UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-4005

December 7, 2005

R. T. Ridenoure
Vice President
Omaha Public Power District
Fort Calhoun Station FC-2-4 Adm.
P.O. Box 550
Fort Calhoun, NE 68023-0550

SUBJECT: FORT CALHOUN STATION - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000285/2005009

Dear Mr. Ridenoure:

On November 30, 2005, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Fort Calhoun Station. The enclosed report documents the inspection findings, which were discussed in a debrief meeting with you and members of your staff at the end of the onsite inspection on September 30, 2005, and again in an exit meeting conducted via conference call with Mr. Bannister and members of your staff on November 30, 2005.

This inspection examined activities conducted under your license as they relate to the identification and resolution of problems, compliance with the Commission's rules and regulations, and compliance with the conditions of your license. The team reviewed approximately 183 condition reports, notifications, root and apparent cause evaluations, and supporting documents. In addition, the team reviewed cross-cutting aspects of NRC and licensee-identified findings and interviewed personnel regarding the safety conscious work environment.

On the basis of the sample selected for review, there were no findings of significance identified during this inspection. The report contains an overall assessment of your corrective action program performance. The team concluded that your corrective action program processes and procedures were adequate, thresholds for identifying issues were appropriate and, with few exceptions, corrective measures were adequate to address adverse conditions. However, your staff did not consistently identify problems at the first opportunity and untimely corrective measures periodically challenged the site, particularly in response to NRC-identified violations and fire protection issues. Based on interviews performed during the inspection, the team concluded that a positive safety conscious work environment exists at your facility.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/ NFO for

Linda Joy Smith, Chief
Engineering Branch 2
Division of Reactor Safety

Docket: 50-285
License: DPR-40

Enclosure:
NRC Inspection Report 05000285/2005009
w/attachment: Supplemental Information

cc w/enclosure:
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DRS Director **(DDC)**
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Branch Chief, DRP/E **(DNG)**
Senior Project Engineer, DRP/E **(VGG)**
Team Leader, DRP/TSS **(RLN1)**
RITS Coordinator **(KEG)**
DRS STA **(DAP)**
J. Dixon-Herrity, OEDO RIV Coordinator **(JLD)**
ROPreports
FCS Site Secretary **(BMM)**

SISP Review Completed: _ljs__ ADAMS: / Yes ☐ No Initials: _ljs__
/ Publicly Available ☐ Non-Publicly Available ☐ Sensitive / Non-Sensitive

R:_FCS\2005\FC2005-09RP-DBA.wpd **ML**

SRI:DRP/E	RI:DRS/EB2	SRI:DRP/A	SRI:DRS/EB2	C:DRP/E	C:DRS/EB2
JDHanna	DOverland	DBAllen	GDReplogle	DNGraves	LJSmith
/RA/	***/RA/***	***/RA/***	***/RA/***	***/RA/***	***/RA/ NFO for***
12/06/05	12/04/05	12/02/05	12/06/05	12/04/05	12/02/05

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U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket:	50-285
License:	DPR-40
Report:	05000285/2005009
Licensee:	Omaha Public Power District
Facility:	Fort Calhoun Station
Location:	Fort Calhoun Station FC-2-4 Adm. P.O. Box 399, Highway 75 - North of Fort Calhoun Fort Calhoun, Nebraska
Dates:	September 12 through November 30, 2005
Inspectors:	D. Allen, Senior Resident Inspector, Project Branch A G. Replogle, Senior Reactor Inspector, Engineering Branch 2 J. Hanna, Senior Resident Inspector, Project Branch E D. Overland, Reactor Inspector, Engineering Branch 2
Accompanying Personnel:	R. Mullikin, Contractor
Approved By:	Linda Joy Smith, Chief Engineering Branch 2 Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000285/2005009; 9/12/2005 - 11/30/2005; Fort Calhoun Station; Biennial Baseline Inspection of Problem Identification and Resolution.

The inspection was conducted by two senior resident inspectors, two reactor inspectors and a contractor. No findings of significance were identified during this inspection.

Identification and Resolution of Problems

- The team reviewed approximately 183 condition reports, notifications, root and apparent cause evaluations, and other supporting documentation to assess problem identification and resolution activities. Overall, the licensee had an adequate problem identification and resolution program. However, the licensee did not consistently identify problems at the first opportunity and sometimes NRC involvement was necessary to ensure proper identification. In addition, untimely corrective measures, particularly in response to NRC identified violations and fire protection concerns, periodically challenged the site. Nonetheless, in most cases the licensee properly identified problems, evaluated and prioritized issues, and implemented acceptable corrective measures.

  Based on the interviews conducted, the team concluded that a positive safety conscious work environment exists at the Fort Calhoun Station. Employees felt free to raise safety concerns to their supervision, to the employee concerns program, and to the NRC. The team received a few isolated comments regarding reluctance to contact the employee concerns program or the NRC due to concern that their identity would be revealed to the licensee. The team determined that licensee management was aware of this perception and was taking actions to address it. All the interviewees believed that potential safety issues were being addressed.

B. Inspector-Identified and Self-Revealing Findings

None.

B. Licensee-Identified Violations

None.

REPORT DETAILS

4 OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems

The team based the following conclusions on issues that were identified in the assessment period, which ranged from April 1, 2003 (the last biennial problem identification and resolution inspection), to the end of the onsite portion of the inspection on September 30, 2005. The issues are divided into two groups. The first group (current issues) includes problems identified during the performance period where at least one performance deficiency also occurred during the same interval. The second group (historical issues) includes issues that were identified during the assessment period where all the performance deficiencies occurred prior to the assessment period.

a. Effectiveness of Problem Identification

(3) Inspection Scope

The inspectors reviewed items selected across the seven cornerstones to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team performed field walkdowns of selected systems and equipment to inspect for deficiencies that should have been entered in the corrective action program. The team also observed control room operations and reviewed operator logs and station work orders to ensure conditions adverse to quality were being entered into the corrective action program. Additionally, the team reviewed a sample of self assessments, audits, surveillances, system health reports, and various other documents related to the corrective action program.

The team interviewed station personnel, attended Condition Review Group and Corrective Action Group meetings, and evaluated corrective action documentation to determine the licensee's threshold for entering problems in their corrective action program. In addition, the team reviewed the licensee's evaluation of selected industry operating experience information, including operation event reports, NRC generic letters and information notices, and generic vendor notifications to ensure that issues applicable to Fort Calhoun Station were addressed.

(4) Assessment

The team determined that the licensee maintained an adequate problem identification program. Problems were generally identified and placed into the corrective action program at an appropriate threshold. For the past 12 months, the licensee had initiated over 5000 condition reports. However, as illustrated in the examples below, the licensee did not consistently identify plant issues at the first opportunity and NRC involvement was sometimes needed to ensure proper issue identification.

Current Issues

Example 1: The NRC identified that the licensee had missed opportunities to identify that transient combustible materials exceeded the fire loading in Room 59 (NRC Inspection Report 05000285/2005002).

Example 2: The NRC identified that the licensee missed several opportunities to identify a design control problem. Specifically, the licensee failed to maintain design control of the turbine-driven auxiliary feedwater pump to ensure that the turbine casing condensate drains would function during accident conditions involving loss-of-condenser vacuum (NRC Inspection Report 05000285/2005002).

Example 3: The NRC identified that the licensee missed several opportunities to identify degraded containment protective coatings (NRC Inspection Report 05000285/2005002).

Example 4: The NRC identified that the licensee failed to promptly identify a fuse failure in the emergency diesel generator excitation circuit (a significant condition adverse to quality). This condition resulted in the emergency diesel generator being inoperable for 29 days (NRC Inspection Report 05000285/2005010).

Example 5: The NRC identified that the licensee failed to identify that fire barriers were not functional nor were appropriate compensatory actions specified in a fire impairment for the open containment personnel hatch and open fuel transfer tube (NRC Inspection Report 05000285/2005002).

Example 6: The NRC identified that the licensee missed opportunities to identify that contractor personnel, performing eddy current testing of the reactor pressure vessel head penetrations, were not qualified in accordance with applicable Code ASNT CP-189-1991 (NRC Inspection Report 05000285/2005003).

Example 7: Plant operators missed several opportunities, over approximately a 3-week period, to write a condition report and to evaluate the significance of a depressurized accumulator for condensate makeup control Valve LCV-1190 (licensee-identified, NRC Inspection Report 05000285/2005004).

Historical Issues

None

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The team reviewed condition reports, notifications, and operability evaluations to assess the licensee's ability to evaluate the importance of adverse conditions. The team reviewed a sample of condition reports, apparent and root-cause analyses to ascertain whether the licensee properly considered the full extent of causes and conditions, generic implications, common causes, and previous occurrences. The team also

attended Condition Review and Corrective Action Group meetings to assess the threshold of prioritization and evaluation of issues identified.

In addition, the team reviewed licensee evaluations of selected industry operating experience reports, including licensee event reports, NRC generic letters, bulletins and information notices, and generic vendor notifications to assess whether issues applicable to Fort Calhoun Station were appropriately addressed.

The team performed a historical review of condition reports and notifications written over the last 5 years that addressed the raw water system and air operated valves in various safety related applications.

(2) Assessment

The team concluded that problems were generally prioritized and evaluated in accordance with the licensee's corrective action program guidance and NRC requirements. However, untimely resolution of known problems, particularly in response to NRC identified violations and fire protection issues, periodically challenged the site. Nonetheless, the team found that for the sample of root-cause reports reviewed, the licensee was generally self critical and thorough in evaluating the causes of significant conditions adverse to quality.

Current Issues

Example 1: The NRC identified that the corrective measures for a prior noncited violation related to an inadequate emergency diesel generator surveillance procedure, were not timely. The licensee performed the same surveillance 6 months later without correcting the procedure (NRC Inspection Report 05000285/2004002).

Example 2: During this inspection, the NRC confirmed that a finding (FIN 05000285/2005011-04), related to a design vulnerability of the raw water system, had problem identification and resolution cross-cutting aspects because of the longstanding nature of the problem. The licensee had not taken comprehensive corrective measures to address a gradual change to the river bottom elevation that had affected raw water system reliability (NRC Inspection Report 05000285/2005011).

Example 3: The NRC identified that the licensee failed to properly evaluate a computer connection vulnerability that had the potential to result in disclosing operator licensing examination materials to plant operators. Consequently, the corrective measures failed to fix the problem (NRC Inspection Report 05000285/2004005).

Example 4: The NRC identified that the licensee failed to take prompt corrective measures to correct three conditions adverse to fire protection. Examples included: 1) the failure to meet separation requirements for redundant trains of equipment required to maintain hot shutdown in Area 32 and the failure to promptly develop procedures and to identify material needed for cold shutdown repairs after October 2003; 2) the failure to

promptly evaluate or repair a degraded fire barrier at the personnel hatch between Rooms 62 and 69; and 3) the failure to meet separation requirements for raw water cables in Manhole 5 and the failure to promptly develop procedures and to identify material needed for cold shutdown repairs (NRC Inspection Report 05000285/2005008).

Example 5: The NRC identified that the licensee failed to take timely actions to address an inadequate technical specification. In 1996, the engineering department had identified that technical specifications for the raw water and component cooling water systems did not provide adequate protection but, as of May 10, 2004, the condition had not been corrected (NRC Inspection Report 05000285/2004003).

Historical Issues

Example 6: The NRC identified that the licensee failed to promptly identify and correct the cause for pitting in the component cooling water system. In 1996, the licensee had identified the pitting but, as of August 2004, had not identified the cause or determined the extent of the problem (NRC Inspection Report 05000285/2004003).

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The team reviewed plant records, primarily condition reports and notifications, to verify that corrective actions related to the issues were identified and implemented, including corrective actions to address common cause or generic concerns. The team sampled specific technical issues to evaluate the adequacy of the licensee's operability determinations.

Additionally, the team reviewed a sample of condition reports and notifications that addressed past NRC-identified violations, for each affected cornerstone, to ensure that the corrective actions adequately addressed the issues, as described in the inspection reports. The team also reviewed a sample of corrective actions closed to other condition reports, notifications, work orders, or tracking programs to ensure that corrective actions were still appropriate and timely.

(2) Assessment

With few exceptions, the licensee's implementation of their corrective action program was effective and the recommended corrective measures were adequate to address the conditions adverse to quality.

Current Issues

Example 1: The NRC determined that corrective actions for a 2003 Severity Level IV violation were inadequate to prevent recurrence. Consequently, the inspectors found that four additional examples of a noncited violation of Technical Specification 5.8.1.a occurred. All instances involved the failure of security personnel to log onto the

appropriate radiological work permit prior to entering a radiological control area (NRC Inspection Report 05000285/2004005).

Example 2: The licensee failed to take effective corrective measures to address a recurring radiological hot spot in excess of 1,000 millirem per hour. Based on historical information, the licensee knew that the area routinely had high dose rates, but took no action to post or blockade the area or to warn plant staff (self-disclosing, NRC Inspection Report 05000285/2005002).

Historical Issues

None.

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

The team interviewed 27 individuals from the licensee's staff, representing a cross-section of functional organizations and supervisory and nonsupervisory personnel. These interviews assessed whether conditions existed that would challenge the establishment of a safety conscious work environment.

(2) Assessment

The team concluded that a positive safety-conscious work environment exists at Fort Calhoun Station. Based on interviews, station personnel felt free to enter issues into the corrective action program, raise safety concerns to their supervision, the employee concerns program, and the NRC. However, the team received a few isolated comments regarding a reluctance to use the Employee Concerns Program or go to the NRC with safety issues because of the perceived potential that an alleger's identity would be released to other plant personnel, including plant management. The interviewees all believed that potential safety issues were being addressed. The team determined that licensee management were aware of the negative perceptions and were taking action to address the concerns.

e. Specific Issues Identified During This Inspection

(1) Inspection Scope

During the reviews described in Sections 4OA2 a.(1), 4OA2 b.(1), 4OA2 c.(1), 4OA2 d.(1) above, the team identified the following finding.

(2) Assessment

Raw Water Strainer Design Control

Introduction. The team identified an unresolved item concerning the use of non-safety related components in the raw water system pump discharge strainers. The licensee

had classified the filtering function of the strainers as nonsafety, but appeared to rely on that function to maintain the operability of the system during design basis accidents.

Discussion. The Fort Calhoun Station raw water system, in part, is composed of four pumps and two pump discharge strainers. The system provides cooling water to the component cooling water heat exchangers and delivers that heat to the ultimate heat sink (the river). The pump discharge strainers continuously filter small debris from the raw water pump discharge stream. If not removed periodically from the strainer, the debris can reduce raw water system flow and clog safety-related heat exchanger.

To maintain the strainers relatively free of debris, the strainer screens are continuously backwashed. Each discharge strainer is equipped with an electric motor that rotates the strainer so that each section is periodically rinsed clean. Both strainer motors receive power from safety-related buses. Following a design basis accident, one strainer remains in service while the second is load shed. The second strainer can be manually placed in service following an accident, as there is sufficient time for operator action since the screens should not immediately foul. Air-operated backwash valves fail in the open backwash position.

Design Basis Document SDBD-AC-RW-101, Attachment 20, "Requirements and Design of Raw Water Pump Discharge Strainers and Motors (AC-12A and 12B)," Revision 26, stipulated that the strainer filtering function was not a safety-related function. The document did not appear to be part of the plant licensing basis. The licensee had utilized nonsafety-related components (including strainer motors) in locations critical to the strainer filtering function.

In contrast to the above, the team noted that the filtering function for the strainers appeared to meet the NRC's formal definition for being considered safety-related. 10 CFR PART 50, "DOMESTIC LICENSING OF PRODUCTION AND UTILIZATION FACILITIES," Section 50.2, defines "safety related" as follows:

> Safety-related structures*, systems and components means those structures, systems and components that are relied upon to remain functional during and following design basis events to assure:*
>
> (1) The integrity of the reactor coolant pressure boundary
>
> (2) The capability to shut down the reactor and **maintain it in a safe shutdown condition [emphasis added]**; or
>
> (3) The capability to prevent or **mitigate the consequences of accidents which could result in potential offsite exposures comparable to the applicable guideline exposures set forth in § 50.34(a)(1) or § 100.11 of this chapter, as applicable [emphasis added]**.

The nonsafety classification of the strainer filtering function was questionable because, if the strainers failed to filter debris, the operability of the raw water system, connected heat exchangers, and quite possibly other components, could be challenged. Further,

the licensee had no analysis or other technical justification that stipulated that the strainers could fail to function without compromising the operability of the raw water system. Therefore, the licensee appeared to rely on the stated function to remain intact for accident mitigation, as well as, to maintain the reactor in a safe shutdown condition.

The team also noted that, while the Updated Safety Analysis Report did not specifically state that any part of the raw water system was safety related, the licensee treated the system as safety related (with the exception of the strainer filtering function) and clearly relied on the system to remain intact for accident mitigation and to maintain the reactor in a safe shutdown condition.

The team performed an initial licensing document search but did not find any licensing documents that would have served to notify the NRC of the licensee's intent to consider the filtering function non-safety related.

At the close of the inspection the licensee believed that historical documents exist that demonstrates that the NRC had approved the non-safety status of the strainer filtering function. This issue is unresolved pending further NRC review of such supporting documents (Unresolved Item 05000285/2005009-01).

Analysis. The NRC will complete a significance determination, if warranted, when closing out the unresolved item.

Enforcement. The NRC will consider enforcement, if necessary, when closing out the unresolved item.

4OA6 Exit Meeting

On September 30, 2005, at the end of the onsite portion of the inspection, an initial debrief of potential findings was conducted with Mr. R. Ridenoure and other members of your staff. The team continued in-office document reviews and conducted an exit meeting via conference call with Mr. Bannister and other members of your staff on November 30, 2005.

ATTACHMENT: SUPPLEMENTAL INFORMATION

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

D. Bannister, Plant Manager
B. Blessie, Supervisor, Operations Engineering
G. Cavanaugh, Supervisor, Regulatory Compliance
P. DeAngelis, Alternate Manager, Radiation Protection
M. Frans, Assistant Plant Manager
S. Gebers, Corporation Health Physics
P. Gunderson, Senior Corrective Action Program Coordinator
A. Hackerott, Supervisor, Systems Analysis (PRA)
A. Hansen, Operations Experience Coordinator
J. Herman, Manager, Engineering Programs
K. Hyde, Supervisor, Design Engineering, Mechanical
J. Kellams, Supervisor, Human Performance, Root Cause Analysis
D. Lakin, Manager, Corrective Action Group
K. Melstad, Acting Manager, Maintenance
A. Richard, Supervisor, Mechanical Systems
R. Ridenoure, Vice President
D. Spires, Manager, Outage and Work Management

LIST OF ITEMS OPENED

Opened

05000285/2005009-01	URI	Use of non-safety related components in the raw water system pump discharge strainers (Section 4OA2 e.(2))

DOCUMENTS REVIEWED

Procedures

Nuclear Operations Division, NOD -QP-19, Cause Analysis Program, Revision 25

Standing Order SO-R-2, Condition Reporting and Corrective Action, Revision 29

Fort Calhoun Station Guide FCSG-24, Corrective Action Program Expectations, Revision 6

Assessments and Audits

Nuclear Safety Review Group Review of Raw Water Strainer AC-12A Problem, 02-QUA-049

Problem Identification, Resolution Self Assessment Report, SA-05-018, August 26, 2005

SARC Audit Report No. 45, Corrective Action Program, September 23, 2004

SARC Audit Report No. 45, Corrective Action Program, August 28, 2003

Quality Assurance Audit Report No. 4, Emergency Response Plan & Implementing Procedures, March 10, 2005

Quality Assurance Audit Report No. 4, Emergency Response Plan & Implementing Procedures, March 25, 2004

2004 QA/SARC Internal Audit Schedule, Revision 0, January 12, 2004

Condition Reports

CR 199600281	CR 200301553	CR 200305339	CR 200402425	CR 200501064
CR 199901002	CR 200301636	CR 200305480	CR 200402429	CR 200501068
CR 200000768	CR 200301794	CR 200305564	CR 200402619	CR 200501069
CR 200001465	CR 200301912	CR 200305587	CR 200402762	CR 200501083
CR 200002145	CR 200301984	CR 200305634	CR 200402893	CR 200501090
CR 200102237	CR 200302012	CR 200305664	CR 200402902	CR 200501117
CR 200103576	CR 200302189	CR 200305744	CR 200402903	CR 200501270
CR 200201162	CR 200302206	CR 200400037	CR 200403011	CR 200501394
CR 200201230	CR 200302377	CR 200400153	CR 200403073	CR 200501401
CR 200202400	CR 200302557	CR 200400156	CR 200403485	CR 200501402
CR 200202508	CR 200302602	CR 200400169	CR 200403634	CR 200501471
CR 200203074	CR 200302623	CR 200400170	CR 200403662	CR 200501523
CR 200203511	CR 200302768	CR 200400187	CR 200403793	CR 200501839
CR 200203513	CR 200303129	CR 200400200	CR 200403795	CR 200501853
CR 200203529	CR 200303410	CR 200400322	CR 200403798	CR 200501912
CR 200203534	CR 200303492	CR 200400348	CR 200403874	CR 200501957
CR 200203655	CR 200303643	CR 200400372	CR 200403875	CR 200502330
CR 200203574	CR 200303660	CR 200400517	CR 200404029	CR 200502434
CR 200203810	CR 200303664	CR 200400823	CR 200404125	CR 200502444
CR 200203864	CR 200303672	CR 200400853	CR 200404338	CR 200502524
CR 200203933	CR 200303706	CR 200400880	CR 200404716	CR 200502675
CR 200204262	CR 200303793	CR 200400928	CR 200500129	CR 200502737
CR 200204316	CR 200303958	CR 200400940	CR 200500151	CR 200502771
CR 200300091	CR 200303986	CR 200401063	CR 200500156	CR 200502802
CR 200300325	CR 200303994	CR 200401108	CR 200500222	CR 200502840
CR 200300772	CR 200304005	CR 200401148	CR 200500357	CR 200502849
CR 200301165	CR 200304335	CR 200401298	CR 200500463	CR 200503018
CR 200301218	CR 200304502	CR 200401372	CR 200500484	CR 200503174
CR 200301231	CR 200304716	CR 200401507	CR 200500631	CR 200503431
CR 200301279	CR 200304783	CR 200401594	CR 200500660	CR 200503650
CR 200301333	CR 200304812	CR 200401672	CR 200500773	CR 200503877
CR 200301396	CR 200304840	CR 200401754	CR 200500943	CR 200504153
CR 200301418	CR 200305066	CR 200401758	CR 200500950	CR 200504223
CR 200301435	CR 200305123	CR 200401761	CR 200500977	CR 200504512
CR 200301436	CR 200305161	CR 200401768	CR 20050993	CR 200504522
CR 200301437	CR 200305298	CR 200401810	CR 200501063	CR 200504527
CR 200301458	CR 200305311	CR 200401885		

Significant Conditions Adverse to Quality (Level 1 and 2 Condition Reports)

CR 200303492, Manual reactor trip due to ASI trending negative during shutdown

CR 200303986, Fuel assembly was ungrappled and resting on fuel racks leaning against the south pool wall

CR 200303994, While posting a room for equipment move, it was noted that two doors for the room were in access mode, neither door had alarm capability.

CR 200304840, CEDM 5 was fully withdrawn, when reinserted, it stopped at 107 inches

CR 200400200, NRC identified ineffective restricted high rad area physical barriers

CR 200401148, Maintenance personnel causes trip of control room air conditioning unit VA-46B when VA-46A was already tagged out

CR 200500773, Reactor trip during plant shutdown due to feedwater transient

CR 200500950, Security not informed of valve opening, compensatory actions were not in place

CR 200501853, Role up of CRs associated with reactor head inspection

Licensee's Response to the following Generic Communications

NRC Information Notice 80-11

NRC Information Notice 83-57

NRC Information Notice 85-17

NRC Bulletin 79-01

NRC Bulletin 78-14

NRC Bulletin 75-03

Self Assessments

CR 200501083, Self-assessment of common cause for 2004 Operational Challenges

CR 200404125, Self-assessment of Operability Determination Process found inconsistent interpretations

CR 200404029, Self-assessment of generic station issue related to CR documentation of immediate corrective actions for significant condition reports related to RP

CR 200403875, Self-assessment of Reliability Engineering Department's assessment of the Maintenance Rule Program

CR 200403795, Self-assessment of Operations Training Department usage of SOER, a deviation was identified related to Davis-Besse Vessel Head Degradation SOER

CR 2004-00153, Self-assessment in SA-03-54, "Assessment of personnel and area contamination control during the 2003 refueling and maintenance outage"

CR 200303129, During 2003 Maintenance Training self-assessment, there was no consistency in incorporating OE, SOER, and CRs into lesson plans

CR 200302012, 2003 RP self-assessment, peer from Wolf Creek made observations and recommendations

CR 200301636, During self-assessment it was identified that TSR 01-38 was completed and approved by System Engineering without a 50.59 evaluation as required by PED-SEI-29

Quality Assurance Surveillance

Surveillance Report 11E-0503, Records Verification, May 23, 2003

Surveillance Report 72E-0203, Configuration Control, June 25, 2003

Surveillance Report 68E-0903, Motor Operated Valve Program, October 24, 2003

Surveillance Report 72E-0903, Refueling Outage Modification Activities, November 19, 2003

Surveillance Report 62E-1203, Operations Training PCM Assessment, January 21, 2004

Surveillance Report 18E-0903, Foreign Material Exclusion and Confined Work Space, February 9, 2004

Surveillance Report 11E-0804, NPD Records, September 24, 2004

Surveillance Report 72E-1004, Engineering Configuration, December 1, 2004

Surveillance Report 48E-0305, Effectiveness of Fuel Handling, April 20, 2005

Surveillance Report 18E-0305 Revision 1, Foreign Material Exclusion, June 15, 2005

Surveillance Report 24E-0505, Quality Program Requirements associated with Reactor Vessel Head Inspection, July 29, 2005

Surveillance Report 6(10)-0905, Security Operations, September 21, 2005

Licensee Event Reports

LER 2003-001, Failed to perform VT-2 inspection of reactor pressure vessel lower head

LER 2003-002, Inadequate testing of emergency diesel generator due to air start system unique design

LER 2003-003, Reactor trip during plant shutdown due to inadequate preparation

LER 2004-001, Failure to perform a leakage test due to lack of understanding of penetration design

LER 2004-002, Inoperable emergency diesel generator for 28 days due to blown fuse during shutdown

LER 2005-001, Unplanned reactor trip due to feedwater transient

Violations and Findings

NCV 2003002-01
NCV 2003003-01
NCV 2003005-01
NCV 2003005-02
NCV 2003006-01
NCV 2003006-02
NCV 2003006-03
NCV 2003006-04
NCV 2003006-05
VIO 2003009-01
NCV 2003011-02
NCV 2003011-04
FIN 2004002-01
VIO 2004002-02
NCV 2004002-03
NCV 2004003-01
NCV 2004003-02
NCV 2004003-03
NCV 2004003-04
NCV 2004003-05
NCV 2004003-06
NCV 2004003-07
NCV 2004003-08
NCV 2004005-01
NCV 2004005-02
NCV 2004005-03
NCV 2004007-01
NCV 2005002-01
NCV 2005002-02
NCV 2005002-03
NCV 2005002-04
NCV 2005002-05
NCV 2005002-06
NCV 2005003-01
NCV 2005003-02
NCV 2005003-03
NCV 2005003-04
NCV 2005003-05
NCV 2005003-06
VIO 2005010-01

Work Orders

00057783
00068531
00071175
00079603
00081442
00088839
00095310
00098903
00099474
00102230
00103285
00106925
00113573
00116024
00126728
00127308
00136518
00137188
00137411
00138656
00139241
00141036
00141605
00159677
00159874
00159875
00166097
00177646
00178096
00178124
00181169
00188407
00203689
00204072
00204202
00204295
00206507
00211630
00211984

Engineering Changes

93-431
0000037217

Drawings

11405-—100, “Raw Water Flow Diagram - P& ID,” Revision 88
11405-—252, Sheet 1, “Flow Diagram Steam - P & ID,” Revision 97

Miscellaneous

Alert Notification System Operability Summary, FCS Siren Operability Percentage for the Last 52 Weeks as of September 12, 2005

Auxiliary Cooling Systems Health Report, 2nd Quarter 2005

Raw Water (RW) System Report Card for the Report Period January 1 through June 30, 2001, dated July 13, 2001

Raw Water (RW) System Report System Updates for the Report Period July 1 through September 30, 2001

Raw Water (RW) System Report Card for the Report Period October 1 through December 31, 2001, dated January 15, 2002

Raw Water (RW) System Report Card for the Report Period January 1 through March 31, 2002, dated April 15, 2002

Raw Water (RW) System Report Card for the Report Period April 1 through June 30, 2002, dated July 12, 2002

Raw Water (RW) System Report Card for the Report Period July 1 through September 30, 2002, dated October 15, 2002

Raw Water (RW) System Report Card for the Report Period October 1 through December 31, 2002, dated January 15, 2003

Raw Water (RW) System Report Card for the Report Period January 1 through March 31, 2003, dated April 15, 2003

Raw Water (RW) System Report Card for the Report Period April 1 through June 30, 2003, dated July 11, 2003

Raw Water (RW) System Report Card for the Report Period July 1 through December 31, 2003, dated January 12, 2004

Raw Water (RW) System Report Card for the Report Period January 1 through March 31, 2004, dated April 13, 2004

Raw Water (RW) System Report Card for the Report Period April 1 through June 30, 2004, dated July 16, 2004

Raw Water (RW) System Report Card for the Report Period July 1 through September 30, 2004, dated October 15, 2004

Raw Water (RW) System Report Card for the Report Period October 1 through December 31, 2004, dated January 11, 2005

Status of Equipment in Maintenance Rule Category (a)(1) Review as of August 17, 2005

Updated Safety Analysis Report, “Section 9.8, Auxiliary Systems, Raw Water System,” Revision 13

SARC Action and Follow-up Items, as of August 5, 2005

Information Request 1
Fort Calhoun Station
PIR Inspection Information Request, August 13, 2005

The inspection will cover the period of April 1, 2003 to September 30, 2005. All requested information should be limited to this period unless otherwise specified. To the extent possible, please provide the information in electronic media in the form of e-mail attachment(s), or CDs. The agency's text editing software is Corel WordPerfect 10, Presentations, and Quattro Pro. However, we have document viewing capability for MS Word, Excel, Power Point, and Adobe Acrobat (.pdf) text files.

Please provide the following by August 22, 2005, to Don Allen by e-mail or to:

Attn: Don Allen c/o Linda Smith
U.S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011

Note: For requested lists, please include a description of problem, significance level, status, initiation date, and owner organization.

1. List of all condition reports related to significant conditions adverse to quality that were opened or closed during the period

2. List of all condition reports related to conditions adverse to quality that were opened or closed during the period

3. List of all condition reports that were up-graded or down-graded during the period

4. List of all condition reports that subsume or "roll-up" one or more smaller issues for the period

5. Lists of operator work arounds, engineering review requests and/or operability evaluations, temporary modifications, and control room and safety system deficiencies opened or closed during the period

6. List of root-cause analyses completed during the period

7. List of root-cause analyses planned, but not complete at end of the period

8. List of plant safety issues raised or addressed by the employee concerns program during the period

9. List of action items generated or addressed by the plant safety review committees during the period

10. Copy of quality assurance audits and Surveillance of corrective action activities completed during the period

11. A list of quality assurance audits and Surveillance scheduled for completion during the period but which were not completed

12. Copy of corrective action activity reports, functional area self-assessments, and non-NRC third party assessments completed during the period (Do not include INPO assessments)

13. Copy of corrective action performance trending/tracking information generated during the period and broken down by functional organization

14. Copy of governing procedures/policies/guidelines for:

    a. Condition reports
    b. Corrective Action Program
    c. Root Cause Evaluation/Determination
    d. Deficiency reporting and resolution

15. List of external events and operating experiences (OERs) evaluated for applicability at Fort Calhoun Station during the period

16. Copy of condition reports or other actions generated for each of the items below during the period:

    a. Part 21 Reports
    b. NRC Information Notices and Bulletins
    c. LERs issued by Fort Calhoun Station (also include a copy of the LERs)
    d. NCVs and Violations issued to Fort Calhoun Station

17. Copy of security event logs during the period

18. Copy of radiation protection event logs during the period

19 Copy of condition reports or corrective action reports generated as a result of emergency planning drills and tabletop exercises during the period

20. Copy of system health reports or similar information during the period

21. Copy of condition reports associated with maintenance preventable functional failures during the period

22. Copy of condition reports associated with adverse trends in human performance, equipment, processes, procedures, or programs during the period

23. Copy of corrective action effectiveness review reports generated during the period

24. Copy of current predictive maintenance summary report or similar information

25. List of corrective actions closed to other programs, such as maintenance action requests/work orders, engineering requests, etc.

26. List of degraded conditions and nonconformances under Generic Letter 91-18 which were not corrected in the last outage

Information Request 2
FORT CALHOUN PI&R

CONDITION REPORT REQUEST

RAY MULLIKIN

22. Need hard copies of the following Condition Reports:

200301165	200400156	200402893	200500660
200301279	200400169	200403011	200501068
200301794	200400187	200403874	200501069
200302768	200400348	200500129	200501853
200303410	200400853	200500222	200502444
200304783	200401063	200500357	200502802
200305161	200401810	200500463	200503018
200305339	200402429	200500484	

23. Need a list (with number and description) of the Condition Reports generated regarding the Raw Water System for the 5-year period from April 1, 2000, to the present.

24. Need a list of Work Orders and Work Requests generated for the Raw Water System from April 1, 2000, to the present.

25. For the Raw Water System, need some of the information requested in our August 13, 2005, letter to go back to April 1, 2000. That information is:

- Item 5
- Item 10
- Item 12 (Assessments)
- Item 15
- Item 20
- Item 24

DEAN OVERLAND

Please provide hard copies of the following condition reports on Monday, Sept. 12, 2005:

CR 200203574	CR 200302206	CR 200305480	CR 200402619
CR 200300325	CR 200302557	CR 200305480	CR 200402619
CR 200303664	CR 200302557	CR 200305564	CR 200402762
CR 200303672	CR 200302602	CR 200305744	CR 200500631
CR 200303643	CR 200302623	CR 200400037	CR 200500943
CR 200300772	CR 200303660	CR 200400200	CR 200500977
CR 200301458	CR 200303706	CR 200400200	CR 200500977
CR 200301218	CR 200304335	CR 200400372	CR 200501090
CR 200301333	CR 200304335	CR 200400517	CR 200501394
CR 200301418	CR 200305066	CR 200302602	CR 200501394
CR 200301435	CR 200304502	CR 200302623	CR 200501401
CR 200301436	CR 200501523	CR 200401148	CR 200501402
CR 200301437	CR 200304812	CR 200401148	CR 200501912
CR 200302189	CR 200304840	CR 200401298	CR 200503174

DON ALLEN

Please provide hard copies of the following condition reports. Monday Sept. 12, 2005 would be timely.

CR 200203529	CR 200302012	CR 200400153	CR 200404125
CR 200304005	CR 200303129	CR 200400322	CR 200404029
CR 200305634	CR 200303793	CR 200403795	CR 200500950
CR 200305664	CR 200303994	CR 200403875	CR 200501083
CR 200301636	CR 200304716		