



Omaha Public Power District

444 South 16th Street Mall
Omaha, NE 68102-2247

LIC-12-0122
August 30, 2012

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

Reference: Docket No. 50-285

Subject: Licensee Event Report 2012-015, Revision 0, for the Fort Calhoun Station

Please find attached Licensee Event Report 2012-015, Revision 0, dated August 30, 2012. This report is being submitted pursuant to 10 CFR 50.73(a)(2)(v)(D).

No commitments are being made in this letter.

If you should have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "D. J. Bannister".

D. J. Bannister
Vice President and CNO

DJB/rjr/epm

Attachment

c: E. E. Collins, Jr., NRC Regional Administrator, Region IV
L. E. Wilkins, NRC Project Manager
J. C. Kirkland, NRC Senior Resident Inspector
INPO Records Center

LICENSEE EVENT REPORT (LER)

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

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 205 55-0001, 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.

1. FACILITY NAME Fort Calhoun Station	2. DOCKET NUMBER 05000285	3. PAGE 1 OF 3
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4. TITLE
Electrical Equipment Impacted by High Energy Line Break Outside of Containment

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
09	16	2011	2012	015	0	08	30	2012		05000
									FACILITY NAME	DOCKET NUMBER
										05000

9. OPERATING MODE 5	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: <i>(Check all that apply)</i>									
10. POWER LEVEL 0	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)						
<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)							
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER							
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A							

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME Erick Matzke	TELEPHONE NUMBER <i>(Include Area Code)</i> 402-533-6855
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED <input checked="" type="checkbox"/> YES <i>(If yes, complete 15. EXPECTED SUBMISSION DATE)</i> <input type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
		12	18	2012

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

While reviewing a draft of the Master List Reconstitution for Electrical Equipment Qualification (EA-FC-08-011), Fort Calhoun Station (FCS) Engineering Department identified that some of the listed components may not be qualified for the environments where they are located. This was discovered during a comprehensive re-evaluation of potential high energy line breaks and radiological impacts outside containment initiated in response to issues identified by the station staff. This condition was identified on September 16, 2011, while the unit was shutdown.

A cause analysis is in progress. The results of the analysis will be published in a supplement to this LER.

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NARRATIVE

BACKGROUND

Fort Calhoun Station (FCS) is a two-loop reactor coolant system of Combustion Engineering (CE) design.

EVENT DESCRIPTION

FCS has been conducting a comprehensive re-evaluation of potential high energy line breaks and radiological impacts outside containment. On September 16, 2011, while reviewing a draft of the Master List Reconstitution for Electrical Equipment Qualification, FCS Engineering Department personnel identified that some of the listed components may not be qualified for the environments where they are located.

Of the 29 items listed, seven were identified that may exhibit spurious operation when exposed to a post-accident harsh environment. Those items are:

- PCS-2937, Low Pressure Safety Injection (LPSI) Pump Suction Valve SI-1B Pressure Control Switch
- PCS-2947, LPSI Pump Suction Valve SI-1A Pressure Control Switch

Failure of these pressure switches in a post-accident harsh environment may result in spurious operation of the low pressure safety injection (LPSI) suction valves. A spurious closure of these valves will result in a loss of LPSI pump suction from the Safety Injection Refueling Water tank (SIRWT) and a spurious opening with the SIRWT below the minimum level may result in air intrusion into the pump.

- VA-40A-M, Contaminated Area Exhaust Unit Fan A Motor
- VA-40B-M, Contaminated Area Exhaust Unit Fan B Motor
- VA-40C-M, Contaminated Area Exhaust Unit Fan C Motor

These fans are required to provide cooling to the safety injection (SI) pump rooms in a post-accident scenario. All trains of SI will become inoperable due to room heat-up after a loss of these fans.

- HCZ-1105, Feedwater Bypass Valve Positioner
- HCZ-1106, Feedwater Bypass Valve Positioner

The failure of the positioners will not affect the ability of the feedwater bypass valves HCV-1105 and HCV-1106 to open and provide auxiliary feedwater as this function can be accomplished by operation of the hand controller. However, the hand controller does not have the ability to close the valves. Therefore, the safety function of the valves closing on a Steam Generator Isolation Signal will be lost.

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NARRATIVE

This condition is being submitted pursuant to 10 CFR 50.73(a)(2)(v)(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,

The condition described in this LER was identified in September 2011, but not promptly investigated as a reportable condition. The station paradigm inappropriately concluded that reportability could be evaluated at a later date since current operating conditions were not challenged, and that the 60-day reporting window commenced when the event was determined to be reportable. FCS has been systematically addressing issues that have been identified since June 2011, in response to the flooding conditions, switchgear fire, and increased oversight. This LER is being submitted beyond the 60-day regulatory reporting requirement due to non-conservative decisions with respect to procedural and regulatory reportability requirements and resource constraints caused by the operating challenges which began in June 2011.

CONCLUSION

A cause analysis is in progress. The results of the analysis will be published in a supplement to this LER.

CORRECTIVE ACTIONS

A cause analysis is in progress. The corrective actions will be published in a supplement to this LER.

SAFETY SIGNIFICANCE

A cause analysis is in progress. The results of the analysis will be published in a supplement to this LER.

SAFETY SYSTEM FUNCTIONAL FAILURE

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

PREVIOUS EVENTS

A cause analysis is in progress. Previous Events will be determined from the results of the cause analysis.