NRC Form 366 (9-83)		LIC	ENSEE EVE	NT RE	PORT	(LER)	U.S. NUR AI E)	CLEAR REGULAT PROVED OMB NO PIRES: 8/31/85	ORY COMMISSION 0. 3150-0104
						In	OCKET NUMBER	(2)	PAGE (3)
Facility NAME (1) Fort Calhoun Station, Unit No. 1						0 15 10 10 10 12 18 15 1 OF 0 13			
TITLE (4)	eron, on							- CIEIE	
VIAS Actuation									
EVENT DATE (5) LER NUMBER (6) REPORT DATE (7) OTHER						OTHER P	ACILITIES INVOLVED (8)		D/el
MONTH DAY YEAR YEAR	NUMBER	REVISION NUMBER	MONTH DAY	YEAR		PACILITY NAM	5	0 15 10 10	
				1 1		DI		0 13 10 10	1*11
0 9 0 2 8 4 8 4	019	-00		8 4	CFR 8: 10	hack one or more o	f the following) (11	0 15 10 10	10111
MODE (9) 1 20.4	402(b)		20.408(c)		X	50.73(a)(2)(iv)		73.71(b)	
POWER 20.4	408(a)(1)(i)		50.38(c)(1)			50.73(a)(2)(v)		73.71(c)	
LEVEL 1010 20.405(a)(1)(II)		50.36(c)(2)			50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form		
20.	20.406(a)(1)(iii) 50.73(a)(2)(i) 50.73(a)(2)(vii			80.73(s)(2)(viii)(A	4) 366A/				
20	406(a)(1)(lv)		50.73(a)(2)(H)			50.73(a)(2)(viii)(8			
20.			ICENSEE CONTAC	T FOR THIS	LER (12)	addr and tarrar			
NAME								TELEPHONE NUN	IBER
Lawrence T. Ku	isek, Supe	rvisor-	Operation	IS		•	AREA CODE		
Fort Calhoun S	itation, l	Init No.	1				4 10 12	4 12 16 1-	4 10 11 11
	COMPLETE	ONE LINE FOR	EACH COMPONEN	T FAILURE	DESCRIBE	D IN THIS REPOR	T (13)	1 1	
CAUSE SYSTEM COMPONENT	MANUFAC. TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS	
					1	1.1.1	111		
	1.1.1	1.1.1.1				111	1111		
	SUPPLEM	ENTAL REPORT	EXPECTED (14)					MONT	H DAY YEAR
							SUBMISSI	ON SI	
MAS (If yes, complete EXPECTED	SUBMISSION DAT	E)	X NO						
progress, an unp occurred at 044 Safety Feature The actuation was was changing the setpoints during "Reset" pushbut panel face and same level as RI setpoint to the VIAS.	planned and 2 on Sept (ESF)] war as caused a confi ton light the selec M-062. W high set	ctuation ember 2, s not in by open tion dis rmed tem for RM- tor swith hen the point, F	n of the , 1984. nitiated rator err scharge d nperature -052 inst tches for low/high RM-051 mod	Ventil The ac to mit or. T uct mo inver ead of high setpo mentar	ation tuati igate he ac nitor sion. RM-Ou and 1 int s ily w	Isolation on of the an event tuation of , RM-061, The ope 61. Both ow setpoi witch was ent into	n Actuati VIAS sig as descr ccurred v to the h rator dep monitors nts for f re-posit high alan	ion System mal [an mibed in while the high Aler pressed t s have th RM-061 ar tioned fr m and in	m (VIAS) Engineered the USAR. operator t/Alarm he green e same e on the om the low itiated
As soon as the reset, and the of Features involve occurred and no To prevent future will be reviewed bility of placi- the panel. This given the lead making any appr- given to the Op	VIAS actu containme ed in thi radioact re unplan d and cha ng RM-061 s inciden in prepar opriate c erations	ation of nt press s incide ive rele ned VIAS nged if 's high, t has be ing this hanges. Departme	ccurred, sure redu ent funct ease occu S actuati necessar /low setp een discu s report, If any ent.	the mo ction ioned rred. ons of y. Th oint s ssed w revie change	nitor was r as de this e pla elect ith t wing es are	s were re estarted. signed. nature, nt will a or switch he involv the appli made, ap	turned to All Eng No equips applicab lso inves directl ed indiv cable pla propriate	o normal, gineered ment malf le plant stigate t y on the idual and ant proce e trainin	VIAS was Safeguards unctions procedures he feasi- face of he was edures, and ag will be
NRC Form 366 PDR (9-83) S	ADOCK 0	841002 500028 PD	IS R					24	TEZZ V,

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	1	LER NUMBER (6)	PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION	
Fort Calhoun Station, Unit No. 1	0 5 0 0 2 8 5	8 4 -	-0119	-010	0 2 OF 0 3
TEXT /// more space is required, use additional NRC Form 366A's) (17)					

During normal plant operation at 100% power with a containment pressure reduction in progress, an unplanned actuation of the Ventilation Isolation Actuation System (VIAS) occurred at 0442 on September 2, 1984. The actuation of the VIAS signal [an Engineered Safety Feature (ESF)] was caused by operator error. The actuation occurred while the operator was changing the ventilation discharge duct monitor, RM-061, to the high Alert/Alarm setpoints during a confirmed temperature inversion. The operator depressed the green "Reset" pushbutton light for RM-062 instead of RM-061. Both monitors have the same panel face and the selector switches for high and low setpoints for RM-061 are on the same horizontal plane as RM-062. When the low/high setpoint switch was re-positioned from the low setpoint to the high setpoint, RM-061 momentarily went into high alarm and initiated VIAS. If the green "Reset" pushbutton for RM-061 had been depressed instead of the one for RM-062, the VIAS actuation would not have occurred.

Temperature inversions are a fairly common occurrence at the Fort Calhoun Station. They are evidenced by a positive AT indication from the weather tower temperature instruments, generally elevated readings on plant area and process monitors, and abnormally high concentrations of short-lived Radon daughters in and around the plant buildings. Once an inversion has been confirmed by lab analysis of grab air samples, the Alert/

Alarm setpoints for RM-061 are switched from the low range to the high range to keep RM-061 out of alarm. When this high/low setpoint switch is re-positioned, the meter on RM-061 spikes high, usually above the alarm setpoint. To prevent RM-061 from going into alarm and initiating VIAS during this evolution, it is normal practice to depress the green "Reset" pushbutton on the face of the monitor in the control room to momentarily bypass the trip function when the high/low setpoints are switched. The operator performing this evolution on September 2 depressed the "Reset" pushbutton on RM-062 instead of RM-061; thus, when he re-positioned the high/low setpoint and RM-061 spiked high, its trip function was not bypassed, the monitor tripped, and VIAS was initiated. The error was precipitated by the fact that RM-061 and RM-062 have nearly identical panel faces. In addition, the high/low selector switch for RM-061 is located on the same horizontal plane as the RM-062 panel face.

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 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 pressure relief valves.
- 3. Stops the containment purge fans.
- Closes the containment air sampling valves.

NRC Form 366A

## 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)	
		YEAR SEQUENTIAL REVISION NUMBER NUMBER		
Fort Calhoun Station, Unit No. 1	0 15 10 10 10 12 18 15	8 4 -0 11 9 -0 0	0 3 0 0 3	

- Opens the inlet and outlet vents to the safety injection pump rooms and the spent regenerant tank room.
- Starts both control room air conditioning units and places this system in a filtered air makeup mode.
- Closes the waste gas header release valve to the stack.

The actuation of the VIAS signal in this case was not initiated to mitigate an event as described in the USAR. The incident was caused by operator error. As soon as the VIAS actuation occurred, the monitors were returned to normal, VIAS was reset, and the containment pressure reduction was restarted. All Engineered Safety Features involved in this incident functioned as designed. No equipment malfunctions occurred and no radioactive release occurred.

To prevent future unplanned VIAS actuations of this nature, applicable plant procedures will be reviewed and changed if necessary. The plant will also investigate the feasibility of placing RM-061's high/low setpoint selector switch directly on the face of the panel. The incident has been discussed with the involved individual and he was given the lead in preparing this report, reviewing the applicable plant procedures, and making any appropriate changes. If any changes are made, appropriate training will be given to the Operations Department.

Other VIAS actuations that have occurred since the new LER rule went into effect on January 1, 1984, were reported in LER 84-005, LER 84-007, LER 84-006, LER 84-014, LER 84-017 and LER 84-018.

NRC Form 366A

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

October 2, 1984 FC-754-84 LIC-84-324

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 84-019 dated October 2, 1984. This report is being submitted per requirements of 10 CFR 50.73.

Sincerely,

110 R. L. Andrews

Division Manager Nuclear Production

RLA/DJM/rh-W

Attachment

cc: Mr. Dorwin R. Hunter, Chief Reactor Project Branch 2 U.S. Nuclear Regulatory Commission Region IV 611 Ryan Plaza Drive, Suite 1000 Arlington, Texas 76011

> INPO Records Center Mr. E. G. Tourigny, Project Manager

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