

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

November 3, 1995  
LIC-95-0202

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

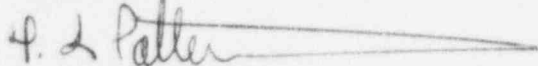
References: 1. Docket No. 50-285  
2. Letter from NRC (J. E. Dyer) to OPPD (T. L. Patterson) dated  
October 4, 1995

SUBJECT: NRC Inspection Report No. 50-285/95-14, Reply to a Notice of  
Violation

The subject report transmitted a Notice of Violation (NOV) resulting from an NRC  
inspection conducted August 13 through September 23, 1995 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,



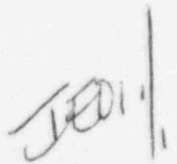
T. L. Patterson  
Division Manager  
Nuclear Operations Division

TLP/grc

Attachment

c: Winston and Strawn  
L. J. Callan, NRC Regional Administrator, Region IV  
S. D. Bloom, NRC Project Manager  
W. C. Walker, NRC Senior Resident Inspector

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PDR ADOCK 05000285  
Q PDR



REPLY TO A NOTICE OF VIOLATION

Omaha Public Power District  
Fort Calhoun Station

Docket: 50-285  
License: DPR-40

During an NRC inspection conducted on August 13 through September 23, 1995, two examples of a violation of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (60 FR 34381; June 30, 1995), the violation is listed below:

Criterion V of Appendix B to 10 CFR 50 States, in part, that activities affecting quality shall be prescribed by procedures, of a type appropriate to the circumstances, and shall be accomplished in accordance with these procedures.

1. Standing Order S0-G-107, Revision 0, "Storage of Transient Equipment and Material to Prevent Seismic Interactions," requires in Step 5.1.4.b that ladders may be secured to cable trays, heating, ventilation, and air conditioning duct work, piping or conduit greater than 2 inches nominal diameter, or any structural support hardware.

Contrary to the above, on August 16, 1995, the inspector observed that maintenance personnel had secured a ladder to an electrical conduit that was less than 2 inches in nominal diameter.

2. Preventive Maintenance Procedure IC-PM-DSS-1001, Revision 4, "Diverse Scram System Actuation Relay Operability," requires that the operator manipulate Manual Trip Switch DSS (B/TS-DSS).

Contrary to the above, on August 24, 1995, a reactor operator failed to accomplish an activity prescribed by procedure IC-PM-DSS-1001 in that the operator manipulated the wrong switch as specified in the surveillance procedure for performance or the diverse scram system test, resulting in a plant trip.

This is a Severity Level IV Violation (285/9514-01) (Supplement I).

OPPD Response

This violation for two examples of failure to accomplish activities in accordance with established procedures was written in two steps, No. 1 and No. 2. In responding to this violation, each example will be responded to as No. 1 and No. 2, respectively.

A. The Reason for the Violation

1. This incident occurred during the installation of a junction box and associated conduit in the West Switchgear Room (Rm. 56B) as part of Engineering Change Notice (ECN) 92-183, "PS-AUPS-0001 (EE-26) Removal". The work was being performed under Construction Work Order 95-0179. The electricians performing the work on this ECN were using a step ladder to access the overhead area above the switchgear. During its use, the ladder was loosely secured to a section of 1 inch conduit. The craft secured the ladder as a precaution, to assure that the ladder could not fall into any adjacent equipment. Standing Order (SO) G-107, "Storage of Transient Equipment and Material (TEM) to Prevent Seismic Interactions," allows ladders to be "stored upright in any area as long as they are secured or restrained," ". . . to cable trays, HVAC ductwork, piping or conduit greater than 2 inches nominal diameter."

The OPPD Construction Management Department Manager and the Site Supervisor for the contractor labor force involved in this incident conducted an evaluation of this event. They concluded that the cause of this violation was an ineffectively written SO coupled with ineffective training provided on the SO. This caused the intent of SO-G-107 to be misunderstood. As a result, the contractor craft did not recognize that the act of loosely securing the step ladder to the conduit would constitute a violation SO-G-107. The craft involved in this work activity indicated that no load was placed on the conduit as a result of securing the ladder.

In response to several condition reports (CR) related to other problems associated with SO-G-107, a review team was formed. The purpose of the team was to review the identified issues, make recommendations for corrective actions and develop an implementation plan. The review team determined that the ineffective training resulted, in part, from the lack of detail contained within SO-G-107 when it was initially issued.

2. On August 24, 1995, with the station at 100% power (Mode 1), one licensed operator and two I&C technicians were performing IC-PM-DSS-1001, "Diverse Scram System Actuation Relay Operability Test." The first six sections of the test had been completed satisfactorily. Section seven, "DSS Matrix Channel B Manual Trip Actuation Relay Test" was being performed to complete the test. The licensed operator performing the test had just completed step 6.7.4 and had

correctly placed the DSS MANUAL TRIP SWITCH, B/TS-DSS, in the TRIP position. This action caused the DSS lock-out relay 86B/DSS to go to the tripped position, as expected. With normal switch alignment, actuation of this lock-out relay would have caused the reactor to trip. However, in an earlier step of the procedure, the CHAN B DSS TEST OR BYPASS SW B1/TS-DSS had been correctly placed in the TEST position. The next step in the procedure sequence (6.7.5) was to place switch DSS MANUAL TRIP SWITCH B/TS-DSS in the NORMAL position. This would have allowed resetting the DSS lock-out relay and recovering from the test. The operator inadvertently repositioned the key operated switch, CHAN B DSS TEST OR BYPASS SW B1/TS-DSS, from the TEST position to the NORMAL position. This action combined with the lock-out being in the tripped position, caused the reactor to trip at 11:14 am.

A Root Cause Analysis (RCA) determined that the root cause of this event was inadequate attention to detail which resulted in a human error that could have been prevented with additional self-checking.

B. Corrective Steps Which Have Been Taken and the Results Achieved

- 1.a Contractor craft on site were given remedial training on the SO-G-107 requirements. Specific items covered included OPPD management expectations on adhering to all requirements for Transient Equipment and Material (TEM), how areas of the plant have been demarcated to assist in complying with the requirements and what to do when it appears that the requirements can not be met. This action was completed on August 24, 1995.
- 1.b SO-G-107 was implemented July 31, 1995. By August 1995, a number of Incident Reports had already been generated on the SO. As a result, management assigned a multi-discipline team to study the SO and associated problems. They were also directed to revise the SO to better define the program's objectives and make it more user friendly. The revised SO was accepted by the Plant Review Committee and issued for training on October 19, 1995. The revised procedure will be implemented when training is completed.
- 2.a The Control Room Operators are now required to verbalize pertinent label information, as an additional self-checking technique, prior to operating equipment from the Control Room.
- 2.b Peer-verification has been implemented, for Control Room Operators, prior to operating equipment from the Control Room that could cause

a significant plant transient.

C. Corrective Steps Which Will be Taken to Avoid Further Violations

- 1.a Ongoing training for S0-G-107 will be incorporated into the Conduct of Maintenance lesson plan. The revised lesson plan for this S0 will emphasize the objectives of TEM control and seismic safe shutdown. This will ensure greater understanding of the basis for the S0. This will be completed by May 31, 1996.
- 2.a During the next Operations Self Assessment an evaluation of self-checking and peer-verification will be included. This assessment will be completed by March 31, 1996.
- 2.b Station management will conduct an evaluation of the Operations Performance Enhancement Program (OPEP) to determine its effectiveness and make any needed corrections to the program. The evaluation and a schedule for corrective actions will be completed by December 31, 1995.

D. Date When Full Compliance Will Be Achieved

1. OPPD is currently in full compliance.
2. OPPD is currently in full compliance.