UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

OCT 19 1998

S. K. Gambhir, Division Manager
Production Engineering
Omaha Public Power District
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 TO DISCUSS OVERSPEED EVENTS ON THE TURBINE-DRIVEN AND DIESEL DRIVEN AUXILIARY FEEDWATER PUMPS

Dear Mr. Gambhir:

This refers to the meeting conducted in the Region IV office on October 15, 1998. This meeting related to an overspeed event of the turbine-driven auxiliary feedwater pump that occurred on May 27, 1998, and an overspeed event of the diesel-driven auxiliary feedwater pump that occurred on September 28, 1998.

The meeting was beneficial in providing us additional information regarding the status of your review of the events and your proposed corrective actions.

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,

Thomas P. Gwynn, Director
Division of Reactor Projects

Docket No.: 50-285
License No.: DPR-40

Enclosures:
1. Attendance List
2. Licensee Presentation

9810220294 981019
PDR ADOCK 05000285
S PDR

cc w/enclosures:
James W. Tills, Manager
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Chairman
Washington County Board of Supervisors
Blair, Nebraska 68008

Cheryl Rogers, LLRW Program Manager
Environmental Protection Section
Nebraska Department of Health
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Lincoln, Nebraska 68509-5007

bcc to DCD (IE45)

bcc distrib. by RIV:

Regional Administrator	DRS-PSB
DRP Director	MIS System
Branch Chief (DRP/B)	RIV File
Project Engineer (DRP/B)	Branch Chief (DRP/TSS)
Resident Inspector	K. Perkins, Director, WCFO
B. Henderson, PAO	C. Hackney, RSLO

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DNGraves:vlh		WDJohnson		TPGwynn					
10/16/98		10/16/98		10/16/98					

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020005

bcc to DCD (IE45)

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DRP Director
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DNGraves:vlh		WDJohnson		TPGwynn					
10/16/98		10/16/98		10/16/98					

OFFICIAL RECORD COPY

ENCLOSURE 1

ATTENDANCE LIST

MEETING: Omaha Public Power District

SUBJECT: Auxiliary Feedwater Pump Overspeed Event

DATE: October 15, 1998

	NAME	ORGANIZATION	POSITION TITLE
	Merl Core	OPPD	MANAGER - System Eng.
	Richard Clemens	OPPD	Manager - Maintenance
	MARK FRANS	OPPD	MGR - NUCLEAR LICENSING
	JOSEPH M. SOLYMOSSY	OPPD	MGR. FORT CALHOUN STATION
	SUDESH K. GAMBHIR	OPPD	
	Claude E. Johnson	USNRC	Senior Reactor Inspector
	Lee Ellershaw	USNRC RIV	Senior Reactor Inspector
	DALE POWERS	NRC REGION IV	CHIEF, MAINTENANCE BRANCH
	DWIGHT D. CHAMBERLAIN	NRC	DEPUTY DIRECTOR, DRS
	Thomas P Gwynn	NRC RIV	Director, DRP
	David N Graves	NRC RIV, DRP	Sr Project Engineer, DRP
	William D. Johnson	NRC RIV	Chief, Project Branch B
	John C Whittemore	NRC RIV	Senior Reactor Inspector, DRS
+	Wayne Walker	NRC RIV	Senior Resident Inspector
+	John Russell	NRC RIV	Resident Inspector
*	Bill Bateman	NRC, NRR	Director, PDIV-2
*	Roy Wharton	NRC, NRR	Licensing Project Manager
*	William Burton	NRC, NRR	Sr Reactor Systems Engineer

\+ via teleconference

* via video conference

ENCLOSURE 2

OPPD

FORT CALHOUN STATION

Safe Event-Free Nuclear Production of Electricity

NRC/OPPD Management Meeting
October 15, 1998 – Arlington, Texas

Fort Calhoun Station
Management Overview
Auxiliary Feedwater Pump (FW-10) Overspeed

INTRODUCTION:

- Root Cause & Generic Implications
- Work Control Practices
- Engineering Support for Maintenance Activities
- Results of Case Study – Lessons Learned

Notes:

Fort Calhoun Station
Management Overview
Auxiliary Feedwater Pump (FW-10) Overspeed

EVENT/CAUSE:

- The Event
  - Steam Driven Auxiliary Feed Pump Speed Control Loop rebuilt
  - "Functional analysis of Speed Control Loop" procedure used to run turbine
  - May 27, 1998 overspeed occurred
- Root Cause Analysis
  - Completed 6-15-98
  - PRC approved corrective actions
- Case Study
  - July, 1998 developed Case Study
  - Operators and System Engineers have completed facilitated Case Study
- Cause Determination
  - Inadequate guidance for:
    - speed control linkage adjustment
    - PMT to test speed limiting governor
    - didn't anticipate worst that could happen
  - Formal training on how linkage adjustment would affect operation not provided
  - Did not answer why post work linkage measurements didn't match as found measurements
  - Over reliance on vendor
    - information over the telephone
    - Vendor Manual unclear

Fort Calhoun Station
Management Overview
Auxiliary Feedwater Pump (FW-10) Overspeed

Notes:

Fort Calhoun Station
Management Overview
Auxiliary Feedwater Pump (FW-10) Overspeed

WORK CONTROL:

- Planning
- Pre-Job Briefing
- Supervision
- Work Practices
- Training
  - Craft
  - Engineering
- Corrective Action Summary

Notes:

Fort Calhoun Station
Management Overview
Auxiliary Feedwater Pump (FW-10) Overspeed

ENGINEERING SUPPORT:

- Communication
  - Lateral – System Engineering/Maintenance
  - Vertical – System Engineer/Supervisor
  - Resolution of Questions
- Post Maintenance Testing
  - Specifying Tests
    - Special Instruction
    - Contingencies
    - Non Routine Activities
- Supervision
  - Oversight/Monitoring
  - Problem/Conflict Resolution
- Vendor Support
  - Reliance on Expertise
  - Verification Methods
- Corrective Action Summary
  - Self Checking/DUCS-STAR
  - Questioning Attitudes
  - Pre-Job Briefing Discussion
  - Effective Supervisory Involvement/Monitoring

Notes:

Fort Calhoun Station
Management Overview
Auxiliary Feedwater Pump (FW-10) Overspeed

GENERIC IMPLICATIONS & RELATIONSHIP WITH INSIGHTS FROM COMMON CAUSE ANALYSIS:

- Common Cause Analysis
- Corrective Actions Resulting From CCA
- Additional Corrective Actions
  - Work Practices
  - Engineering Support

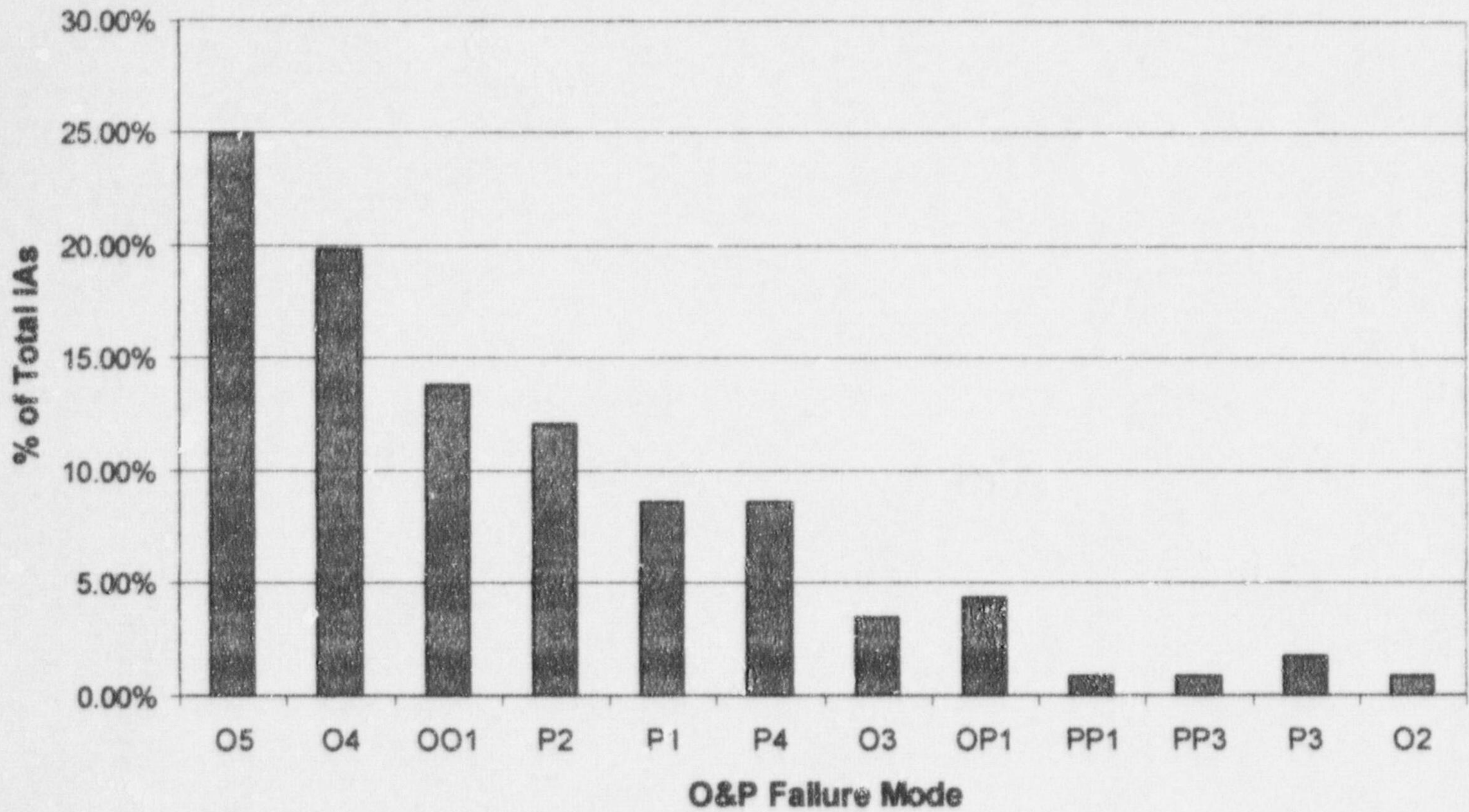
Notes:

Fort Calhoun Station
Management Overview
Auxiliary Feedwater Pump (FW-10) Overspeed

<u>FW-54</u>

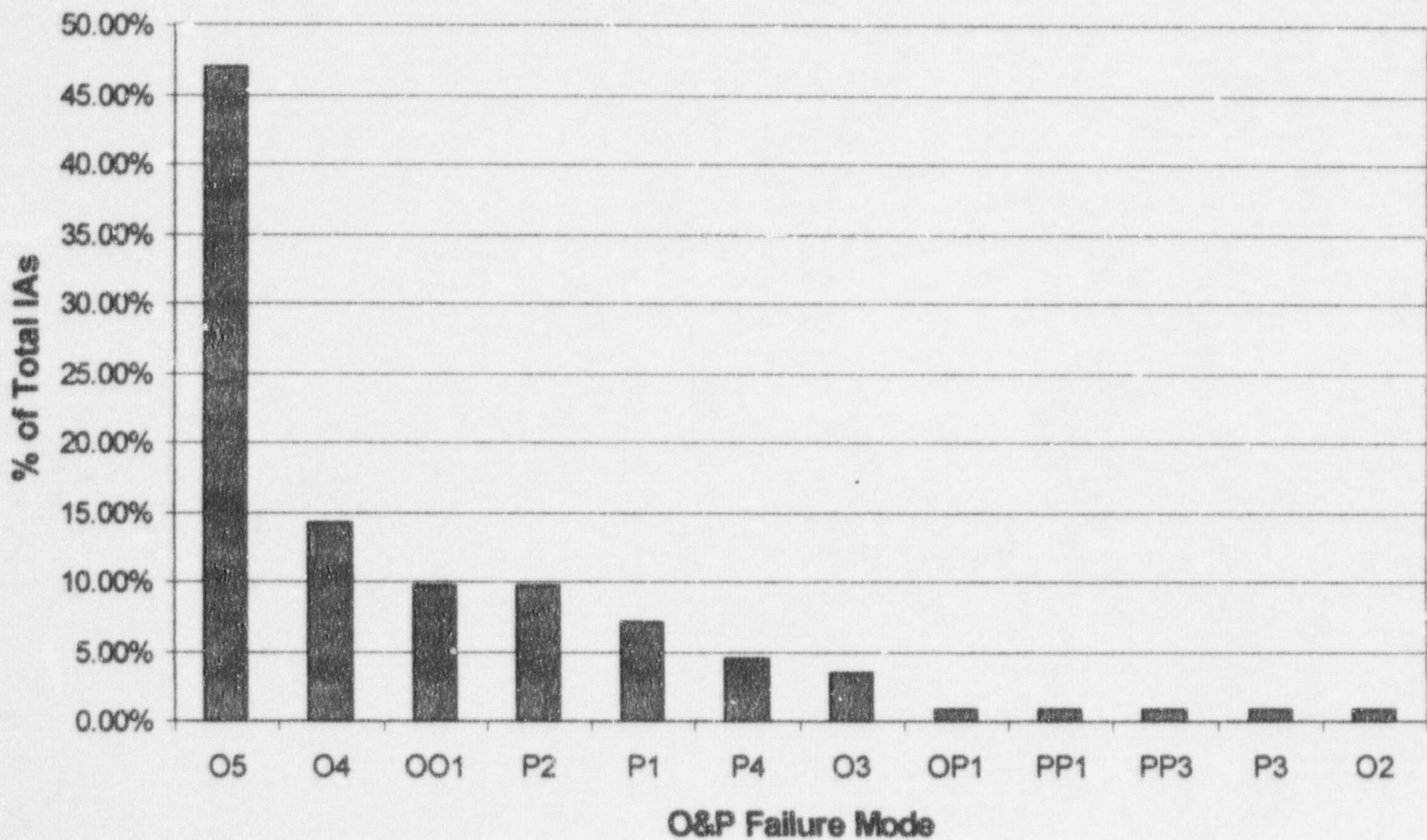
- The Event
    - Diesel Driven Auxiliary Feedwater Pump Flush
    - September 28, 1998 Overspeed Trip
- Cause Determination
    - Inadequate Guidance For:
        - Verifying proper adjustment of throttle lever
        - Formal training not sufficiently detailed

Notes:



Category	Description
O5	Inadequate Job Skills, Work Practices, or Decision Making
O4	Inadequate Communication within the Organization
OO1	Inadequate Interface Among Organizations
P2	Inadequate Scope
P1	Insufficient Detail
P4	Inadequate Self Verification Process

The PII CCA identified a large number of Organization and Programmatic Deficiencies in the category of "Inadequate Job Skills, Work Practice, or Decision Making." Kevin Rackley stated he defaulted to this category when he did not have enough information to allow further categorization. Based on my understanding of the events and the PII categorization I have re-categorized a number of these items into other categories. The following graph shows the result of this reclassification.

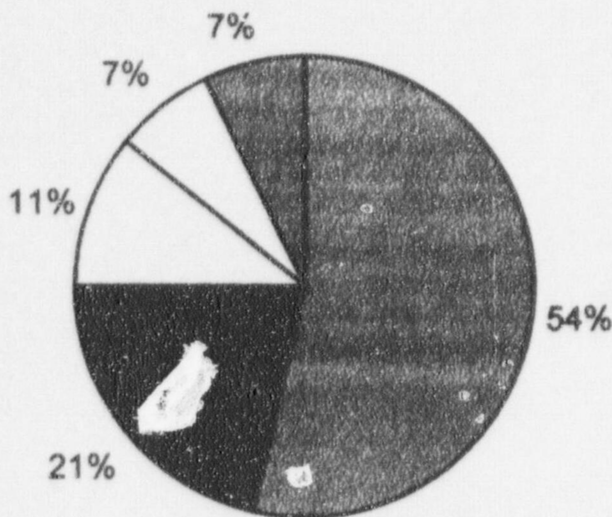


This can be compared to the following graph from the draft report.

The only significant difference between the two graphs is that the P4 failure mode is greater than the 5% threshold value for the latest analysis. This change does not impact the focus of the Phase 2 analysis.

Secondly I looked at the Inappropriate Action categories for the items classified as an Inadequate Job Skills, Work Practices, or Decision-Making deficiency. The following graph shows the breakdown between job skills, work practices and decision making.

Inappropriate Actions for O&P Deficiency O-5
(Inadequate Job Skills, Work Practice or Decison Making)



- Misjudgement (Decision Making)
- Committed Actions Not Carried Out
- Inadequate Job Skills or Knowledge
- Inattention to Detail
- Inadequate Mental State

The graph shows that only 11% of the inappropriate actions are due to inadequate job skills or knowledge while 54% are due to inadequate decision making. This is consistent with the CCA conclusion that the dominant failure mode is misjudgment. The inadequate work practice deficiency is captured by the inappropriate actions of "committed actions not carried out" and "inattention to detail." Inadequate work practices account for 28% of the inappropriate actions. The remaining 7% of the inappropriate actions are categorized as "inadequate mental state" and are assigned to the "fear of failure", "fatigue" or "overconfidence" subcategories. These inappropriate actions are due to internal states the worker brings to the task and reveal themselves through work practices.

Corrective Actions

- Based on review of CCA completed by NRC and Performance Improvement International
- Review of initiatives in progress

Corrective Actions

- Initiatives in progress
  - "CHOICE" Program
  - Organization Changes
  - Alignment Initiative
  - Leadership Development Training
  - Resolution of INPO Findings
  - Development of Business Plans

Corrective Actions

- Additional/continued emphasis is needed in the following areas:
  - Improving Lateral and Vertical Integration/ Communications
  - Implementation of an Effective Accountability System and Follow-up

Corrective Actions

- Areas for Additional/Continued Emphasis (Cont.):
  - Administrative Burden Reduction
  - Procedure/Program Quality Improvement
  - Human Error Reduction Tools and Training
  - Supervisory Effectiveness in Human Error Reduction Skills

Corrective Actions Improve Lateral Integration

- Integrated Business Planning Process
  - 1999 Resource Loaded Business Plan
    - Departmental Business Plans Completed
    - Division Manager review to assure integration and consistency with "CHOICE" Program Initiatives (in progress)
    - Review by Division Managers on at least a quarterly basis in 1999

Corrective Actions Improve Lateral Integration

- Site-wide work prioritization system (in progress)
- Behavior-Based Performance Expectations
  - FCS Values identified by Management (complete)
    - Safety Conscious, Individual Respect
    - Integrity, Accountability, Teamwork
    - Simplicity

Corrective Actions Improve Lateral Integration

- Behavior-Based Performance Expectations
  - Behaviors to support values developed by management team (complete)
  - Sought additional input during Nuclear Performance Meeting
  - Behaviors being communicated (in progress)
  - Using Multi-discipline teams to resolve problems and improve buy-in (e.g. CHOICE teams)
- Next Step Is Adoption of These Behaviors at the Work Group Level

Corrective Actions Vertical Communication Loop

- Started with "Team Building" Meetings at the top
- Several Process Team Building Sessions scheduled over next three months
- Additional New Leadership Training for Managers will focus on:
  - Alignment - Creating a Common Reality
  - Integration - Helping people connect
  - Commitment - Franchising high performance
  - Culture - Passenger, Navigator, or Architect

Corrective Actions Vertical Communication Loop

- FCS Leadership Meetings to Go Over Training & Leadership Issues - scheduled for Mondays
- Expectations for Face-to-Face Communication Up & Down the Chain
- More Frequent use of FCS On-Line
- Better Use of 3N
- Nuclear Performance Meetings

Corrective Actions Accountability System

- Management Changes/Reorganization
  - Four Division Managers
  - Plant Manager from INPO
  - New Training Manager
  - Two Assistant Plant Managers
  - Two Operations Supervisors

Corrective Actions Accountability System

- Holding People Accountable for Management's Expectations
- Motivating Work Force to Maintain Desired Behavior
- Coaching & Counseling Process
- Developed a New Disciplinary Policy
  - Requires peer review

Corrective Action
Implement a Burden Reduction Strategy

- Focus on Most Burdensome Procedures/ Processes

Corrective Action
Improve Procedure Quality

- SO-G-30 revised to implement procedure "owner" concept and facilitate procedure revision process (complete)
- Evaluate further improvement to procedure revision process
- Eliminate, downgrade and simplify current administrative procedures and policies
  - Operations Standards Handbook

Corrective Actions
Improve Procedure Quality

- Address Procedure/Program Quality Issue
  - Line Management Oversight
  - Functional Group Ownership
  - Production Quality (I.E. Writer Training)
  - Process Simplification

Corrective Actions
Improve Procedure Quality

- Operations Procedures
  - Emphasize Operating crew procedure ownership
  - Operator training on the Writer's Guide
  - All operating procedures will be reviewed to meet the Writer's Guide

Corrective Actions

Provide Personnel at All Levels With Human Error Reduction Tools

- Exemplary Human Performance (CHOICE)
- C - Critical Self Assessments
- H - Human Performance is Exemplary
- O - Operations are Event Free
- I - Initiatives in High Visibility Areas Have Strong Performance
- C - Corrective Actions are Broad & Lasting
- E - Excellence in Materiel Condition

Corrective Actions

Provide Personnel at All Levels With Human Error Reduction Tools

- INPO Human Performance Assist Visit
- Developed Human Performance Plan
- Training is Being Provided to Improve Human Error Reduction
  - Human Performance Fundamentals Course
  - "Titanic" Training

Corrective Actions

Supervisory Effectiveness in Reducing Human Error

- Improving Supervisory Effectiveness in Reducing Human Errors
  - Organizational Changes in the Operations Area
    - Additional Supervisor in Operations Group
    - Additional Assistant Plant Manager
    - Plant Manager focused on day-to-day operation, leadership skills improvement and communication of management expectations

Corrective Actions
Supervisory Effectiveness in Reducing Human Error

- Improving Supervisory Effectiveness in Reducing Human Errors
  - Supervisors will receive human performance training
  - Pre-job briefings have improved
  - Scorecard concept introduced
  - Improvements discussed previously will have major impact
  - Additional training needs are being evaluated

Summary

- The Majority of the Issues Identified Through the CCA Are Being Addressed Through Initiatives Started Prior to the Last Refueling Outage
- Additional Corrective Actions Are Being Identified to Address Some of the Newer Insights

Summary
Next Steps

- Build on Successes to Date in Operations Area
- Factor Corrective Actions Into Business Plan
- Repeat CCA

REPORT NO : 199801831

CRG REMARKS

ASSIGNED BY CAG 9/28/98
****

9/29/98 REVIEWED BY CRG, REF. CAG RECOMMENDATIONS IN COMMENT #1. ASSIGN AS LEVEL 3. (LATE UPDATE, 10/6/98 MGB)

RESPONSE DUE DATE 10/29/98 **OWNER** RIDENOURE ROSS T

INDUSTRY EVENTS

RELATED PROCEDURES

ARP-CB-10,11/A21 OP-PM-AFW-0004 SO-G-96

AFFECTED EQUIPMENTS

FW-54

CAUSE DESCRIPTION

1 THE FOLLOWING E-MAIL WAS SENT TO THE OPS DEPT ON FRIDAY, OCTOBER 2ND, 1998 AND EXPLAINS WHAT CAUSED THE EVENT AND ALSO THE LINK BETWEEN THIS EVENT AND A PREVIOUS, SIMILAR EVENT THAT OCCURRED IN JANUARY, 1998.

HI EVERYONE,

ON MONDAY, SEPTEMBER 28TH, THE OPERATIONS "EVENT FREE" CLOCK WAS RESET DUE TO AN FW-54 OVERSPEED PROBLEM THAT HAPPENED ON NIGHTSHIFT. I'D LIKE TO TAKE A FEW MINUTES TO EXPLAIN BRIEFLY WHAT HAPPENED AND WHY THE EVENT CLOCK WAS RESET.

DURING THE SEPTEMBER 28TH PREPARATIONS ON NIGHTSHIFT TO FLUSH FW-54 AFW PIPING FOR A CHEMISTRY SAMPLE, FW-54 WAS STARTED AND ALMOST IMMEDIATELY TRIPPED ON OVERSPEED. AN INVESTIGATION LATER THAT DAY REVEALED THAT THE THROTTLE LEVER ON TOP OF THE ENGINE HAD BEEN INCORRECTLY ADJUSTED - IT WAS MOVED BEYOND THE "2 O'CLOCK" POSITION BY ABOUT 1/4" AND WAS ROTATED 180 DEGREES FROM WHERE IS WAS SUPPOSED TO BE. THE COMBINATION OF THESE TWO ADJUSTMENT ERRORS CAUSED THE DIESEL TO OVERSPEED WHEN IT WAS STARTED.

RELATED TO THIS EVENT WAS A SIMILAR EVENT THAT OCCURRED EARLIER THIS YEAR IN JANUARY. IN THIS EARLIER CASE, FW-54 WAS STARTED BUT DIDN'T COME UP TO FULL SPEED. INSTEAD, IT CAME UP TO IDLE SPEED DUE TO A MISUNDERSTANDING BY OPERATORS ON HOW TO ADJUST THE SAME THROTTLE CONTROL LEVER THAT CAUSED THE OVERSPEED EARLIER THIS WEEK. THE "FIX" IN JANUARY WAS TO "TRAIN ALL OPERATORS ON HOW TO ADJUST THE FW-54 THROTTLE CONTROL LEVER" AND WE ALSO INCORPORATED A PICTURE INTO THE FW-54 OPERATING INSTRUCTION ON HOW TO PROPERLY ADJUST THE THROTTLE. BOTH OF THESE ACTIONS WERE COMPLETED AND EVERYTHING UP TO THIS POINT SEEMED OK.

HOWEVER, IN HINDSIGHT, WE DIDN'T GO FAR ENOUGH IN TRAINING EVERYONE ON HOW TO CORRECTLY ADJUST THE FW-54 THROTTLE. SPECIFICALLY, WE DIDN'T:

1) TRAIN ON THE ADJUSTMENT "BARREL" (THE PIECE THAT ROTATES 180 DEGREES) AND,
2) TRAIN ON WHICH "TANG" AT THE BOTTOM OF THE ADJUSTMENT BARREL (THE LONG ONE WITH TEETH OR THE SHORT ONE) IS SUPPOSED TO MAKE UP WITH THE TOOTHED WHEEL AND THE ADJUSTMENT SLOTS. THE ADJUSTMENT BARREL FOR THIS EVENT WAS "BACKWARDS" FROM WHERE IT SHOULD HAVE BEEN.

IN SHORT, WE DIDN'T TAKE THE STEPS NECESSARY TO ENSURE OUR CORRECTIVE ACTIONS WERE "BROAD AND LASTING" PER OUR SIX FACTOR FORMULA - AND THIS IS REALLY WHY THE EVENT CLOCK WAS RESET. THE CR THAT WAS WRITTEN EARLIER THIS WEEK WAS RATED AS A "LEVEL 3" WHICH, WHEN TRANSLATED FROM CORRECTIVE ACTIONS GROUP LINGO INTO ENGLISH, REALLY MEANS THAT THIS IS A REPEAT EVENT THAT SHOULD HAVE BEEN CORRECTED EARLIER BUT WASN'T.

NOW I'VE USED THE WORD "WE" QUITE A BIT AND I WANT TO MAKE SURE YOU UNDERSTAND WHO MADE THE MISTAKE IN THIS CASE. THE PERSON WHO REALLY MADE THE MISTAKE WAS ME. THE REASON I'M AT FAULT IS BECAUSE I'M THE ONE WHO SPECIFIED WHAT THE CORRECTIVE ACTIONS WOULD BE IN RESPONSE TO THE JANUARY EVENT AND I DIDN'T ENSURE THAT THE CORRECTIVE ACTIONS WOULD REALLY FIX THE PROBLEM. IN REALITY, OUR EVENT CLOCK IS BEING RESET BECAUSE I FAILED TO ENSURE THAT APPROPRIATE CORRECTIVE ACTIONS FROM AN

REPORT NO : 199801831

CAUSE DESCRIPTION

1 EARLIER EVENT WOULD PREVENT A REPEAT EVENT, NOT BECAUSE OF A SINGLE FW-54 OVERSPEED EVENT. (TRUST ME, NO ONE FEELS AS BADLY ABOUT THIS ONE AS I DO.)

SOME OF YOU MAY FEEL IT'S UNFAIR TO RESET THE EVENT CLOCK DUE TO THIS EVENT WHEN THE OPERATORS INVOLVED WEREN'T TRAINED ON HOW TO MAKE THE CORRECT THROTTLE LEVER ADJUSTMENT AND IT WASN'T SPECIFIED CORRECTLY IN THE PROCEDURE. I UNDERSTAND YOUR CONCERN AND SHARE MANY OF THE SAME THOUGHTS - THIS WAS A TOUGH CALL FOR ME TO MAKE ONCE THE FACTS BECAME KNOWN ABOUT WHAT CAUSED THIS EVENT AND ITS RELATIONSHIP TO THE EARLIER JANUARY EVENT (AND ESPECIALLY MY INVOLVEMENT IN IT). ON THE ONE HAND, THE OPERATORS DIDN'T DO ANYTHING WRONG (IN FACT, THE OPERATORS THAT NIGHT DIDN'T ADJUST THE THROTTLE - THAT WAS DONE SOMETIME EARLIER - WE JUST DON'T KNOW WHEN) THEY JUST DIDN'T GET CORRECT TRAINING ON HOW TO ADJUST THE THROTTLE. ON THE OTHER HAND, CORRECTIVE ACTIONS FROM AN EARLIER EVENT WEREN'T GOOD ENOUGH TO PREVENT RECURRENCE OF ANOTHER, SIMILAR EVENT. WHEN I WEIGHED EACH ARGUMENT AGAINST EACH OTHER AND AGAINST OUR EVENT FREE CRITERION, I FELT THAT THE INADEQUATE CORRECTIVE ACTIONS "WON" AND I DIRECTED THE EVENT FREE CLOCK TO BE RESET.

BEFORE I CLOSE, LET ME EMPHASIZE THE POSITIVES (YES... THERE ARE SEVERAL):

1. WE OPERATED EVENT FREE FOR 168 DAYS. THIS IS A RECORD FOR THE DEPARTMENT AND WE SHOULD TAKE GREAT PRIDE IN THIS ACCOMPLISHMENT. OVERALL, WE'VE BEEN DOING A GREAT JOB. WE ARE CONTINUING TO IMPROVE OUR PERFORMANCE AND NEXT TIME I'M CONFIDENT WE'LL BE >168 DAYS.

2. THE FW-54 EVENT DIDN'T CAUSE ANY PERSONAL INJURIES OR EQUIPMENT DAMAGE AND THE CORRECTIVE ACTIONS IN RESPONSE TO THIS EVENT WILL BE VERY STRAIGHTFORWARD AND RELATIVELY SIMPLE. THIS SHOULDN'T HAPPEN AGAIN.

IN CLOSING, DON SHULA, LONG-TIME COACH OF THE MIAMI DOLPHINS, ONCE SAID:

"SUCCESS ISN'T FOREVER, BUT FAILURE ISN'T FATAL."

LET'S ALL DO OUR PART TO ENSURE THE NEXT EVENT FREE RUN IS BETTER THAN THE LAST ONE. YOU'RE DOING A GREAT JOB, KEEP IT UP!

ANY QUESTIONS OR COMMENTS, PLEASE LET ME KNOW.

THANKS

ROSS

CREATED BY RIDENOURE ROSS T | CREATED DATE 10/05/98

WORK ACCOMPLISHED

RESPONSE BASIS

RESPONSE COMPLETED BY RIDENOURE ROSS T | COMPLETED ON 10/05/98

PRC APPROVAL DATE

REPORTS OR EVALUATIONS