Omaha Public Power District
444 South 16th Street Mall
Omaha, Nebraska 68102-2247
402/636-2000

April 27, 1994

LIC-94-0085

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, DC 20555

References: 1. Docket No. 50-285
2. Letter from NRC (A. B. Beach) to OPPD (T. L. Patterson) dated March 29, 1994

Gentlemen:

SUBJECT: NRC Inspection Report 50-285/94-03, Reply to a Notice of Violation

The subject report transmitted a Notice of Violation (NOV) resulting from an NRC inspection conducted on January 2 through February 12, 1994, at the Fort Calhoun Station. Attached is the Omaha Public Power District (OPPD) response to this NOV.

If you should have any questions, please contact me.

Sincerely,

W. G. Gates
Vice President

WGG/jrg

Attachment

c: LeBoeuf, Lamb, Greene & MacRae
L. J. Callan, NRC Regional Administrator, Region IV
S. D. Bloom, NRC Project Manager
R. P. Mullikin, NRC Senior Resident Inspector

REPLY TO A NOTICE OF VIOLATION

Omaha Public Power District
Fort Calhoun Station

Docket: 50-285
License: DPR-40

VIOLATION

During an NRC inspection conducted on January 2, 1994, through February 12, 1994, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violations are listed below:

10 CFR Part 50, Appendix B, Criterion V, and the Fort Calhoun Quality Assurance Plan, Revision 3, Section 2.1, Paragraph 4.2.1, state, in part, that activities affecting quality shall be prescribed by documented instructions or procedures and shall be accomplished in accordance with these instructions or procedures.

1. Standing Order SO-G-18, "Operational Nonconformance Reports," Section 1.3.3, states, in part, that the shift technical advisor or shift supervisor shall be notified immediately when operational nonconformances are discovered to ensure that the actions necessary to maintain the plant in a safe condition in accordance with the Technical Specifications are taken.

   Contrary to the above, on December 16, 1993, a nonconformance involving a broken valve stem on a safety-related raw water system valve was discovered but was not reported to the shift technical advisor or the shift supervisor. As a result, an operability determination by operations personnel was not made until these personnel were notified of the condition by the NRC on December 17.

2. Chemistry Sampling Procedure CH-SMP-RE-0013, "Auxiliary Building Exhaust Stack Sampling Particulate and Iodine," Sections 6.1.4 and 6.1.5, state, in part, that upon removal of the charcoal cartridge and prefilter for Radiation Monitor RM-060, both are to be placed in separate bags.

   Contrary to the above, on February 8, 1994, both the prefilter and charcoal cartridge were placed in the same plastic bag.

3. Standing Order M-100, "Conduct of Maintenance," states, in part, that craft personnel shall not climb on piping, snubbers, hangers or cable trays.

   Contrary to the above, on January 20, 1994, craft personnel stepped on the actuator and handwheel for the main steam isolation valve Bypass Valve HCV-1042C, while performing maintenance.

This is a Severity Level IV violation. (Supplement I) (285/9403-01)

OPPD RESPONSE

1. The Reason for the Violation

OPPD admits that the violation occurred as stated.

1. The System Engineer who identified the broken handwheel stem on valve HCV-2881B considered the valve to be operable because use of the handwheel is not required for the valve to perform its safety function. The individual did not initiate an Incident Report (IR) or notify the Control Room of the incident, but did immediately generate a Maintenance Work Request (MWR) to correct the deficiency. The failure to initiate an IR or notify the Control Room occurred due to a lack of understanding, on the part of the System Engineer, of the requirements of Standing Order G-18, "Operational Nonconformance Reports."

2. The placement of both the prefilter and charcoal cartridge in the same plastic bag occurred due to failure to follow procedure/lack of attention to detail. The procedure provided adequate guidance for performance of the assigned task and the individual had a copy of the procedure at the time.

3. The incident in which an individual stepped on the actuator and handwheel for valve HCV-1042C involved a contractor who was being escorted by an OPPD maintenance craftsperson. This event occurred as a result of inadequate control of the contractor by the escort, and lack of attention to detail by personnel monitoring the work being performed.

2. Corrective Steps That Have Been Taken and the Results Achieved

With respect to the three incidents discussed in the violation:

1. The Supervisor - System Engineering has issued a memo to System Engineering personnel, outlining requirements for reporting equipment problems to the Control Room. Management met with System Engineers to reinforce the System Engineers' responsibilities with respect to the requirements of Standing Order G-18. Management also counseled the individual System Engineer who discovered the broken valve stem.

   The Manager - Station Engineering discussed the Standing Order requirements for reporting nonconformances to the Control Room at a meeting of Design Engineering personnel.

   A memo was also issued from the Vice President, to nuclear managers, supervisors and exempt personnel, outlining responsibilities for reporting equipment problems to the Control Room.

2. The Supervisor - Chemistry counseled the individual who failed to follow procedure CH-SMP-RE-0013, on his accountability for procedural adherence.

3. The responsible maintenance craft supervisor discussed the event in which the contractor stepped on the valve actuator and handwheel, with his personnel. This discussion addressed the responsibilities of an escort to brief escorted individuals on: the job to be performed, safety issues and policies, and standing orders that may apply to the specific job. These responsibilities were also discussed by the Plant Manager with the other maintenance crafts, at a Quarterly Maintenance Meeting held on February 23, 1994.

   In addition, a memo was issued from the Plant Manager to plant department heads to emphasize that personnel who serve as escorts are to be aware of their responsibilities and accept them.

   A letter was sent from the Acting Division Manager - Production Engineering Division to the vendor discussing: OPPD requirements for conduct of maintenance activities, the significance of the event, and actions to prevent recurrence.

To address general concerns associated with these three incidents, the Plant Manager has had one-on-one meetings with his direct reports to discuss his expectations at Fort Calhoun Station. The one-on-one meetings included discussion of: incidents which occurred in the previous year, accountability, procedure adherence, and ownership. The three incidents were also discussed at a Plant-Wide Meeting on March 2, 1994.

3. Corrective Steps That Will Be Taken to Avoid Further Violations

With respect to the incident in which the contractor stepped on the valve actuator and handwheel:

- Security Form SDF-117, "Duties and Responsibilities of Visitor Escorts," will be revised by June 1, 1994 to address the need to ensure that visitors adhere to the requirements of Standing Orders, including not walking on piping or equipment.

  Security Form SDF-116, "Visitor/Tour Authorization Form," will be revised to indicate that visitor escorts are responsible for ensuring that visitors read and sign the Visitor Briefing on the form. Also, the Visitor Briefing section of the SDF-116 will be revised to indicate that walking on piping and certain plant equipment is not allowed. These revisions will be completed by June 1, 1994.

A memo will be issued to plant personnel to outline the incident and discuss the revised visitor escort procedures. This will be completed by June 1, 1994.

To address the general issue of failure to follow procedures:

- Meetings will be held with individual personnel in departments that report to the Plant Manager and with personnel in the Production Engineering Division to discuss issues related to these events. These meetings will address recent incidents, accountability, procedure adherence and ownership. These meetings will be completed by May 31, 1994.

- Standing Order G-78, "Observation Program," will be evaluated. This evaluation will focus on whether the observation program adequately addresses resolution of problems/deficiencies identified through the program, and whether the program adequately addresses dissemination of information on identified problems/deficiencies. This evaluation will be completed by May 31, 1994.

4. Date When Full Compliance Will Be Achieved

OPPD is presently in full compliance based on completed actions listed above.