



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064

MAR - 1 1994

Docket: 50-298  
License: DPR-46

Nebraska Public Power District  
ATTN: Guy R. Horn, Vice President - Nuclear  
P.O. Box 98  
Brownville, Nebraska 68321

SUBJECT: APPARENT VIOLATIONS OF REGULATORY REQUIREMENTS (NRC INSPECTION  
REPORT 50-298/93-202)

This refers to the findings of the Operational Safety Team Inspection (OSTI) conducted from November 1-5 and November 13-19, 1993. The NRC staff has reviewed the inspection findings and concluded that they constitute apparent violations of various requirements at Cooper Nuclear Station (CNS). The purposes of this letter are to inform Nebraska Public Power District (NPPD) that the NRC is considering escalated enforcement action for these apparent violations and to inform NPPD that the NRC plans to conduct an enforcement conference in its Arlington, Texas, office on March 7, 1994, as previously agreed between you and Mr. J. E. Gagliardo of my staff.

The OSTI team identified deficiencies in the areas of: (1) procedure adequacy; (2) procedure adherence; (3) equipment operability; (4) training; (5) configuration control; (6) problem disposition to prevent recurrence; and (7) engineering modifications. Descriptions of the findings and their regulatory significance are discussed more fully in the attached summary of apparent violations.

The apparent violations documented in the attachment are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), 10 CFR Part 2, Appendix C. Accordingly, no Notice of Violation is presently being issued for these findings. Please be advised that the number and characterization of apparent violations described above may change as a result of further NRC review.

These apparent violations are of concern because they are similar to violations identified by the NRC during previous inspections or self-identified by your staff. It appears that you may not have assessed the root cause or fully implemented appropriate corrective actions for those previous violations. These apparent violations continue to demonstrate a lack of a questioning attitude within your staff, a lack of procedure adequacy, a lack of procedure adherence, and a weakness on the part of management to establish the desired levels of quality expectations for the performance of routine tasks and in communicating these expectations to the plant staff.

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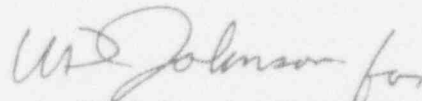
JED

The NRC plans to conduct an enforcement conference on March 7, 1994, to discuss these apparent violations. The decision to hold an enforcement conference does not mean that the NRC has made a final determination that violations have occurred or that enforcement action will be taken. The purposes of this conference are to discuss the apparent violations, their causes and safety significance; to provide you the opportunity to point out any factual disagreement with the description of the events or the apparent violations discussed above; and to provide an opportunity for you to present corrective actions you have taken or plan to take. In addition, this is also an opportunity for you to provide any information concerning your perspectives on: (1) the severity of the issues, (2) the application of the factors that the NRC considers when it determines the amount of a civil penalty that may be assessed in accordance with Section VI.B.2 of the Enforcement Policy, and (3) the possible basis for exercising discretion in accordance with Section VII of the Enforcement Policy. You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding these apparent violations is required at this time.

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

Should you have any questions concerning this matter, please contact Mr. J. E. Gagliardo (817/860-8270) or myself (817/860-8223).

Sincerely,



A. Bill Beach, Director  
Division of Reactor Projects

Attachment: As stated

cc:  
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Columbus, Nebraska 68602-0499

Nebraska Public Power District  
ATTN: Mr. David A. Whitman  
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Nebraska Department of Environmental  
Control

ATTN: Randolph Wood, Director  
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Lincoln, Nebraska 68509-8922

Nemaha County Board of Commissioners

ATTN: Larry Bohlken, Chairman  
Nemaha County Courthouse  
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Nebraska Department of Health

ATTN: Harold Borchert, Director  
Division of Radiological Health  
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Department of Natural Resources

ATTN: Ronald A. Kucera, Department Director  
of Intergovernmental Cooperation  
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Kansas Radiation Control Program Director

MAR - 1 1994

E-Mail report to D. Sullivan (DJS)

bcc to DMB (IE01)

bcc distrib. by RIV:

L. J. Callan  
Branch Chief (DRP/C)  
MIS System  
Branch Chief (DRP/TSS)  
RIV File  
Senior Resident Inspector - Fort Calhoun

Resident Inspector  
Lisa Shea, RM/ALF, MS: MNBB 4503  
DRSS-FIPB  
Project Engineer (DRP/C)  
Senior Resident Inspector - River Bend

RIV:G:DRP/C	PE:DRP/D	NRR	D:DRP	
JGagliardo;df	WBJones	JDW Cox	ABBeach	
3/1/94	3/1/94	3/1/94 pro Sullivan	3/1/94	

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RIV:C:DRP/C	PE:DRP/D	NRR	D:DRP	
JGagliardo;df	WBJones	JDW/cox	ABBeach	
3/1/94	3/1/94	3/1/94	3/1/94	

## ATTACHMENT

### SUMMARY OF APPARENT VIOLATIONS NRC INSPECTION REPORT 50-298/93-202

This document summarizes the issues in NRC Inspection Report 50-298/93-202 that are apparent violations of regulatory requirements and are being considered for escalated enforcement action. The applicable section of the report that provides the specific details of each issue is referenced.

#### I. INADEQUATE PROCEDURES

The following are examples of procedures that were found to be inappropriate to the circumstances:

1. Procedures for sampling the standby liquid control (SLC) tank and the diesel generator fuel oil storage tanks had not incorporated the housekeeping requirement as specified in the quality Assurance Program for Operations. (Section 2.1.2)
2. Preventive Maintenance (PM) tasks dealing with cleaning the 24-V battery chargers and with performing a visual inspection of the diesel fuel oil transfer pump could not be performed as written. (Section 2.2.3)
3. PM Task 07272, developed for the control building ventilation fan motors had no provision to prevent the mixing of incompatible greases. (Section 2.1.6.2)
4. The weekly PM cycle of five control room dampers had not been performed since they were installed in 1992. The PM item had been identified in the design change package under which the dampers were installed, but the PM task was not prepared and incorporated into the maintenance program. (Section 2.1.6.2)
5. During the performance of a surveillance test for standby liquid control (SLC) pump operability, an operator manipulated two valves that were required to perform the test but were not included in the procedural guidance. (Section 2.1.8)
6. Procedure 2.0.7 failed to provide measures to ensure that the necessary reviews associated with temporary modifications, which were deferred because the affected system was out of service, were performed in the event the system was placed back in service with the temporary modification still installed. As a result of this procedural deficiency, at least two in-service temporary modifications had not been properly reviewed. (Section 2.5.2.1)

#### II. PROCEDURE ADHERENCE

The following are examples in which plant personnel did not comply with plant procedures:

1. A maintenance work request (MWR) was improperly used to perform additional work on a component, including postmaintenance testing and the correcting of an incorrect level reading on an instrument after the work identified on the MWR had been completed. The additional work was not specified in the approved MWR. (Section 2.1.4)
2. MWR 93-3590 was written to adjust the oil pressure on the high pressure coolant injection (HPCI) turbine lube oil system to a specific pressure, but it did not specify the acceptable tolerance for the pressure setting. The crafts person adjusted the pressure to a value other than that specified and provided no explanation for the discrepancy. (Section 2.2.2)
3. Contrary to approved maintenance procedures, MWRs were found to have been left open for extended periods to permit multiple work activities to be performed on the component using the open MWR. Two examples are cited in the inspection report. (Section 2.2.3)
4. Engineering Procedure 3.9 requires that pumps failing inservice testing be repaired, replaced, or have an engineering analysis performed demonstrating that the condition did not impair pump operability and that the pump would perform its intended function. The SLC pumps and 11 additional components were found to have been on increased frequency testing without the required repair, replacement, or engineering analysis having been performed. The SLC pumps had been on increased testing frequency since December 1990 without having been repaired, replaced, or analyzed. (Section 2.3.3)
5. Contrary to Procedure 2.0.9, operator aids, including "green band" markings in the plant, were found that were not being controlled in accordance with the procedure. (Section 2.3.3)
6. Contrary to Procedure NTI-02, the start and completion dates in various attendance records concerning the fourth quarter 1992 and first quarter 1993 fire brigade training were changed by overwriting the original dates on the form. (Section 2.4.1)

### III. VIOLATION OF TECHNICAL SPECIFICATION LIMITING CONDITIONS FOR OPERATIONS

The following is an example of failing to comply with Technical Specification requirements relative to suppression chamber/torus water level instrument operability:

On January 30, 1993, both suppression chamber/torus water level instruments (PC-LI-12 and PC-LI-13) were found to be inoperable during the performance of a maintenance work request, and an orderly shut down was not commenced after 6 hours and the reactor was not placed in hot shutdown within the following 6 hours. The instruments were not declared inoperable until the following day. (Section 2.1.4)

#### IV. INADEQUATE TRAINING

The following are examples of failure to satisfy training requirements:

1. Between October 14 and 21, 1993, with the plant in the run mode, five shift technical advisors (STAs) stood watch even though their training had expired. (Section 2.1.9)
2. During 1993, security officers who were members of the fire brigade were not undergoing quarterly fire brigade training. In addition, training sessions had not been held quarterly for all members of the fire brigade. (Section 2.4.1)

#### V. LOSS OF CONFIGURATION CONTROL

The following are examples of failure to apply engineering controls:

Engineering controls were not properly applied to work performed under MWRs. MWR 93-2691 was issued to fabricate a replacement restricting orifice plate for HPCI-RO-137C. The licensee fabricated a duplicate orifice to an adjacent flange rather than determining the design requirements for the missing orifice plate. Secondly, MWR 93-0855 was used to modify a drain line from a residual heat removal (RHR) pipe in accordance with two memoranda from the Nuclear Engineering Department rather than under an approved design package. Thirdly, MWR 93-0801 was used to replace the RHR pump suction spool pieces. The spool piece was torqued to the maximum value allowed in Maintenance Work Practice 5.1.2 0. When the pipe was filled with water for inservice leak testing, one or more of the joints leaked. The craftsmen subsequently tightened the bolts to prevent leakage. No engineering involvement was obtained to ensure that the bolts had not been overstressed. (Section 2.2.2)

#### VI. FIRE DOORS

The following is an example of failing to comply with Technical Specification requirements relative to fire door operability:

On November 2 and 13, Fire Doors R1 and R3, respectively, were found to be inoperable. Further inspection revealed that a total of 20 fire doors were inoperable. (Section 2.4.3)

#### VII. DESIGN MODIFICATION ERRORS

The following is an example of failing to implement the design change process:

Changes to the design and configuration of piping and equipment insulation were routinely made without the use of the design change process. As a result, reviews were not performed in a manner commensurate with those applied to the original insulation design. (Section 2.5.2)