your energy partner
OPPD
Omaha Public Power District
444 South 16th Street Mall
Omaha, NE 68102-2247

LIC-13-0065
May 17, 2013

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555-0001

References: 1. Docket No. 50-285
2. Letter from OPPD (D. J. Bannister) to NRC (Document Control Desk) dated March 1, 2012 (LIC-12-0022)

Subject: Licensee Event Report 2012-001, Revision 1, for the Fort Calhoun Station

Please find attached Licensee Event Report 2012-001, Revision 1, dated May 17, 2013. This report is being submitted pursuant to 10 CFR 50.73(a)(2)(v)(B) and (D). No commitments are being made in this letter.

If you should have any questions, please contact Terrence W. Simpkin, Manager, Site Regulatory Assurance, at (402) 533-6263.

Sincerely,

Louis P. Cortopassi
Site Vice President and CNO

LPC/epm/rjr

Attachment
c: A. T. Howell, NRC Regional Administrator, Region IV
L. E. Wilkins, NRC Project Manager
J. M. Sebrosky, NRC Project Manager
J. C. Kirkland, NRC Senior Resident Inspector

NRC FORM 366 (10-2010) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB: NO. 3150-0104 EXPIRES: 10/31/2013

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
Fort Calhoun Station	05000285	1 OF 3

4. TITLE

Inadequate Flooding Protection Procedure

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
										05000
2	10	2012	2012	- 001 -	1	5	17	2013	FACILITY NAME	DOCKET NUMBER 05000

9. OPERATING MODE

5

10. POWER LEVEL

0

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: *(Check all that apply)*

- ☐ 20.2201(b)
- ☐ 20.2201(d)
- ☐ 20.2203(a)(1)
- ☐ 20.2203(a)(2)(i)
- ☐ 20.2203(a)(2)(ii)
- ☐ 20.2203(a)(2)(iii)
- ☐ 20.2203(a)(2)(iv)
- ☐ 20.2203(a)(2)(v)
- ☐ 20.2203(a)(2)(vi)
- ☐ 20.2203(a)(3)(i)
- ☐ 20.2203(a)(3)(ii)
- ☐ 20.2203(a)(4)
- ☐ 50.36(c)(1)(i)(A)
- ☐ 50.36(c)(1)(ii)(A)
- ☐ 50.36(c)(2)
- ☐ 50.46(a)(3)(ii)
- ☐ 50.73(a)(2)(i)(A)
- ☐ 50.73(a)(2)(i)(B)
- ☐ 50.73(a)(2)(i)(C)
- ☐ 50.73(a)(2)(ii)(A)
- ☐ 50.73(a)(2)(ii)(B)
- ☐ 50.73(a)(2)(iii)
- ☐ 50.73(a)(2)(iv)(A)
- ☐ 50.73(a)(2)(v)(A)
- ☒ 50.73(a)(2)(v)(B)
- ☐ 50.73(a)(2)(v)(C)
- ☒ 50.73(a)(2)(v)(D)
- ☐ 50.73(a)(2)(vii)
- ☐ 50.73(a)(2)(viii)(A)
- ☐ 50.73(a)(2)(viii)(B)
- ☐ 50.73(a)(2)(ix)(A)
- ☐ 50.73(a)(2)(x)
- ☐ 73.71(a)(4)
- ☐ 73.71(a)(5)
- ☐ OTHER

Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME	TELEPHONE NUMBER *(Include Area Code)*
Erick Matzke	402-533-6855

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED

☐ YES *(If yes, complete 15. EXPECTED SUBMISSION DATE)* ☒ NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

ABSTRACT *(Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)*

On February 10, 2012, during an inspection of flood preparations by the NRC in response to previously identified NRC findings, it was concluded that Abnormal Operating Procedure (AOP) 01 Revision, 28, Acts of Nature, Section I, Flooding, did not adequately protect equipment required to maintain safe shutdown from external flooding to an elevation of 1014 feet Mean Sea Level (MSL). This condition could have prevented the raw water pumps from being available to provide cooling to the component cooling water system. This condition was entered into the station's corrective action program.

The causal analysis determined that station senior management, at the time the condition was identified, did not effectively lead recovery efforts to address the NRC component design basis inspection (CDBI) and FCS self-identified flooding issues in AOP-01. This resulted in important flooding related corrective actions not being effectively planned, prioritized or resourced to ensure a success path for AOP-01 within the established timeline.

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
		YEAR	SEQUENTIAL NUMBER	REV NO.	
Fort Calhoun Station	05000285	2012	- 001 -	1	2 OF 3

NARRATIVE

EVENT DESCRIPTION

On February 10, 2012, during an inspection of flood preparations by the NRC in response to NRC findings, it was concluded that Abnormal Operating Procedure (AOP) 01 Revision. 28, Acts of Nature, Section I, Flooding, did not adequately protect equipment required to maintain safe shutdown from external flooding to an elevation of 1014 feet Mean Sea Level (MSL). This condition could have prevented the raw water pumps from being available to provide cooling to the component cooling water system. This condition was entered into the station's corrective action program as Condition Report 2012-01021.

On February 10, 2012, at 1754 CST, an 8-hour report was made under 10 CFR 50.72 (b)(3)(ii)(B) to the NRC Headquarters Operation Office (HOO) (Event Number (EN) 47658). The initial written report made on April 10, 2012, was made in accordance with 10 CFR 50.73(a)(2)(v)(B), any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to remove residual heat and (D), any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident.

Since the initial reporting of this condition, Omaha Public Power District (OPPD) has made the following reports related to this Licensee Event Report (LER):

- On June 7, 2011, OPPD responded to Notice of Violation (NOV) EA-10-084, Failure to Maintain External Flood Procedures.
- On April 24, 2013 OPPD responded to NOV EA-13-043, Continued Failure to Classify Intake Structure Sluice Gates as Safety Class 3.

CONCLUSION

The causal analysis performed as a result of the condition identified in this LER determined that station senior management, at the time the condition was identified, did not effectively lead recovery efforts to address the NRC component design basis inspection (CDBI) and FCS self-identified flooding issues in AOP-01. This resulted in important flooding related corrective actions not being effectively planned, prioritized or resourced to ensure a success path for AOP-01 within the established timeline.

CORRECTIVE ACTIONS

The corrective actions identified in the responses made on June 7, 2011 and April 24, 2013, in conjunction with these additional actions will reduce the probability of similar events occurring in the future.

1. External senior manager advisors/mentors were contracted to provide guidance and to improve performance in the area of planning, prioritizing, and resource loading station recovery efforts to improve management leadership effectiveness.
2. SO-G-74, Fort Calhoun Station EOP/AOP Generation Program, was revised to require a multi-disciplinary team review for validating AOPs. The change identifies a specific team member composition for each AOP (CR 2012-01021-024, completed 9/20/12).

NARRATIVE

3. SO-G-30, Procedure Changes and Generation, was revised to require a multi-disciplinary team review for validating flood related procedures (CR 2012-01021-023, completed 7/31/12).

SAFETY SIGNIFICANCE

The Fort Calhoun Station is required to be protected from flooding within the station's licensing basis. The safety related equipment required to mitigate the consequences of an accident were affected by these findings. The flood barrier openings could have jeopardized the ability of the safety related equipment to perform their design basis function during an accident. Although other methods of removing decay heat and mitigating the consequences of a flooding event were available, this external flooding concern has substantial importance to safety as indicated by the Yellow Finding issued for this event.

SAFETY SYSTEM FUNCTIONAL FAILURE

This event does result in a safety system functional failure in accordance with NEI-99-02.

PREVIOUS EVENTS

Sixteen LERs with event dates since May 1, 2010, were identified with the same reporting criteria. One LER was cancelled and one is the initial submittal of this condition. Of the remaining 14 LERs, 6 causal analysis were still in progress, but are not expected to determine similar underlying concerns; 6 are not related. Two LERs identified insufficient or ineffective oversight by station leadership as part of the cause of the condition/event and are discussed below.

LER 2011-003, Inadequate Flood Protection Due to Ineffective Oversight

Identified in February of 2011, a summary of the root causes included: a weak procedure revision process; insufficient oversight of work activities associated with external flood matters; ineffective identification, evaluation and resolution of performance deficiencies related to external flooding; and "safe as is" mindsets relative to external flooding events. As a result, the corrective actions for previously identified conditions did not resolve issues with AOP-0 1.

LER 2011-006, Inoperability of Both Trains of Containment Coolers Due to a Mispositioned Valve

Identified in March of 2011, a summary of the root causes included: the station's leadership oversight effort has not been effective in the areas of use of the station's Corrective Action Program, human performance tools and safe work practices in reducing the potential for mispositioning events.

The weaknesses identified in AOP-01 were already built into the procedure when these previous LERs were being reviewed and corrective actions developed. In either of these cases, the corrective actions could not have prevented the latent issues discovered in AOP-01.