first quarter of 1985. This program has clearly defined written goals, a complete schedule for classroom and onshift time, and a structured system of lesson plans, qualification cards, and practical factors to be completed. This program is one of many being developed by the licensee to qualify for INPO certification in 1986.

The in-house training program for five inexperienced chemistry/health physics technicians was completed this evaluation period and all five trainees became qualified to work shift-technician duties. It was noted in an NRC inspection report that the training department did not have an instructor qualified or experienced in nuclear power plant chemistry and that a comprehensive training program for radwaste operators did not exist. The chemistry/radiochemistry training program was being conducted primarily by the chemistry section senior staff personnel under the supervision of the plant chemist. A review

of qualification verification records for Chemistry and Radiation Protection supervisory personnel revealed that no training had been completed in any of the study areas listed in Section 6.1 of the Fort Calhoun Station Training Manual.

The NRC resident inspector noted that the training manual prepared for Cycle 9 modifications was the most complete and informative of those issued to date. The licensee provided acceptable training on short notice in response to the steam generator tube failure incident and covered the applicable emergency procedures, the lessons learned from the Ginna tube rupture incident, and the revised Technical Specification/Surveillance Tests.

2. Conclusions

The licensee has done an excellent job of identifying and evaluating the problems in this functional area, and has expressed a strong commitment to resolve these matters. The initial results of their efforts have been positive, but the overall training program has not yet seen the benefits of OPPD's commitments and plans. During this evaluation period the licensee's record in licensee examinations and requalification examinations remained poor. Many of the personnel changes to the training department and the appointment of the Supervisor-Station Training occurred too late in this SALP evaluation period to have had a significant impact on performance.

The licensee is considered to be in Performance Category 3 in this functional area.

Trend: Improved

3. Board Recommendations

a. Recommended NRC Actions

The NRC inspection effort in this functional area should be increased. An evaluation of the licensee's corrective actions and their impact on the training program should be performed by August 31, 1985.

b. Recommended Licensee Actions

Licensee management should provide aggressive action to ensure control of the training program in order to maintain the positive trend that appears to have been established toward the end of this evaluation period. The effort at

upgrading lesson plans and student material needs to be carried through to completion. The need for an expanded training staff remains and this shortcoming should be resolved as soon as possible. The licensee should further consider the benefits of obtaining access to a site-specific simulator for training of the Fort Calhoun Station operators.

The quality of instructors should be evaluated and training provided as required to increase the effectiveness of the training staff. Training in the areas of security, chemistry, and radiation protection needs to be better coordinated and administered under the training department.

V. SUPPORTING DATA AND SUMMARIES

A. Licensee Activities

1. Major Outages

The refueling outage occurred during the period March 5 to July 8, 1984. In addition to the insertion of 40 new fuel bundles into the core, major planned maintenance activities included eddy current testing of both steam generators, sludge lancing of the secondary side of both steam generators, repair of the reactor coolant pump gaskets, work on the QSPDS, and replacement of the high pressure turbine rotor. Three additional activities that occurred during this outage included the "rim cut" on the steam generator's tube support plate, plugging of the failed tube in Steam Generator RC-2B, and rework of 638 containment penetration lead wires to protect them from the harsh environment of a LBLOCA.

Fort Calhoun Station experienced a 2-week outage from November 18 to December 3, 1984, to repair a body-to-bonnet flange leak on a pressurizer spray valve.

2. Power Limitations

The reactor was not limited in power level below the licensed limits during this appraisal period.

3. License Amendments

Amendment No. 75	Authorized Spent Fuel Pool Rerack, September 9, 1983
Amendment No. 76	Administrative Changes, January 26, 1984

Amendment No. 77	Cycle 9 Restart, April 26, 1984
Amendment No. 78	Shift Manning and QC Personnel Changes, May 16, 1984
Amendment No. 79	Snubber Changes, May 23, 1984
Amendment No. 80	Add Operability and Surveillance Requirements for RCS Vents and Administrative Requirements for Analysis of Plant Effluents, July 9, 1984
Amendment No. 81	Add Operability and Surveillance Requirements for Containment Wide Range Radiation Monitors, Wide Range Noble Gas Monitors, and Main Steam Lines Radiation Monitor, July 12, 1984
Amendment No. 82	Add Operability and Surveillance Requirements for Containment Hydrogen, Water, and Pressure Monitors, August 2, 1984
Amendment No. 83	Update Surveillance Capsules Removal Schedule, September 7, 1984
Amendment No. 84	Plant Support and Plant Organization Changes, September 7, 1984
Amendment No. 85	Limit Overtime and Report PORV/SV Failures and Challenges, October 11, 1984

4. Significant Modifications

Major modifications completed during this appraisal period included the installation of new spent fuel racks, removal of steam generators drilled tube support plate rim, implementation of new secondary chemistry control in response to the failed tube in Steam Generator RC-2B, and the upgrading of instrumentation, limit switches, containment penetrations, etc. to meet EEQ requirements.

B. Inspection Activities

1. Violations

See Table 1.

2. Major Inspections

During this appraisal period, one special inspection was conducted in the area of security and safeguards. The

inspection was performed by a team of three inspectors and one observer from outside Region IV and involved a total of 235 direct inspection man-hours. (NRC Inspection Report 50-285/84-20)

C. Investigations and Allegations Review

One investigation was conducted during this appraisal period and it addressed the material false statement made by the licensee in their response to IE Bulletin 82-02, "Degradation of Threaded Fasteners in Reactor Coolant Pressure Boundaries of PWR Plants." It was confirmed by the investigation that the OPPD response to the NRC was false in that "Super-Moly" (molybdenum disulfide) was used on the reactor vessel and reactor coolant pump studs and that a mixture of 50 percent oil and 50 percent graphite was designated for use on manway studs. These failures by the licensee to perform an adequate review of the related documentation, to coordinate the response with knowledgeable personnel, and to identify the false statement during the OPPD required procedural review, resulted in a Severity Level III Violation. An enforcement conference was held on December 20, 1984, between the NRC and the licensee to discuss this matter.

One allegation was received during this appraisal period that identified certain incidents which had occurred over the past five years and alleged poor management practices in the area of supervision and discipline that could affect the safety and health of the public. The review and followup of this allegation was still in progress at the close of this appraisal period, and is expected to be resolved during the first quarter of the next SALP period.

D. Escalated Enforcement Actions

1. Civil Penalties

Two notices of violation with proposed imposition of civil penalties were issued to the licensee during this appraisal period.

- A Severity Level III Violation and a proposed civil penalty of $40,000 were issued as a result of the material false statement made by the licensee in their response to IE Bulletin 82-02, "Degradation of Threaded Fasteners in Reactor Coolant Pressure Boundaries of PWR Plants." In consideration of OPPD's prior good performance in this area, and their prompt and extensive corrective actions, the Regional Administrator determined that the civil penalty should be fully mitigated.

- A Severity Level III Violation was issued in the area of security and safeguards that comprised a composite of seven Severity Level IV and V Violations and reflected an overall weakness in the Fort Calhoun Station security program. A civil penalty of $50,000 was proposed, but this amount was mitigated to $25,000 on the basis of the licensee's previous good enforcement history in this area.

E. Management Conferences Held During Appraisal Period

1. Conferences

The following conferences were held between Region IV and the licensee during this appraisal period:

- Enforcement conference of September 9, 1983, at the Region IV office to discuss NRC concerns related to construction QA records and the QA records file room. The bases for this meeting were the findings described in NRC Inspection Report 50-285/83-17.

- Management meeting of September 21, 1984, at the Region IV office to discuss the licensee's operator licensing program in response to Mr. J. T. Collins letter of August 13, 1984, to Mr. W. E. Miller of OPPD.

- Enforcement conference of October 11, 1984, at the Region IV office to discuss the results of NRC Inspection Report 50-285/84-20 which documented nine violations and two deviations identified by the special inspection team.

- Enforcement conference of December 20, 1984, at the Region IV office to discuss the licensee's response to IE Bulletin 82-02 and the associated material false statement cited in NRC Inspection Report 50-285/84-12.

2. Confirmation of Action Letters (CALs)

The following CALs were issued by Region IV during this appraisal period:

- J. T. Collins letter of June 5, 1984, to W. C. Jones of OPPD to confirm the actions and conditions required of OPPD in relation to the failed tube in Steam Generator RC-2B.

- J. T. Collins letter of August 16, 1984, to Mr. R. L. Andrews of OPPD to confirm the actions required of OPPD in response to security matters identified in NRC Inspection Report 50-285/84-17.

F. Review of Licensee Event Reports and 10 CFR Part 21 Reports Submitted by the Licensee

1. Licensee Event Reports (LERs)

The SALP Board reviewed the LERs for the period September 1, 1983, through February 28, 1985. This review included LERs 83-008 through 83-013, and 84-001 through 84-025. The SALP Board reviewed the licensee's cause classification for these LERs and did not identify any significant differences between those made by the licensee and those made independently by the board.

Due to the revised LER rule that went into effect on January 1, 1984, the licensee was required to report a significant number of unplanned VIAS actuations that were not performing a safety function. This resulted in an increase of LERs this appraisal period even though the new rule was intended to eliminate inconsequential reports. The licensee is considering a Technical Specification revision to modify this specific LER requirement.

The NRC Office for Analysis and Evaluation of Operational Data performed a review of licensee LERs, focusing on the accuracy and completeness of the reports. Refer to Attachment 2 for details of this review.

2. Part 21 Reports

None

G. NRR Activities

1. NRR License Meetings

December 20, 1983	SALP
March 23, 1984	Environmental Qualification
April 17, 1984, and October 11 & 13, 1983	Radiological Effluent Technical Specifications
May 29, 1984	Steam Generator B Major Leakage Event
December 13, 1984	Plant Security
February 5-8, 1985	In-Progress Audit of Licensee's Detailed Control Room Design Review

2. NRR Site Visits

October 11 & 14, 1983	Discussed Licensing Actions with Resident Inspector and Visited Local PDR
May 23-26, 1984	Emergency Trip to Address Steam Generator B Major Leakage Event
August 27-29, 1984	Toured Plant, Reviewed TMI Related Modifications, and Discussed Licensing Actions with Resident Inspector
February 6-7, 1985	Toured Control Room and Remote Shutdown Panel and Discussed Licensing Actions with Resident Inspector

3. Commission Briefings

None

4. Schedular Extensions Granted

IST 2nd 10-year program, interim schedular relief for 1 year, September 30, 1983

IST 2nd 10-year program, interim schedular relief for 1 year, October 9, 1984

EQ Schedular Extension, May 16 1984

5. Reliefs Granted

ISI 1st 10-year program, 2 reliefs, November 14, 1984

ISI 2nd 10-year program, 1 relief, September 30, 1983

ISI 2nd 10-year program, 8 reliefs, April 6, 1984

6. Exemptions Granted

None

7. Emergency Technical Specifications Issued

None

8. Orders Issued

Order confirming licensee commitments on emergency response capability as required by Supplement 1 to NUREG-0737, February 22, 1984.

9. NRR/Licensee Management Conferences

None

TABLE 1

INSPECTION ACTIVITY AND ENFORCEMENT

FUNCTIONAL AREA	NO OF VIOLATIONS IN EACH SEVERITY LEVEL V	IV	III	II	I	DEVIATIONS
A. Plant Operations		4				
B. Radiological Controls	1					
C Maintenance	2	2				
D. Surveillance						
E. Fire Protection						
F. Emergency Preparedness						
G. Security and Safeguards		5	1*			3
H. Refueling						
I. Quality Programs and Administrative Controls Affecting Quality	1	4	1			
J. Licensing Activities						
K. Training		3				
TOTAL	4	18	2*	0	0	3

*This comprises seven Severity Level IV and V Violations identified in NRC Inspection Report 285/84-20.