NAS form 386 (9-83) LICENSEE EVENT REPORT (LER)											APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/86							
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ABSTRACT (Limit to 1400 speces, i.e. approximately diffusen single space typewritten lines) (16)

Technical Specification 2.11(2) states the following:

YES III yes, complete EXPECTED SUBMISSION DATE

SUPPLEMENTAL REPORT EXPECTED (14)

The Auxiliary Building crane shall not be used to move material over irradiated fuel in the fuel storage pool. If the crane interlocks are inoperable or bypassed, the crane operation will be under the direct control of a supervisor.

NO

The hooks on the Auxiliary Building crane cannot travel over the Spent Fuel Pool unless the travel interlocks are bypassed by means of a key switch on the crane. Contrary to Technical Specification 2.11(2), the crane supervisor left the Spent Fuel Pool Area while the key was still in the interlock bypass switch in the bypassed position. When the Quality Control inspector at the job site discovered that the crane supervisor had left, he immediately called for another crane supervisor. Approximately twenty minutes elapsed between the departure of the first crane supervisor and the arrival of the second. At no time during this period was the crane operated inside the interlocked zone over the Spent Fuel Pool. The certification of the crane supervisor who failed to maintain proper administrative control of the key was withdrawn. The incident and its significance were discussed with the individual by plant supervision. The training and certition of crane supervisors was reviewed and was found to be adequate with regard to this incident.

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NRC Form 386A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104 EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)					PAGE (3)		
Fort Calhoun Station, Unit No. 1		YEAR	F	SEQUENTIAL	REVISION NUMBER	N R	T			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Technical Specification 2.11(2) states the following:

The Auxiliary Building crane shall not be used to move material over irradiated fuel in the fuel storage pool. If the crane interlocks are inoperable or bypassed, the crane operation will be under the direct control of a supervisor.

Operating Instruction OI-HE-2 on normal operation of the Auxiliary Building crane lists the following precaution:

If the crane interlocks are inoperable during crane use, or if they are defeated by means of the bypass key, the crane must be under the administrative control of a certified/qualified Crane Supervisor.

Certification of Crane Supervisors includes training on Technical Specification 2.11 and Operating Instruction OI-HE-2.

The hooks on the Auxiliary Building crane cannot travel over the Spent Fuel Pool unless the travel interlocks are bypassed by means of a key switch on the crane. Contrary to Technical Specification 2.11(2) and Operating Instruction OI-HE-2, the crane supervisor left the Spent Fuel Pool Area while the key was still in the interlock bypass switch in the bypassed position. Before leaving the area, the Crane Supervisor had verified that the crane was out of the interlocked zone over the pool. When the Quality Control inspector at the job site discovered that the Crane Supervisor had left, he immediately called for another crane supervisor. Approximately twenty minutes elapsed between the departure of the first crane supervisor and the arrival of the second. The Quality Control inspector knew the provisions of Technical Specification 2.11(2) and Operating Instruction OI-HE-2 and understood the basis for the administrative requirement on the interlock bypass key. The crane operator was also aware of the basis for the administrative requirement. However, neither the Quality Control inspector nor the crane operator were certified Crane Supervisors. At no time during the absence of a Crane Supervisor was the crane operated in the interlocked zone over the Spent Fuel Pool. This incident occurred on January 22, 1984 at approximately 1330 hours. The personnel error was a cognitive error and was contrary to approved procedures.

The certification of the Crane Supervisor who failed to maintain proper administrative control of the key was withdrawn. The individual is an engineer employed by the Omaha Public Power District. The incident and its significance was discussed with the individual by plant supervision.

The training and certification of crane supervisors was reviewed and was found to be adequate with regard to this incident.

The Fort Calhoun Station was operating at 100% power at the time of the incident.

Omaha Public Power District

1623 Harney Ornaha, Nebraska 68102 402/536-4000

> February 22, 1984 FC-037-84 LIC-84-041

U. S. Nuclear Regulatory Commission Document Control Desk Washington, D.C. 20555

Reference: Docket No. 50-285

Gentlemen:

Licensee Event Report for the Fort Calhoun Station

Please find attached Licensee Event Report 84-001 dated February 20, 1984. This report is being submitted per requirements of 10 CFR 50.73.

Sincerely,

W. C. Jones

Division Manager Production Operations

WCJ/JCB:jmm

Attachment

cc: Mr. Richard P. Denise, Director
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& Engineering Programs
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INPO Records Center Mr. E. G. Tourigny, Project Manager

SARC Chairman
PRC Chairman
Mr. L. A. Yandell, Senior Resident
Inspector
Fort Calhoun File (2)

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