NRC Form 366
(9-83)

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

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Fort Calhoun Station, Unit No. 1	0 5 0 0 0 2 8 5	1 OF 0 3

TITLE (4)
VIAS Actuation

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 5	2 2	8 4	8 4	0 0 6	0 0	0 6	2 1	8 4	N	0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
5	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 0 1 0 0	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Lawrence T. Kusek, Supervisor-Operations Fort Calhoun Station	AREA CODE 4 0 2 — 4 2 6 - 4 0 1 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)				
X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

An unplanned actuation of the Ventilation Isolation Actuation System (VIAS) occurred at 0931 on May 22, 1984, during routine weekly replacement of an iodine-collector cartridge on RM-060, the ventilation discharge duct iodine monitor. The VIAS actuation [an Engineered Safety Feature (ESF)] was apparently spurious, since no equipment malfunctions, operator errors or procedure violations were noted. The alarm cleared and VIAS lockout reset once the filter was replaced and RM-060 was returned to service.

The iodine-collector cartridge showed no iodine accumulation and no further alarms occurred.

To prevent future spurious VIAS actuations of this nature, a procedure change requiring RM-060 to be taken out of service during filter replacement will be investigated.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

The ventilation discharge duct gaseous iodine monitor, RM-060, alarmed spuriously on May 22, 1984 at 0931 during routine weekly replacement of the RM-060 collection filter. The alarm initiated a VIAS trip, considered part of the engineered safety feature (ESF) system.

VIAS, as described in the USAR, is designed to mitigate a release of significant radioiodine or radiogas from the containment to atmosphere from such sources as reactor coolant leaks. VIAS is initiated by a safety injection actuation signal (SIAS) or a containment spray actuation signal (CSAS) or a containment radiation high signal (CRHS). The CRHS feature employs five radiation monitors taking samples from the containment and/or ventilation stack. These monitors supply a 1-out-of-5 logic network to trip the VIAS lockout relays.

The five ventilation radiation monitors that actuate VIAS are also used for an isolation function similar to that performed by other process radiation monitor systems. The ventilation monitors are used as process monitors in order to satisfy the Technical Specification 2.9 objective of controlling the release of radioactive effluents to the environs to as low as practicable.

The VIAS performs the following functions:

1. Closes the containment purge valves.
2. Closes the containment relief valves.
3. Stops the containment purge fans.
4. Closes the containment air sampling valves.
5. Opens the inlet and outlet vents to the safety injection pump rooms and the spent regenerant tank room.
6. Starts both control room air conditioning units and places this system in a 100% recirculation mode.
7. Closes the waste gas header release valve to the stack.

Laboratory counting of the filter being removed at the time of the VIAS actuation showed concentrations of less than the minimum detectable activities for all gaseous radioisotopes tested.

The actuation of the VIAS signal in this case was not initiated to mitigate an event, as described in the USAR. The actuation occurred while the plant was in a shutdown refueling condition and during the replacement of the filter as per Chemistry Manual Procedure, CMP-4.38. The alarm cleared and VIAS was reset with no further actuations following completion of the filter replacement and returning the monitor to service. All plant systems involved in this incident operated within their design basis with no equipment damage or failure.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

To prevent future spurious VIAS actuations of this nature, a procedure change requiring RM-060 to be taken out of service during filter replacement will be investigated.

Other VIAS actuations that have occurred since the new LER rule went into effect on January 1, 1984 were reported in LER 84-005 and LER 84-007.

Omaha Public Power District
1623 Harney Omaha, Nebraska 68102
402/536-4000

June 21, 1984
FC-335-84
LIC-84-164

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 84-006 dated June 21, 1984. This report is being submitted per requirements of 10 CFR 50.73.

Sincerely,

W. C. Jones
Division Manager
Production Operations

WCJ/JJF:jmm

Attachment

cc: Mr. Richard P. Denise, Director
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Fort Calhoun File (2)

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