

UNITED STATES

NUCLEAR REGULATORY COMMISSION

REGIONIV

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JAN 22 1992

Docket No. 50-285 License No. DPR-40 EA 91-184

Omaha Public Power District ATTN: W.G. Gates, Division Manager Nuclear Operations 444 South 16th Street Mall Mail Stop 8E/EP4 Omaha, Nebraska 68102-2247

Gentlemen:

SUBJECT: NOTICE OF VIOLATION (NRC INSPECTION REPORT NO. 50-285/91-26)

This is in reference to NRC's November 18-December 3, 1991, inspection at Omaha Public Power District's Fort Calhoun Station facility in Blair, Nebraska, the results of which were documented in a report issued on December 10, 1991, and to an enforcement conference which was held in NRC's Arlington, Texas office on December 19, 1991.

NRC's inspection reviewed the safety and regulatory implications of OPPD's November 18 discovery that Fort Calhoun Station personnel had circumvented plant procedures and primary containment integrity requirements on 20 occasions in the preceding six weeks when sampling water from the reactor coolant drain tank.

OPPD's investigation of this event revealed that on each of the 20 occasions, plant personnel, including the system engineer responsible for Racwaste Systems, opened valve WD-1060 for approximately 45 seconds. This was done without a Plant Review Committee approved procedure for valve operation, without the approval of the shift supervisor, without documenting the activity in the Locked Component Deviation Log, and without independently verifying that the valve had been returned to its normal closed and locked position, all violations of plant procedures. The individuals involved in this activity disregarded the obvious prohibitions to repositioning WD-1060, as indicated by a seal wire on the valve, and failed to recognize the effect of opening this valve on the integrity of the primary containment as it is defined in plant Technical Specifications.

Admittedly, this sampling activity had no effect on the safe operation of the plant and a minimal effect on the containment integrity. The significance of this event rests not on the details of the sampling activity. The serious safety implications arise from the fact that a number of trained and experienced plant personnel operated a valve without following an approved procedure, when that valve was identified by the presence of a seal wire as a valve which should not be repositioned without exercising special controls.

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Opening this valve in this manner was a clear violation of the Fort Calhoun Station Quality Assurance Plan and plant Standing Order 0-44, "Administrative Controls for Locks of Components," which permits the repositioning of such valves only with the approval of the shift supervisor or by utilizing a procedure approved by the Plant Review Committee. Neither occurred in this case.

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NRC recognizes fully the positive actions taken by OPPD upon discovery of this event and views OPPD's corrective actions as prompt and extensive. These include immediate action to halt the activity, the initiation of a thorough root cause analysis, the bringing of the event to the attention of plant staff in writing and in meetings, the condul of a review of all other non-routine sampling activities for nearly a two-year period, and, as of the date of the enforcement conference, commitments to evaluate a series of recommendations resulting from the root cause analysis. The recommendations include, among other things, developing labels for locking devices, enhancing training on standing orders in general and additional training on Standing Order 0-44, and enhancing the formality of and communications associated with non-routine activities.

Nonetheless, the lack of formality demonstrated by the system engineer during the troubleshooting process, the lack of training, and the lack of inquisitiveness indicated by this event -- all factors which OPPD's root cause analysis attributed this event to -- are significant regulatory concerns to NRC because they represent a disregard for safety that could, under other circumstances, result in more serious consequences. Therefore, the violations associated with this event are classified at Severity Level III.

In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C (1991), a civil penalty is considered for a Severity Level III violation. However, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research, I have decided that a civil penalty will not be proposed in this case. This decision is based on NRC's consideration of the civil penalty adjustment factors in Section V.B. of the Enforcement Policy.

In particular, the fact that OPPD discovered this event and promptly brought it to NRC's attention, the promptness and extensiveness of OPPD's corrective actions, and OPPD's generally good past performance in the two years preceding this event were significant factors in this determination. Had NRC observed recent examples of violations with similar root causes -- lack of formality, lack of training, and lack of questioning attitudes -- a civil penalty would have been assessed. From NRC's perspective, this event is inconsistent with the improvements that have occurred in OPPD's overall regulatory performance.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice of Violation (Notice) when preparing your response. In your response, you should document the specific actions taken and

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any additional actions you plan to prevent recurrence. You should also specifically address any actions taken to ensure that troubleshooting activities are properly controlled. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

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Although the December 10, 1991 inspection report indicated that containment integrity Technical Specifications were violated by this event, we have not included a violation of Technical Specifications in the enclosed Notice because we have elected to focus in the Notice on those violations that, from NRC's perspective, are central to our regulatory concerns.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

Colist Mark

Robert D. Martin Regional Administrator

Enclosure: Notice of Violation

cc: LeBoeuf, Lamb, Leiby & MacRae ATTN: Harry H. Voigt, Esg. 1333 New Hampshire Avenue, NW Washington, D.C. 20036

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

Combustion Engineering, Inc. ATTN: Charles B. Brinkman, Manager Washington Nuclear Operations 12300 Twinbrook Parkway, Suite 330 Rockville, Maryland 20852 Omaha Public Power District -4-

Nebraska Department of Health AT 1: Harold Borchert, Director Division of Radiological Health 301 Centennial Mall, South P.O. Box 95007 Lincoln, Nebraska 68509

Fort Calhoun Station ATTN: T. L. Patterson, Manager P.O. Box 399 Fort Calhoun, Nebraska 68023