

# LICENSEE EVENT REPORT

CONTROL BLOCK: \_\_\_\_\_ (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	N	E	F	C	S	1	2	0	0	0	0	0	0	0	0	0	0	0	3	4	1	1	1	1	4	5	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	
LICENSEE CODE														LICENSE NUMBER						LICENSE TYPE					57 CAT 58			

0	1	L	6	0	5	0	0	0	2	8	5	7	0	3	2	1	7	9	8	0	3	2	2	7	9	9
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
CON'T		REPORT SOURCE		DOCKET NUMBER									EVENT DATE					REPORT DATE								

### EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | During normal power operation while performing ST-ESF-2, Loop Safety injection valve

0 3 | HCV-311 failed to open from lockout relay actuation. The remaining loop injection

0 4 | valves remained operable (Tech. Spec. 2.3) See Abnormal Occurrence 74A-8, 75-23 and

0 5 | 76-14.

0 6 | \_\_\_\_\_

0 7 | \_\_\_\_\_

0 8 | \_\_\_\_\_

0	9	S	F	11	E	12	B	13	C	K	T	B	R	K	14	E	15	Z	16																					
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26																					
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE						COMP SUBCODE		VALVE SUBCODE																										
17		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.		ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER												
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47
LER RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.		ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER												
17		7 9		0 0 8		0 3		L		0		X		Z		Z		Z		0 0 0 0		Y		N		A		G 0 8 0												

### CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The General Electric type CR105X auxiliary interlock switch was found to be binding.

1 1 | thus preventing the valve from electrically driving open. This switch was cleaned

1 2 | and lubricated and the valve cycled three times satisfactorily.

1 3 | \_\_\_\_\_

1 4 | \_\_\_\_\_

1	5	E	28	0	9	9	29	NA	30	B	31	Surveillance Test	32
7	8	9	10	11	12	13	14	15	16	17	18	19	20
FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION					
15		0 9 9		NA		B		Surveillance Test					
16		Z		Z		NA		NA					
17		0 0 0		Z		NA		NA					
18		0 0 0		NA		NA							
19		Z		NA		NA							
20		N		NA		NA							

NAME OF PREPARER J. L. Connolley

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NRC USE ONLY

LER 79-008  
Omaha Public Power District  
Fort Calhoun Station Unit No. 1  
Docket No. 05000285

Attachment No. 1

Safety Analysis

The Engineered Safeguards System is so designed that no single failure can jeopardize the safe shutdown of the plant if required. The safeguards system at Fort Calhoun Station is separated into two trains of systems either of which would provide adequate accident protection. The failure of a single high pressure loop valve does not degrade any of the safety analyses performed on Fort Calhoun Station No. 1.

During the time HCV-311 was inoperable, the remaining loop safety injection valves were considered operable and available to perform their design function.

Since the last failure of this type, (April 1976), the surveillance tests associated with the operational testing of all Safety Injection valves have been revised to electrically verify the operability of these valves. The failure to verify operability of HCV-311 was a result of operating HCV-311 to correct level in a safety injection tank during back shift hours. This problem will be resolved by verification of valve operability following each valve operation in accordance with the revised operating instruction.

It should be noted that during the 1978 Refueling Outage, the problems described in IE Bulletin 78-05 of this type of Aux. Interlock switch binding was resolved by removing and installing new plunger arms and overload relay insulation.



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Attachment No. 2

Failure Data

This is the fourth failure of an auxiliary interlock switch on a safety injection valve, due to binding.

A handwritten signature or set of initials, possibly "JAS", written in dark ink. The signature is somewhat stylized and appears to be a personal mark.