



Omaha Public Power District
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May 8, 1996
LIC-96-0061

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 April 8, 1996

SUBJECT: NRC Inspection Report No. 50-285/96-01, Reply to a Notice of Violation

The subject report transmitted a Notice of Violation (NOV) resulting from an NRC inspection conducted January 28 through March 9, 1996 at the Fort Calhoun Station (FCS). 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
L. R. Wharton, NRC Project Manager
W. C. Walker, NRC Senior Resident Inspector

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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 January 28 through March 9, 1996, two violations 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:

- A. Technical Specification 5.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Appendix A, recommends, in part, that procedures should be written covering administrative procedures for safe operation.
1. Standing Order SO-R-2, Revision 0, "Condition Reporting and Corrective Action," requires in step 2.2.13 that a condition report be initiated whenever entry into a Technical Specification Limiting Condition for Operation is made.
 2. Contrary to the above, the licensee did not properly implement the governing procedure applicable to the activity such that on February 13, 1996, the licensee did not initiate a condition report as required when the Technical Specification limiting condition for operation for a control room toxic gas monitor was entered.

This is a Severity Level IV Violation (285/9601-01) (Supplement I)

- B. Technical Specification 5.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Appendix A, recommends, in part, that procedures should be written covering administrative procedures for surveillance tests.
1. Standing Order SO-G-23, Revision 44, "Surveillance Test Program," requires in Step 5.2.2 that routine performance of surveillance tests be performed using verbatim compliance.

Procedure IC-ST-IA-3003, Revision 7, "Raw Water Instrument Air Accumulator Check Valve Operability Test," Step 7.2.10, instructs

personnel to open Instrument Air Vent Valve IA-HCV-2851-T.

On February 8, 1996, the inspector observed an instrument and control technician manipulate Valve IA-HCV-2852-T during performance of Step 7.2.10 of Procedure IC-ST-IA-3003, instead of Valve IA-HCV-2851-T.

2. Standing Order SO-G-23, Revision 44, "Surveillance Test Program," requires in Step 5.2.2 that routine performance of surveillance tests be performed using verbatim compliance.

Procedure EM-ST-EE-003, Revision 9, "Quarterly Surveillance Test for Station Battery #1," requires in part that all steps in the procedure be conducted in the sequence written unless otherwise noted.

On March 6, 1996, the inspectors identified that electrical maintenance failed to perform the surveillance as written by performing the surveillance for Station Battery 2, using the surveillance procedure for Station Battery 1.

This is a Severity Level IV violation (285/9601-02) Supplement I)

OPPD Response

These violations were cited separately as Violation A (9601-01) and Violation B (9601-02). OPPD is providing a separate response to each violation.

Violation "A" Response

The aforementioned NOV states that Standing Order SO-R-2, Revision 0, "Condition Reporting and Corrective Action," requires in step 2.2.13 that a condition report be initiated whenever entry into a Technical Specification Limiting Condition for Operation is made. This violation is stated incorrectly, in that, Standing Order SO-R-2 actually required that a condition report be initiated when an "unplanned" entry into a Limiting Condition for Operation was made.

1. **The Reason for the Violation**

This violation occurred during the evening shift on February 13, 1996 when the "B" Toxic Gas Chlorine Monitor (YIT-6286B) began to alarm below its normal alarm setpoint. The "B" Toxic Gas Monitor was declared inoperable

at 1910 hours and the Control Room Operators logged into Technical Specification (TS) 2.22 which has a 7 day Limiting Condition for Operation (LCO). At the time the Toxic Gas Monitor was declared inoperable, neither the Shift Supervisor nor the Control Room Operators recognized the requirement to write a Condition Report (CR) for any unplanned entry into a Technical Specification LCO. As a result, a CR was not generated.

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

- a. The requirement of Standing Order (SO) R-2 for initiating a CR for entry into an unplanned TS LCO entry was reviewed with the Shift Supervisors during the March 5 and April 2, 1996 Shift Supervisor's meetings by Operations Management.
- b. A reminder was added to the Operations Department Night Notes on the requirement to initiate a CR on April 12, 1996. In addition, a temporary reminder has been added to the Shift Supervisor's status board (in the Shift Supervisors Office) stating a CR is required whenever entry into an unplanned TS LCO is made.

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

- a. SO-R-2 will be revised by May 31, 1996 to require the initiation of a CR for any unplanned TS LCO entry of less than or equal to seven days. This will make it clear to the operating crews when a CR is to be written and also meet the intent of SO-R-2 to initiate CR's for significant conditions (potentially) adverse to quality.
- b. Licensed Operators will be trained on the proposed changes to SO-R-2 via "Hotline" by June 14, 1996.
- c. SO-R-2 requirements for initiating a CR will be discussed in Licensed Operator Requalification training. This will be completed by July 31, 1996.

4. Date When Full Compliance Will Be Achieved

OPPD is currently in full compliance.

Violation "B" Response

1. Reason for the Violation

In example one of the violation, Surveillance Test (ST) IC-ST-IA-3003, Step 7.2.10, instructs personnel to open Instrument Air Vent Valve IA-HCV-2851-T. The Instrument and Control (I & C) technician involved in this incident was interviewed to determine the cause. When performing the ST, he immediately realized that the wrong valve had been manipulated. Just prior to the evolution on valve IA-HCV-2851-T, the I & C technician was having difficulty replacing a vent cap on a different valve. This caused him to lose his train of thought. The valve which was incorrectly manipulated was in close proximity to the valve which should have been manipulated. The cause of this event was lack of attention-to-detail and inadequate self-checking.

In example two of the violation, during the performance of EM-ST-EE-0003 and EM-ST-EE-0004 (Battery #1 and Battery #2 Quarterly Surveillance Test), the craft involved had both STs in their possession when obtaining authorization to complete the STs from the Shift Supervisor. At the job site, both STs were present. During the performance of the test, the craft inadvertently recorded the data for Battery No. 1 on the ST for Battery No. 2, and vice versa. The cause of this violation was a lack of attention-to-detail and inadequate self-checking. A contributing cause of this violation was that the labeling of the battery rooms was inadequate. Although the battery rooms are labeled on the outside, they were not labeled on the inside. Furthermore, they do not follow the typical plant numbering system (south to north and west to east).

2. Corrective Steps Taken and Results Achieved

- a. In example one of the violation, an I & C technician incorrectly opened valve IA-HCV-2852-T during the performance of IC-ST-IA-3003 instead of IA-HCV-2851-T. Upon realizing that the incorrect valve had been manipulated, the valve was closed and the cap was replaced. The valve was leak checked and no leakage was revealed. This was completed on February 8, 1996.
- b. In example one of the violation, Raw Water Pump AC-10B was operating when IC-ST-IA-3003 was to be completed. Valve HCV-2852 was open during this ST. HCV-2852 is designed to fail in the open position upon a loss of air pressure. It was determined that Raw Water Pump AC-10B continued to operate and was capable of performing its safety

function throughout the incident. This was completed on February 8, 1996.

- c. In example one of the violation, an investigation was completed to determine if there was a procedural or tagging deficiency. None were identified. This was completed on February 8, 1996.
- d. In example one of the violation, CR 199600157 was issued to document the problem experienced while performing IC-ST-IA-3003. This action was completed on February 8, 1996.
- e. In example one of the violation, the I & C technician involved in this incident was counseled on his attention-to-detail and use of self-checking techniques when performing maintenance at FCS. This was completed on February 8, 1996.
- f. In example two of the violation, to document the problem with the Battery ST, Condition Report 199600271 was generated. This action was completed on March 5, 1996.
- g. In example two of the violation, the battery test data was transcribed to the proper ST and verified to be in specification. At no time was the operability of either station battery in question. This action was completed on March 8, 1996.
- h. In example two of the violation, the individuals involved in the battery ST evolution were counseled on their attention-to-detail and using self-checking techniques when performing maintenance at FCS. This action was completed on March 14, 1996.
- I. In example two of the violation, the Electrical Maintenance Shop was briefed on this incident. They were made aware of the necessity of their attention-to-detail and proper self-checking. Also discussed were management expectations on complacency, even when performing easy or repetitive tasks. This action was completed on April 12, 1996.
- j. In example two of the violation, although the battery rooms were labeled on the outside of the rooms, they were not labeled on the inside. Therefore, to prevent any confusion, labels were placed inside of each battery room to indicate the associated battery tag number. This will further provide opportunities for self-checking. This action was completed on April 12, 1996.

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

- a. For example two of the violation, a procedure change will be completed to both battery STs (EM-ST-EE-003/004) to provide opportunities for the craft to employ self-checking during their performance. These changes will be in place prior to performance of the next quarterly surveillance. This will be completed by May 31, 1996.
- b. For examples one and two of the violation, the Maintenance Department personnel (craft) will be provided additional training on attention-to-detail and self-checking techniques. This training will use simulated exercises to demonstrate the use of self-checking when using procedures. This training will be completed by August 30, 1996.

4. The date when full compliance will be achieved

Fort Calhoun Station is currently in full compliance.