



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV

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

MAR - 6 1995

Omaha Public Power District
ATTN: T. L. Patterson, Division Manager
Nuclear Operations
Fort Calhoun Station FC-2-4 Adm.
P.O. Box 399, Hwy. 75 - North of Fort Calhoun
Fort Calhoun, Nebraska 68023-0399

SUBJECT: MANAGEMENT MEETING

This refers to the meeting conducted in the Region IV office on March 2, 1995. This meeting related to the implementation of your corrective action program during the recent assessment of a design basis concern with the control room air conditioners and planned enhancements to your corrective action program. The causes of the delay in the performance of an operability evaluation involving the design issue were discussed as were the corrective actions. In addition, planned enhancements to the corrective action program and the schedule for implementing these changes were presented. The NRC staff appreciated your candor in the presentations. We plan to review the implementation of your revised corrective action program during a future inspection.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter will be placed in the NRC's Public Document Room.

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

Sincerely,

A. Bill Beach, Director
Division of Reactor Projects

Attachments:

1. Attendance List
2. Licensee Presentation

cc:

LeBoeuf, Lamb, Greene & MacRae
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P PDR

JE45

Washington County Board
of Supervisors
ATTN: Jack Jensen, Chairman
Blair, Nebraska 68008

Nebraska Department of Health
ATTN: Harold Borchert, Director
Division of Radiological Health
301 Centennial Mall, South
P.O. Box 95007
Lincoln, Nebraska 68509-5007

Nebraska Department of Health
ATTN: Dr. Mark B. Horton, M.S.P.H.
Director
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Fort Calhoun Station
ATTN: James W. Chase, Manager
P.O. Box 399
Fort Calhoun, Nebraska 68023

MAR - 6 1995

bcc to DMB (IE45) 5624

bcc distrib. by RIV:

L. J. Callan

DRSS-FIPB

Branch Chief (DRP/A)

RIV File

Senior Resident Inspector - Cooper
Director, WCFO; PAO; SLO

Resident Inspector

MIS System

Project Engineer (DRP/A)

Branch Chief (DRP/TSS)

Leah Tremper (OC/LFDCB, MS: TWFN 9E10)

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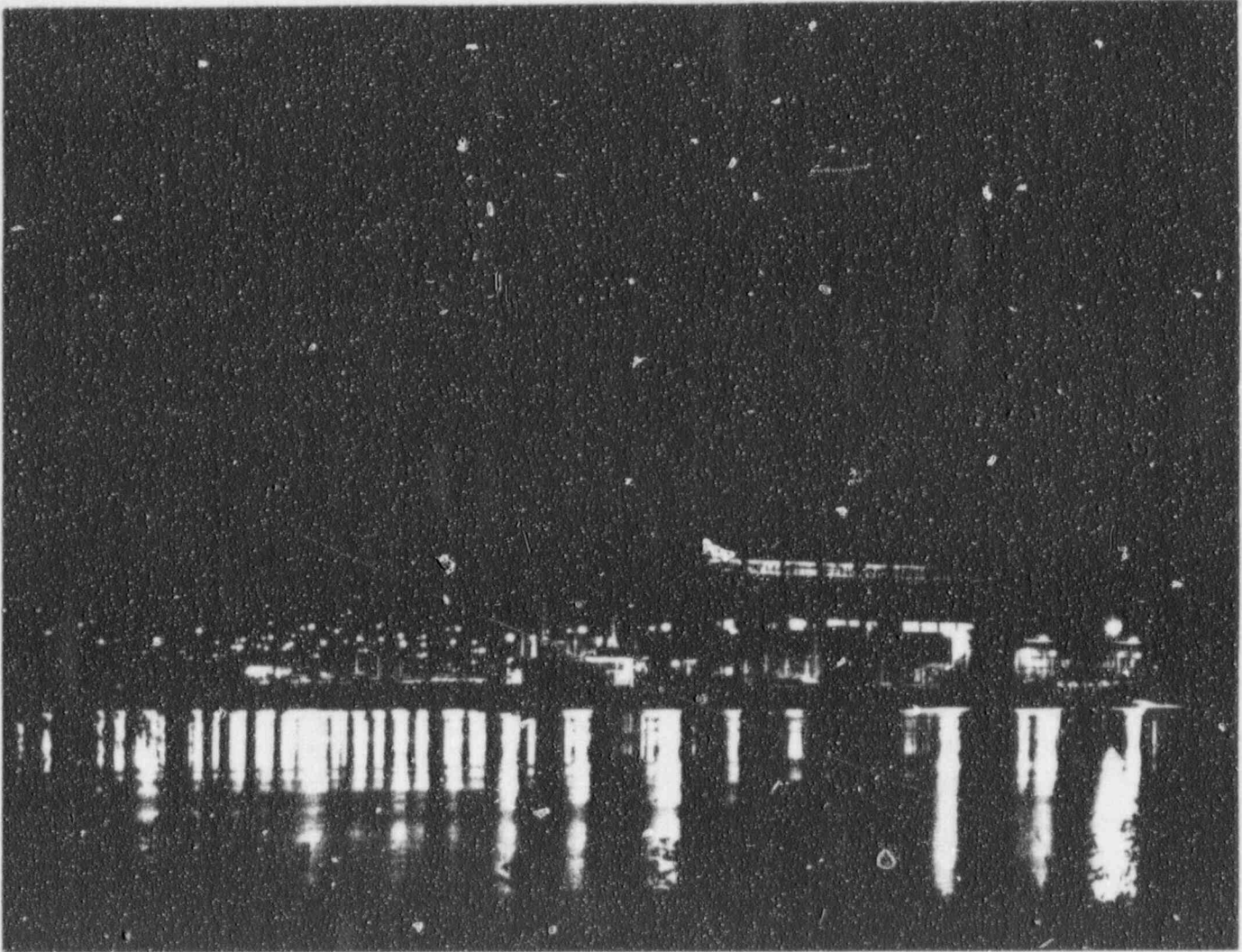
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FORT CALHOUN STATION

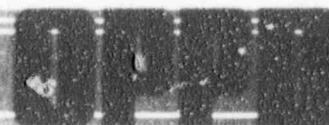


**OMAHA PUBLIC POWER DISTRICT
NRC/OPPD MANAGEMENT
MEETING
MARCH 2, 1995**

FORT CALHOUN STATION



OMAHA PUBLIC POWER DISTRICT
NRC/OPPD MANAGEMENT
MEETING
MARCH 2, 1995



Omaha Public Power District

NRC/OPPD MANAGEMENT MEETING

AGENDA

- | | |
|---|-----------------|
| I. OPENING REMARKS | Gary Gates |
| II. EVENT DEVELOPMENT | Ralph Phelps |
| III. EVALUATION PROCEDURE FOR POTENTIALLY REPORTABLE EVENTS | Ralph Phelps |
| IV. ROOT CAUSE | Terry Patterson |
| V. CORRECTIVE ACTIONS | Ralph Phelps |
| VI. CORRECTIVE ACTION PROGRAM ENHANCEMENTS | Dick Andrews |
| VII. SUMMARY/CLOSING REMARKS | Gary Gates |

OPENING REMARKS

- **Introduce OPPD Participants**

- **OPPD Presentation Format and Presenters**

- **Overview**

EVENT DEVELOPMENT

- **Service Water Self Assessment Preparation**
 - Process addressed several DBD open issues
- **CCW Performance Calculations Revised**
 - Potential for loss of Control Room air conditioning discovered
- **PED-QP-19 (Evaluation of Potentially Reportable Conditions) Evaluation**
 - Proceduralized process
- **Reportability Determination**
 - Short term corrective actions for Control Room AC
 - Modification to Control Room HVAC

EVALUATION PROCEDURE FOR POTENTIALLY REPORTABLE EVENTS

■ History

- SSOMI/DBD issues
- Development of PED-QP-19
- Previous NRC reviews of methodology
- Need to update to ensure consistency with corrective action management goals

**EVALUATION PROCEDURE FOR POTENTIALLY
REPORTABLE EVENTS (cont.)**

- Comparison of the Procedures that Control Reportability Evaluations
 - Standing Order R-4, "Station Incident Reports"
 - NOD-QP-31, "Operability and Reportability Determinations"
 - PED-QP-19, "Evaluation of Potentially Reportable Conditions"

ROOT CAUSE

■ Primary Cause

- Management expectations for Incident Report generation were not clearly established

■ Contributing Causes

- Generic Letter 91-18 not fully incorporated into PED-QP-19
- Reluctance to bring issues forward without complete documentation
- Tendency to treat design basis issues as routine occurrences

CORRECTIVE ACTIONS

- Issued Memorandum on Initiation of Incident Reports (Complete)

- Engineering Group Meetings on Initiation of Incident Reports in accordance with the Memorandum (Complete)

- Revision to PED-QP-19 to Implement Earlier Incident Report Initiation (Complete)

- Design Engineering Internal Review of Open Issues for the Need to Initiate IR's (Complete - No additional IR's initiated)

CORRECTIVE ACTION PROGRAM ENHANCEMENTS

- **Process Management Team Review of Corrective Action Program**
- **Plant Review Committee Subcommittee Review of the Operability Determination Process**
- **Daily Management Reviews of Incident Reports**
- **Oversight Activities**
 - Periodic review of selected tracking systems
 - Independent review of the implementation of Generic Letter 91-18
 - Continuing emphasis on monitoring plant activities to ensure that the corrective action system is promptly used when appropriate

CORRECTIVE ACTION PROGRAM ENHANCEMENTS (cont.)

■ New Corrective Action Process

- IR/CAR → Condition Report
- A dedicated group has been formed
- A plan and schedule have been developed
- Implementation is currently scheduled for September 1995

CONDITION REPORTING SYSTEM CURRENT SCHEDULE

Customer / computer needs analysis	March 6, 1995
Prepare draft plan and procedure revisions	April 10, 1995
Approve plan and procedure revisions	April 24, 1995
Develop and test corrective action program computer system	July 27, 1995
Develop employee training	August 3, 1995
Move IR and CAR items to the new system	August 17, 1995
Complete employee training on new process	September 15, 1995
Implement Condition Report process	September 21, 1995
Process performance evaluation	On-going

SUMMARY/CLOSING REMARKS

- Prompt Initiation of Incident Reports
- Identified Causes
- Corrective Action Summary
 - Personnel
 - Procedural
 - Corrective Action Group