

Omaha Public Power District
444 South 16th Street Mall
Omaha, Nebraska 68102-2247
402/636-2000

January 27, 1995
LIC-95-0013

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-137
Washington, DC 20555

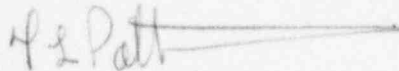
Reference: Docket No. 50-285

Gentlemen:

Subject: Licensee Event Report 94-011 for the Fort Calhoun Station

Please find attached Licensee Event Report 94-011 dated January 27, 1995. This report is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B). If you should have any questions, please contact me.

Sincerely,



T. L. Patterson
Division Manager
Nuclear Operations

TLP/jrg

Attachment

c: LeBoeuf, Lamb, Greene & MacRae
L. J. Callan, NRC Regional Administrator, Region IV
S. D. Bloom, NRC Project Manager
R. P. Mullikin, NRC Senior Resident Inspector
INPO Records Center

9502010308 950127
PDR ADOCK 05000285
S PDR

010055

IK22
11

LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Fort Calhoun Station Unit No. 1

DOCKET NUMBER (2)

05000285

PAGE (3)

1 OF 4

TITLE (4)

Failure to Satisfy Surveillance Requirement for Steam Generator Level Check

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER	
12	28	94	94	-- 011 --	00	01	27	95	FACILITY NAME	DOCKET NUMBER	
										05000	
OPERATING MODE (9)		1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more) (11)								
POWER LEVEL (10)		100	20.402(b)			20.405(c)			50.73(a)(2)(iv)		73.71(b)
			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
			20.405(a)(1)(iii)		X	50.73(a)(2)(i)			50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)
			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

Scott A. Lindquist, Shift Technical Advisor

TELEPHONE NUMBER (Include Area Code)

(402) 533-6829

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)

YES

(If yes, complete EXPECTED SUBMISSION DATE)

X

NO

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On December 28, 1994 at approximately 0800, a Control Room Operator failed to record steam generator level readings on the data sheet for Surveillance Test OP-ST-SHIFT-0001, "Operations Technical Specification Required Shift Surveillance". This resulted in a violation of Technical Specification 3.1, Table 3-1, Item 6.a, which requires that steam generator level instrumentation be checked on a frequency of once per shift, and that a comparison of indications from redundant channels be made.

The root cause of this event was determined to be inadequate review. Following an interruption in the performance of the surveillance, the operator failed to ensure that the surveillance was resumed where it had been interrupted.

Corrective actions will include training operations department personnel on this event, stressing the importance of attention to detail during the performance of routine activities.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Fort Calhoun Station Unit No. 1	05000285	94	-- 011 --	00	2 OF 4

TEXT (if more space is required, use additional copies of NRC Form 366A) (17)

BACKGROUND

The Fort Calhoun Station (FCS) Reactor Coolant System (RCS) includes two steam generators, RC-2A and RC-2B respectively. Each Steam Generator (SG) is provided with four independent narrow-range SG level instrumentation channels. The level indicators for these channels are designated as A/LI-901, B/LI-901, C/LI-901 and D/LI-901 for SG RC-2A, and A/LI-904, B/LI-904, C/LI-904 and D/LI-904 for SG RC-2B. These instrumentation channels provide inputs to the Reactor Protective System (RPS) for the Low Steam Generator Water Level reactor trip.

Technical Specification (TS) 3.1, Table 3-1, "Minimum Frequencies for Checks, Calibrations and Testing of Reactor Protective System," Item 6.a, requires that, once per shift, a check/comparison be done of the four SG level indications for each SG. This SG level check is addressed in Surveillance Test OP-ST-SHIFT-0001, "Operations Technical Specification Required Shift Surveillance," which is performed each shift. The check consists of comparing independent channels measuring the same variable to ensure the difference is within the specified acceptance criteria. The required data is recorded on page 32 of OP-ST-SHIFT-0001, Revision 41. A single copy of this page accommodates data for an entire week, recorded on 21 data lines (i.e., one line of data for each of the three shifts for each of the seven days of the week).

EVENT DESCRIPTION

On December 28, 1994 at approximately 0800, with FCS at approximately 100% power, a Control Room Operator failed to record the SG level data required for page 32 of OP-ST-SHIFT-0001, Revision 41. This resulted in a failure to satisfy TS 3.1, Table 3-1, Item 6.a, which requires that steam generator level instrumentation be checked on a frequency of once per shift, and that a comparison of readings from redundant channels be made.

Prior to reaching the page of OP-ST-SHIFT-0001 requiring the SG level instrumentation check, the Control Room Operator performed a Primary and Secondary Control Element Assembly Position Indication System (CEAPIS) check which is also required by OP-ST-SHIFT-0001. During the CEAPIS check the Operator noted a minor discrepancy in the secondary position indication of Control Element Assembly (CEA) 18. The operator brought this discrepancy to the attention of the Licensed Senior Operator and the Reactor Engineer. Following discussion of this discrepancy, the Operator resumed performance of OP-ST-SHIFT-0001, but inadvertently skipped the page associated with the SG level instrumentation check.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Fort Calhoun Station Unit No. 1	05000285	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 4
		94	-- 011 --	00	

TEXT (if more space is required, use additional copies of NRC Form 366A) (17)

Both the Shift Supervisor and the Shift Technical Advisor are responsible for reviewing the results of surveillance tests performed during their shift. In this case, both reviewed the results of the performance of OP-ST-SHIFT-0001, but failed to note that the SG level data for the current shift was missing. Subsequently, each of the following two shifts performed the required checks of SG level indicators, but recorded the SG level readings on the wrong data line of the OP-ST-SHIFT-0001 data sheet (i.e., the afternoon shift data was entered on the line for day shift data, and the night shift data was entered on the line for afternoon shift data). This was not detected by reviews performed during these shifts. On the day shift of December 29, 1994, the SG level readings were also recorded on the wrong data line, however, the Shift Supervisor noted this during his review. Further investigation determined that data had not been recorded for the previous day shift.

This event was determined to be reportable pursuant to 10 CFR 50.73(a)(2)(i)(B).

SAFETY ASSESSMENT

The failure to perform and record a steam generator level instrumentation check for one shift had minimal direct safety consequences. The instrument channel check is a qualitative determination of acceptable operability by observation of channel behavior during normal plant operation. The required surveillance was performed on previous and subsequent shifts with no problems noted related to channel operability. Also, although the December 28, 1994 day shift SG level data was not formally checked and recorded via OP-ST-SHIFT-0001, operators were monitoring SG levels during the shift in conjunction with a calibration that was being performed on RPS SG level channels.

CONCLUSIONS

A root cause analysis was performed for this event which evaluated the failure to perform and record the steam generator level instrumentation channel check and the failure of the review process to identify the missed readings until the following day.

The root cause of the failure to perform and record the steam generator level instrumentation check was determined to be a lack of adequate review. Following the discussions concerning CEA 18 secondary CEAPIS indication, the operator failed to ensure that the surveillance was resumed where it had been interrupted.

LICENSEE EVENT REPORT (LER) TEX CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Fort Calhoun Station Unit No. 1	05000285	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	4 OF 4
		94	-- 011 --	00	

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

The root cause of the failure of the review process to identify the missing readings was also determined to be inadequate review. The reviewers failed to ensure that the readings they were reviewing were taken on their shift. The format of OP-ST-SHIFT-0001 was identified as a contributing cause to this failure. A more apparent delineation between days and shifts in the data entry area may have assisted the reviewers in identifying the missing readings.

An event similar to this occurred in May 1989. Licensee Event Report (LER) 89-013 documents the failure to perform and record a toxic gas monitor check required by TS 3.1, and the failure of the review process to identify the missing readings over subsequent shifts. However, based on the time span between these events and the number of times these and other similar checks have been successfully performed over this time span, the current event is considered to be an isolated incident.

CORRECTIVE ACTIONS

The following corrective actions have been or will be completed:

1. The operator and reviewers involved in this event have been counselled regarding the event, and operating crews have been briefed on the event.
2. Operations department personnel will be trained on this event, stressing the importance of attention to detail during the performance of routine activities. This training will be completed by May 1, 1995.
3. The format of OP-ST-SHIFT-0001 will be revised by February 28, 1995, to more clearly distinguish between days and shifts in the data entry area.

PREVIOUS SIMILAR EVENTS

The failure to perform and record a toxic gas monitor check required by TS 3.1 was reported in LER 89-013.