



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV

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SEP 29 1995

Omaha Public Power District  
ATTN: T. L. Patterson, Division Manager  
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SUBJECT: FORT CALHOUN STATION INTEGRATED PERFORMANCE ASSESSMENT - IN-OFFICE  
REVIEW RESULTS (REFERENCE NRC INSPECTION REPORT 50-285/95-18)

During the period of September 11-22, 1995, an assessment team under the direction of Region IV and composed of members from NRC Region I, the Office for Analysis and Evaluation of Operational Data, and NRC Region IV, performed an in-office assessment of safety performance at the Fort Calhoun Station. This assessment was conducted using Inspection Procedure 93808, "Integrated Performance Assessment Process (IPAP)." A summary of the in-office assessment is contained in the enclosed report, including a preliminary performance assessment/inspection planning tree.

The next step in the IPAP process is to perform an assessment of performance on site. The results of the in-office assessment will be used to focus the on-site assessment which is scheduled for October 23 through November 3, 1995. The overall IPAP recommendations for each functional area will be finalized after the on-site assessment. The final assessment results, including an updated performance assessment/inspection planning tree, will be transmitted to you in NRC Inspection Report 50-285/95-18.

I want to emphasize that the enclosed summary report is preliminary and is provided for your information only. No response to this letter or to these assessment results is required or expected. Should you have any questions, contact me or Mr. Elmo E. Collins of my staff at (817) 860-8291.

Sincerely,

Thomas P. Gwynn, Director  
Division of Reactor Safety

Docket: 50-285  
License: DPR-40

Enclosure:  
Summary of In-Office Assessment

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## ENCLOSURE

### FORT CALHOUN STATION Integrated Performance Assessment In-Office Review Results

In an effort to better integrate and assess licensee performance, and to better utilize inspection resources, the NRC has initiated the Integrated Performance Assessment Process. This process is described in Inspection Procedure 93808, "Integrate Performance Assessment Process (IPAP)." A team of NRC personnel not normally associated with routine inspection activities at the Fort Calhoun Station was assembled. This team developed an integrated perspective of licensee strengths and weaknesses based upon a review of historical NRC documents and licensee historical information. The information reviewed is listed in Attachment 1.

The in-office review results are visually displayed in Attachment 2, "Performance Assessment/Inspection Planning Tree, Assessment of Licensee Performance, In-Office Review Results." The following paragraphs provide a summary discussion of the in-office review conclusions. The recommendations of the level of inspection effort discussed below are preliminary. The team's recommendations will be finalized after the on-site assessment.

#### 1 SAFETY ASSESSMENT/CORRECTIVE ACTION

(Elmo Collins, IPAP Team Leader, NRC Region IV, Division of Reactor Safety, and John Jolicoeur, NRC Office for Analysis and Evaluation of Operational Data)

##### 1.1 Problem Identification

The team found that the licensee documents many problems using the formal incident report process; however, there were examples of plant problems that required questioning by the NRC before an incident report was generated. The lack of full use of the formal problem reporting system was a continuing weakness since some of the examples were recently observed. The team noted that the licensee was in the process of implementing a new problem reporting process.

The licensee appeared to be self-critical in its identification of problems. The quarterly trend report was noteworthy in that it provided a comprehensive assessment of plant activities and identified trends at a low threshold. In several instances, the licensee had identified trends that required corrective action. Self-assessments in training, radiological controls, and emergency preparedness were good. The licensee's independent assessment activities, including quality assurance, the plant review committee, the nuclear safety review group, and the safety audit and review committee, were effective at identifying plant problems. Some performance problems had been identified by an outside audit of the quality control program.

The team recommended that the NRC maintain normal inspection effort in this area.

## 1.2 Problem Analysis and Evaluation

The licensee had established a strong program for trending and evaluating site-wide problems. The quarterly trend report was effective at developing performance trends at a low threshold. The licensee performance indicator program and the system report card programs were well established and provided useful tools to indicate systematic, as well as programmatic problems. Equipment failure rates and equipment history were well documented. The team noted that the safety audit and review committee had questioned the effectiveness of the root-cause analysis program.

The team recommended that the NRC maintain normal inspection effort in this area. The team will assess the effectiveness of root-cause analyses during the on-site inspection period.

## 1.3 Problem Resolution

Licensee actions to correct problems had not always been timely or effective. Examples included protracted implementation of corrective actions to improve problem reporting processes, lingering human performance issues, and lack of aggressive resolution of some plant equipment problems. Equipment problems have resulted in reduced plant safety (diesel generator governor problem) and multiple plant trips (reactor coolant pump lube oil coolers). Other lingering equipment problems of concern included the long-standing raw water and component cooling water interface valve and sand problems, the reactor coolant pump motor internal oil leak, the high vibration problems of Pump FW-54, and the degrading bearing in one low pressure safety injection pump.

The team recommended that the NRC increase inspection effort in this area.

## 2 OPERATIONS (Steve McCrory, NRC Region IV, Division of Reactor Safety)

### 2.1 Safety Focus

The licensee's performance with regard to outage planning and consideration of shutdown risk appeared adequate. However, certain activities indicated weaknesses with safety focus during normal operation. Specific examples included: operators did not review Technical Specifications requirements when declaring portions of the control room ventilation system inoperable and failed to recognize that a shutdown requirement was imposed based on the inoperable determination; failure to make a prompt operability determination following notification of performance inadequacies of the control room air conditioning units; a poor prejob briefing and a low level of shift management involvement contributed to a Technical Specifications violation when a heavy load was passed over irradiated fuel; following maintenance on the waste holdup tank recirculation sample valve, the system was restored to service with the valve open resulting in water discharge into the auxiliary building; and, operations had not been proactive in establishing communications with engineering to resolve long-standing equipment and design deficiencies.

The team recommended that the NRC maintain normal inspection effort in this area. The team will perform additional assessment of the safety focus of plant operation during the on-site assessment.

## 2.2 Problem Identification and Resolution

The licensee appeared capable of identifying problem areas through quality assurance, internal self-assessments, and direct operator identification activities. However, weaknesses with the licensee's resolution of long-standing concerns had apparently contributed to a significant reliance on operator "work arounds." The condition was exemplified by those work-arounds affecting emergency operating procedures. Specific examples included: emergency operating procedure revisions to compensate for leakage around Valve HCV-1040, pressurizing Penetration M-3, possible over-pressurization of containment spray pump suction piping, failure of flow control Valves 269X and Y to close on a safety injection actuation signal, and inadvertent offsite power low signal.

The team recommended that the NRC maintain normal inspection effort in the area of problem identification and increase inspection effort in the area of problem resolution. Additional team assessment is required with regard to operator "work arounds," responsiveness to external quality assurance, self-assessment findings, and resolution to long-standing concerns.

## 2.3 Quality of Operations

Quality of operations during event response was generally good. While performance during the recent refueling outage was generally sound, there were two instances in which the licensee permitted the movement of heavy loads in containment and over irradiated fuel without fully understanding important requirements. Additionally, during defueling at the beginning of the outage, a fuel bundle was moved out of sequence. In contrast, performance deficiencies during routine operations have been recurrent throughout the assessment period. Examples included: failure to recognize that a shutdown requirement was imposed by Technical Specifications after declaring part of the control room ventilation system inoperable; multiple instances of failure to follow procedures during surveillances; and, accepting long-standing control room deficiencies and operator "work arounds." A combined external and internal assessment of operations training highlighted several weaknesses in operations training and implied that the training organization had difficulty focusing on more than one area of training at a time. Shift technical advisor and nonlicensed operator training appeared to have been somewhat neglected compared to licensed operator training. Additionally, line and training management appeared to have low involvement in supporting training and clearly delineating responsibilities.

The team recommended that the NRC increase inspection effort in this area. Additional team assessment is required in the area of training of operations personnel and the operations performance enhancement program.



## 2.4 Programs and Procedures

The licensee had identified that procedure deficiencies had contributed to operator errors and procedure violations. Examples included: Surveillance Test OP-ST-ESF-0002 provided the wrong indication for the off-site power low supervisory relay; the procedure for operation of Crane HE-2 contained inadequate requirements for determining the location of irradiated fuel; and several procedures for movement of heavy loads in the containment did not provide guidance regarding containment integrity. Additionally, following a recent reactor trip, it appeared there was no clear transition point from the emergency operating procedures to the normal operating procedures. The licensee's equipment labeling program was slow in implementation. Inspectors continued to find labeling errors that should have been identified in previous equipment and system lineups.

The team recommended that the NRC increase inspection effort in this area. Additional team assessment is required in the areas of procedure revision backlog, emergency operating procedure adequacy and usage, and equipment labeling upgrade.

## 3 ENGINEERING (Harold Gray, NRC Region I, Division of Reactor Safety)

### 3.1 Safety Focus

The recent NRC engineering team inspection found that engineering had addressed safety-significant issues. Engineering was providing good support to the plant, surveillance tests were adequate, and Technical Specification requirements were met. A sample of licensee quality assurance audits in the engineering area found no safety significant issues. From licensee event reports, there were areas where pre-event engineering involvement was not apparent, e.g., in planning lifts, fuel movement, snubber testing, and reactor trips due to water in reactor coolant pump lube oil. The systems engineers had provided a high-quality safety contribution, but the corresponding level of design engineering safety focus was not clear.

The team recommended that the NRC maintain a normal inspection effort in this area. The team will examine the engineering involvement in resolving operator "work arounds" and control room deficiencies, and the extent of engineering involvement with operations, maintenance, and systems engineers.

### 3.2 Problem Identification and Resolution

#### Problem Identification

Engineering had been effective in identifying problems. The licensee conducted a service water system self-assessment and identified new and pre-existing issues with the system. This effort showed a good self-assessment capability. Some examples were seen where engineering became aware of problems and did not initiate corrective action documents. Knowledge of

system status was considered to be a strength. The system engineers exhibited ownership for their systems, which was reflected in detailed system report cards.

The team recommended that the NRC maintain a normal inspection effort in this area. Inspection in the problem identification area should determine the scope and effectiveness of other licensee system reviews.

### Problem Resolution

Although problems had been identified, their resolution was often significantly delayed or incomplete. For control room air conditioning upgrades, engineering did not follow through to complete issues. Long-standing problems with reactor coolant pumps and the raw water/component cooling water systems had not been resolved. Raw water pump trips caused by the buildup of sand had been a continuing problem and the resolution has not been timely. Also, the team found that outside review committees had questioned the thoroughness of root-cause analyses. The NRC engineering team inspection found that, in some cases, engineering actions had been nonconservative, showed a lack of design knowledge, and that engineering assistance request resolutions had been delayed. The effects of high ambient temperature on the operability of the diesels had not been accurately communicated to plant operations. Technical resolution to operator "work arounds" had not been timely.

The team recommended that the NRC increase inspection effort in this area. The team plans to assess the engineering priorities and timeliness in resolving plant problems.

### 3.3 Quality of Engineering Work

The overall quality of engineering work was generally high, but exceptions were noted. The engineering evaluation of raw water pump seal water problems in Licensee Event Report LER 94-07 did not address the effect of raw river water on pump seal life. While system engineering training was found current, the engineering team inspection noted design engineering training to be lagging, especially in electrical and reactor engineering areas. Also noted were a lack of attention to detail in 50.59 safety evaluations and the absence of diagnostic testing of air-operated valves.

The team recommended that the NRC maintain normal inspection effort in this area.

### 3.4 Programs and Procedures

The engineering team inspection did not identify engineering programs and procedures to be a problem except for the absence of programmatic efforts to perform diagnostic testing of air-operated valves. The root-cause analysis procedure appeared good.

The team recommended that the NRC maintain normal inspection effort in this area. The reportability and operability procedures need to be examined during the team assessment.

#### 4 MAINTENANCE

(Tom Stetka, NRC Region IV, Division of Reactor Safety, and John Jolicoeur, NRC Office for Analysis and Evaluation of Operational Data)

##### 4.1 Safety Focus

Outage planning was considered strong. The ability to smoothly enter the refueling outage early was directly attributable to comprehensive advanced planning. Pre-activity briefings have generally been good, with few exceptions noted.

The appropriate NRC inspection effort in this area was indeterminate. Further team assessment is required to determine how priorities are set for work activities, including consideration of shutdown risk, how management expectations are communicated, the level of management oversight and involvement in decision making, and how the maintenance department coordinates with other departments.

##### 4.2 Problem Identification and Resolution

###### Problem Identification

The licensee had a formal process for documentation of problems, which appeared to be functioning. The team noted that the licensee was in the process of implementing a new problem reporting process. Trending of information was considered to be a strength. The licensee rigorously applied trending of performance data to identify problems across the spectrum of plant activities.

The team recommended that the NRC reduce inspection effort in this area.

###### Problem Resolution

Resolution of long-standing maintenance problems and backlogs appeared to be a weakness. The backlog of maintenance work orders, overdue preventive maintenance items, and unresolved control room deficiencies showed an increasing trend. The licensee appeared to have an effective plan for resolving the control element assembly seal leakage problems.

The appropriate NRC inspection effort in this area was indeterminate. Additional team assessment is required in the areas of responsiveness to internal and external assessment findings and in setting the priority of backlogged maintenance items.

#### 4.3 Equipment Performance/Material Condition

Overall plant material condition appeared to be strong. Most systems appeared to be well maintained. One noted problem area was pump failure rates. The performance indicator for pump failures was high due primarily to problems with reactor coolant and raw water pumps. Valve performance had been mixed. Motor-operated valve testing was considered a strength. Relief valve problems have been excessive, apparently due to a lack of preventive maintenance. This problem was identified by the licensee and corrective actions had been initiated.

The team recommended that the NRC maintain normal inspection effort in this area.

#### 4.4 Quality of Maintenance Work

Overall quality of maintenance work appeared to be a strength. The craft personnel appeared to be well trained and knowledgeable in their areas. Work practices, as documented in inspection reports, were within the skill of the craft and characterized by procedural compliance. One foreign material exclusion weakness was identified during maintenance on the control room air conditioning units. An improving trend in the area of repeat maintenance (rework activities) was noted by the team, which reflected management attention to that performance area. Although the skill level of the crafts appeared to be high, it was noted that outside review committees have been critical of maintenance training.

The team recommended that the NRC reduce inspection effort in this area.

#### 4.5 Programs and Procedures

The licensee had a well established program of standing orders and work control procedures governing maintenance. In addition, corrective and preventive maintenance procedures were noted to be technically correct and properly implemented in the field. One recent finding, identified by the licensee and involving discrepancies between the maintenance work orders and forms required for reconciliation on ASME Section XI repairs, indicated a programmatic problem. The licensee appeared to be actively pursuing a resolution to this problem.

The team recommended that the NRC reduce inspection effort in this area.

## 5 PLANT SUPPORT

### 5.1 Safety Focus

**Radiation Protection** (Larry Ricketson, NRC Region IV, Division of Radiation Safety and Safeguards)

Communications between the members of the radiation protection organization and other work groups appeared to be effective. Prejob briefings presented by radiation protection personnel were generally good. Additional information was needed to assess how management communicates expectations to workers and the level of management involvement in decision making.

The appropriate NRC inspection effort was indeterminate. Additional team assessment is required for a complete assessment of radiation protection.

**Security** (Dennis Schaefer, NRC Region IV, Division of Radiation Safety and Safeguards)

A strength in this area was strong senior management support. Additionally, the security management staff was experienced and dedicated.

The team recommended that the NRC reduce inspection effort in this area.

**Emergency Preparedness** (Steve McCrory, NRC Region IV, Division of Reactor Safety)

Two forced shutdowns, due to equipment problems, each caused the licensee to declare a Notification of Unusual Event. Management appeared to have been appropriately involved in the decision process that led to the shutdowns and subsequent emergency action level classifications.

The team recommended that the NRC maintain normal inspection effort in this area. In the upcoming inspections, attention to management communication of expectations, coordination, and communication with other departments will be highlighted for extra emphasis.

### 5.2 Problem Identification and Resolution

**Radiation Protection**

Audits were a strength, but additional team assessment is required to evaluate the radiation protection organization's effectiveness in the use of corrective action documents and responsiveness to problems identified through audits and assessments.

The appropriate NRC inspection effort in this area was indeterminate.

## Security

Strengths in this area included: (1) a strong audit of the Security and Contingency Plan; and (2) an apparent strong security department self-assessment and surveillance program. Weaknesses in this area included: (1) the resolution of continued concerns involving the searching of personnel entering the protected area, especially during high traffic periods; and (2) a licensee-identified concern where the 'blind' (positive) drug identity could be known prior to laboratory testing.

The team recommended that the NRC maintain a normal inspection effort in this area.

## Emergency Preparedness

The licensee performed a self-assessment, which appeared to be thorough and candid. It strongly criticized several areas in the emergency planning functional area. Examples included: weak and possibly ineffective training of emergency personnel; weak management involvement; focus, direction, and leadership; and, lack of clarity in the definition of roles and responsibilities of the emergency response organization "chain of command." Several of these same issues had been previously identified by quality assurance in September and October 1994, and discussed with concern in the November 18, 1994, safety audit and review committee meeting.

The team recommended that the NRC maintain a normal inspection effort in this area. In the upcoming inspections, attention to resolution of long-standing or repetitive problems and responsiveness to external and internal assessment findings will be emphasized.

## 5.3 Quality of Plant Support

### Radiation Protection

The licensee had a good level of performance in radiation protection; however, there was evidence of occasional poor work practices by radiation workers or contract radiation protection technicians.

The team recommended that the NRC maintain normal inspection effort in this area.

### Security

Strengths in this area included: (1) assessment aids, which provided excellent assessment of the perimeter detection zones; and, (2) an excellent security radio communications system. A weakness identified in this area was the manner in which vital area access was controlled.

The team recommended that the NRC maintain normal inspection effort in this area.

### Emergency Preparedness

As previously noted the emergency plan was activated at the unusual event classification level on two separate occasions in this assessment period. The licensee's event assessment, classification, and activation of the emergency plan appeared adequate.

The licensee's self-assessment identified examples of problems in emergency preparedness training and drills. The resident inspection staff observed one example where a drill impacted control room operations. During an emergency preparedness drill, participants attempting to contact the control room via the plant paging system often failed to preface their communications as being part of a drill. As a result, the plant control room responded to communications that were intended for the simulator control room. Other concerns expressed in the self-assessment included: only one trainer for 400 emergency response personnel; no systems approach to training; missed training opportunities during drills; and frequent cancellation or rescheduling of training.

The team recommended that the NRC maintain normal inspection effort in this area. In the upcoming inspections, attention to quality of training and drills will be emphasized.

### 5.4 Programs and Procedures

#### Radiation Protection

The licensee appeared to have consistently implemented strong radiation protection programs characterized by good procedures. Overall, few problems have been identified in this area. The team recommended that the NRC reduce inspection effort in this area.

#### Security

A strength in this area was the continued operation of a strong security program. A weakness in this area included the timeliness and thoroughness of changes to security plans. The team recommended that the NRC maintain normal inspection effort in this area.

#### Emergency Preparedness

The core inspection effort has yet to be completed for this functional area; however, a review of inspection information from the last assessment period indicated an adequate scope and focus to permit a meaningful assessment of licensee performance. No areas for emphasis were identified for future inspections. The team recommended that the NRC maintain normal inspection effort in this area.

## ATTACHMENT 1

### Documents and Information Reviewed In-Office

#### Information

- NRC inspection reports for the current assessment period
- Licensee event reports for 1994 and 1995
- NRC performance indicators
- Site performance indicators
- Component failure analysis reports for the last 2 years
- History of major equipment problems
- Lists of open and closed maintenance work orders
- List of open engineering action requests
- Lists of open, cancelled, and implemented modifications
- List of operability evaluations
- List of self-assessments and the most recent self-assessment for each functional area (if it exists)
- Plant review committee meeting minutes for the last 6 months
- List of root-cause analyses performed for the last 2 years
- List of quality assurance audits performed for the last 2 years and a copy of the most recent audit for each functional area
- Safety audit and review committee and nuclear safety review group charters, plant review committee standing order
- Safety audit and review committee minutes for last 2 years
- List of open and closed incident reports
- List of corrective action requests for the past 2 years
- Post-trip Review reports for 1995
- Performance enhancement program efforts for each functional area
- Safeguards event logs for 1995
- Semi-annual fitness-for-duty reports
- Security Department internal assessment and surveillance reports

#### Procedures

- Conduct of operations and maintenance
- Station maintenance work control
- Operability determination
- Reportability determination
- Selected station modification
- Root-cause procedure



ATTACHMENT 2

ASSESSMENT/INSPECTION PLANNING TREE

FORT CALHOUN STATION  
 PERFORMANCE ASSESSMENT/INSPECTION PLANNING TREE  
 ASSESSMENT OF LICENSEE PERFORMANCE  
 IN-OFFICE REVIEW RESULTS

