

**CONTROL BLOCK:**

|  |  |  |  |  |     |
|--|--|--|--|--|-----|
|  |  |  |  |  | (Y) |
|--|--|--|--|--|-----|

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

ALPHABET  
NUMERIC

6 15 10 10 10 12 18 15 7 10 13 10 17 18 13 8 01 3 2 2 8 3 9

60 61 DOCKET NUMBER 66 67 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

While the core was off-loaded for performance of the ten year ISI of the reactor vessel, safety related shock suppressor SIS-134 was removed to accommodate maintenance on ICEDM's. The snubber was not replaced within 72 hours after core reloading had begun, as required by Tech. Spec. 2.18. The probable consequences would have been the inability of the snubber to perform its desired function during a seismic event.

|              |      |                       |      |                 |      |                |   |                      |      |                 |      |                      |      |                        |      |      |      |   |   |   |      |
|--------------|------|-----------------------|------|-----------------|------|----------------|---|----------------------|------|-----------------|------|----------------------|------|------------------------|------|------|------|---|---|---|------|
| SYSTEM CODE  |      | CAUSE CODE            |      | CAUSE SUBCODE   |      | COMPONENT CODE |   |                      |      | COMP SUBCODE    |      | VALVE SUBCODE        |      |                        |      |      |      |   |   |   |      |
| S            | F    | (11)                  | D    | (12)            | Z    | (13)           | S | U                    | P    | O               | R    | T                    | (14) | D                      | (15) | Z    | (16) |   |   |   |      |
| EVENT YEAR   |      | SEQUENTIAL REPORT NO. |      | OCCURRENCE CODE |      | REPORT TYPE    |   | REVISION NO.         |      |                 |      |                      |      |                        |      |      |      |   |   |   |      |
| 8            | 3    | (17)                  | 0    | 0               | 2    | (18)           | 0 | 3                    | (19) | 0               | (20) |                      |      |                        |      |      |      |   |   |   |      |
| ACTION TAKEN |      | EFFECT ON PLANT       |      | SHUTDOWN METHOD |      | HOURS          |   | ATTACHMENT SUBMITTED |      | NPR-4 FORM SUB. |      | PRIME COMP. SUPPLIER |      | COMPONENT MANUFACTURER |      |      |      |   |   |   |      |
| A            | (19) | G                     | (20) | Z               | (21) | 0              | 0 | 0                    | 0    | (22)            | Y    | (23)                 | N    | (24)                   | A    | (25) | B    | 2 | 0 | 9 | (26) |

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

151S-134 was removed from its station while the core was off-loaded. Reloading of the  
core began at 1830 on 3-6-83 and was completed at 2030 on 3-7-83. The snubber was  
reinstalled at 2220 on 3-8-83.

FACILITY STATUS: [ ] [H] [M] [P]  
% POWER: [0] [0] [0] [29]  
OTHER STATUS: NA  
METHOD OF DISCOVERY: A  
DISCOVERY DESCRIPTION: Supervisory Observation

| ACTIVITY CONTENT    |    | AMOUNT OF ACTIVITY (38) |  | LOCATION OF RELEASE (39) |  |
|---------------------|----|-------------------------|--|--------------------------|--|
| RELEASED OF RELEASE |    |                         |  |                          |  |
| 1                   | 2  | NA                      |  | NA                       |  |
| 3                   | 4  |                         |  |                          |  |
| 5                   | 6  |                         |  |                          |  |
| 7                   | 8  |                         |  |                          |  |
| 9                   | 10 |                         |  |                          |  |
| 11                  | 12 |                         |  |                          |  |
| 13                  | 14 |                         |  |                          |  |

[illegible]

NA

1 2 3 4 5 6 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 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

8401050085 831025  
PDR FOIA  
CRABER82-504 PDR

GRABER 8.3-578 PDR

NA (4)

NRC (SE ONLY)

8401050085 831025  
PDR FOIA  
GRABER83-596 PDR

NAME OF PREPARER M. G. Burggraf *RG*

PHONE: (402) 426-4011

LER No. 83-002  
Omaha Public Power District  
Fort Calhoun Station Unit No. 1  
Docket No. 05000285

ATTACHMENT NO. 1

Safety Analysis

Snubbers are designed to prevent unrestrained pipe motion under dynamic loads as might occur during an earthquake or severe transient while allowing normal thermal motion during startup or shutdown. The consequences of an inoperable snubber is an increase in the probability of structural damage to piping as a result of a seismic, or other, event initiating dynamic loads.

Snubber SIS-134 is located upstream of the LPSI loop isolation valve HCV-327. It is on one of the four branch lines to the reactor cold legs off the LPSI/shutdown cooling header. Shutdown cooling was in service at the time of this incident. Had a seismic event occurred which resulted in a pipe rupture, a portion of the normal shutdown cooling flow to the reactor core would have been lost. Isolation of the break would have required securing all of normal shutdown cooling. However, the alternate shutdown cooling path through the HPSI loop valves could have been put into service had a pipe rupture occurred.

Since a seismic event of the magnitude required to cause a pipe rupture with this snubber out of service is highly unlikely and since the alternate shutdown cooling path could have been put into service, plant safety was not compromised. This problem is considered to be administrative in nature.

LER No. 83-002  
Omaha Public Power District  
Fort Calhoun Station Unit No. 1  
Docket No. 05000285

ATTACHMENT NO. 2

Cause and Corrective Action

SIS-134 was removed to facilitate maintenance on the CEDM's while the core was off-loaded. This removal was done under a maintenance order which identified the need to replace the snubber prior to core reload. Due to the lack of an administrative tracking mechanism, this requirement for snubber replacement was inadvertently overlooked. A contributing factor in this oversight was the unique operating situation presented by the core off-load.

Upon discovery, immediate corrective action taken was to reinstall the inoperable snubber.

In order to prevent recurrence of this incident, a procedure change has been initiated to amend Operating Procedure OP-11, "Reactor Core Refueling Procedure". This change entails an addition to the required initial conditions. The new step reads: "If the core has been off-loaded, verify that all safety-related system shock suppressors required operable in Mode 5 are operable as per Technical Specification 2.18 before reloading." This condition must be signed off by the Supervisor - Maintenance.



LER No. 83-002  
Omaha Public Power District  
Fort Calhoun Station Unit No. 1  
Bucket No. 05000285

ATTACHMENT NO. 3

Failure Data

This is the first instance at the Fort Calhoun Station in which a safety related system snubber was inoperable for more than 72 hours as a result of not being installed.

Other instances in which one or more safety related snubbers were found inoperable are documented in LER's 80-019, 79-020, 77-031, and 76-42.

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

April 6, 1983  
FC-194-83

000-637007

Mr. W. C. Seidle, Chief  
Reactor Project Branch 2  
U. S. Nuclear Regulatory Commission  
Region IV  
611 Ryan Plaza Drive, Suite 1000  
Arlington, TX 76011

RLW  
ADR

285-83002

830207

830413 KCC

Subject: Fort Calhoun Station Unit No. 1  
Docket No. 05000285

Dear Mr. Seidle:

In accordance with the Fort Calhoun Station's Technical Specifications, the Omaha Public Power District, as holder of facility operating license DPR-40, submits three copies of licensee event report 83-002, (regarding Technical Specification 2.1j) to satisfy requirements of Regulatory Guide 1.16.

Sincerely,

*W. C. Jones for*

William C. Jones  
Division Manager  
Production Operations

Enclosures

cc: Director, Office of Management  
Information and Program Control  
U. S. Nuclear Regulatory Commission  
Washington, DC 20555 (3)

Director, Office of Inspection and  
Enforcement  
U. S. Nuclear Regulatory Commission  
Washington, DC 20555 (30)

Institute of Nuclear Power Operations

Mr. B. L. Andrews  
Vice Chairman  
NRC Chairman  
Fort Calhoun File (2)  
Mr. Lawrence A. Yandell  
NRC Senior Resident Inspector

**LICENSEE EVENT REPORT**

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 T N S N P 1 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 1 4 5  
7 8 9 LICENSE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 31 CAT 32

CON'T

REPORT SOURCE: L 8 0 5 10 0 0 3 2 7 7 0 1 3 1 1 1 8 2 8 0 4 1 3 8 3 9

60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

DECK 2 NUMBER: 0 3 2 7 7 0 1 3 1 1 1 8 2 8 0 4 1 3 8 3 9

EVENT DATE: 0 3 1 1 1 8 2 8 0 4 1 3 8 3 9

REPORT DATE: 0 4 1 3 8 3 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

03 With unit 1 in mode 1 (100% Rx power) at 1200 CST on 03/31/83, all four 125 volt

03 DC vital battery channels were declared inoperable due to failure to perform the

0 4 weekly inspection surveillance within its required frequency. The unit complied

05 | with ICO 3.0.3. There was no effect upon public health and safety. Previous

0 6 occurrences - none.

0 2

0 8

| SYSTEM<br>CODE | CAUSE<br>CODE | CAUSE<br>SUBCODE | COMPONENT CODE | COMP.<br>SUBCODE | VALVE<br>SUBCODE |
|----------------|---------------|------------------|----------------|------------------|------------------|
|----------------|---------------|------------------|----------------|------------------|------------------|

0 9 E C 11 A 17 C 13 Z Z Z Z Z Z 14 Z 15 Z 16

| EVENT YEAR | SEQUENTIAL<br>REPORT NO | OCCURRENCE<br>CODE | REPORT<br>TYPE | REVISION<br>NO |
|------------|-------------------------|--------------------|----------------|----------------|
|------------|-------------------------|--------------------|----------------|----------------|

(17) REPORT NUMBER 83-0431-01 T-0

|        | 21     | 22     | 23       | 24 | 25 | 26 | 27  | 28         | 29    | 30       | 31       | 32 |
|--------|--------|--------|----------|----|----|----|-----|------------|-------|----------|----------|----|
| ACTION | FUTURE | EFFECT | SHUTDOWN |    |    |    | (C) | ATTACHMENT | MEDIA | EMBEDDED | COLORING |    |

[illegible]

33 34 35 36 37 38 39 40 41 42 43 44

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (2)

10 Investigation revealed that the late performance of SI-100.1 for weekly inspection

of all 125-V D.C. vital battery channels was caused by personnel error in that the

1 2 maintenance foreman responsible for the work had placed the surveillance instruct

(SI) package in his desk and forgot to take it out when it was due. Upon discovery

the performance of the test was completed successfully.

|                   |       |             |      |                        |                       |      |
|-------------------|-------|-------------|------|------------------------|-----------------------|------|
| FACTORY<br>STATUS | POWER | OTHER STATE | (30) | METHOD OF<br>DISCOVERY | DISCOVERY DESCRIPTION | (32) |
|-------------------|-------|-------------|------|------------------------|-----------------------|------|

|   |   |   |      |   |   |   |      |    |   |      |                             |
|---|---|---|------|---|---|---|------|----|---|------|-----------------------------|
| 1 | 5 | E | (18) | 1 | 0 | 0 | (29) | NA | B | (31) | Review of surveillance test |
|---|---|---|------|---|---|---|------|----|---|------|-----------------------------|

ACTIVITY CONTENT

| RELAYED OF RELEASE |  | AMOUNT OF ACTIVITY (35) |  | LOCATION OF RELEASE (36) |  |
|--------------------|--|-------------------------|--|--------------------------|--|
| NA                 |  | NA                      |  | NA                       |  |

7 8 9 10 11 44 45

| PERSONNEL EXPOSURES |      |             |
|---------------------|------|-------------|
| NUMBER              | TYPE | DESCRIPTION |
| 30                  |      |             |

000 17 Z 38 NA

|                    | 8 | 9 | 11 | 12 | 13 |
|--------------------|---|---|----|----|----|
| PERSONNEL INJURIES |   |   |    |    |    |

| NUMBER |      | DESCRIPTION | UNIT |
|--------|------|-------------|------|
| 8      | 0000 | 40          | NA   |

8 9 11 12

| LOSS OF OR DAMAGE TO FACILITY (43) |             |
|------------------------------------|-------------|
| TYPE                               | DESCRIPTION |
|                                    |             |

1 2 47 NA

PUBLICITY DESCRIPTION (45) NAC USE ONLY

|   |   |   |    |
|---|---|---|----|
| 7 | 0 | 4 | NA |
|---|---|---|----|

Name of Preparer: H. R. Rogers /M. R. Harding

Phone: (615) 870-6422

Sequoyah Nuclear Plant

LER SUPPLEMENTAL INFORMATION

SQRC-50-327/83043

Technical Specification Involved: 1.8.2.3

Reported Under Technical Specification: 6.9.1.12.b

Date of Occurrence: 03/31/83 Time of Occurrence: 1200 CST

Identification and Description of Occurrence:

During a review of surveillance instruction (SI) 100.1 on the weekly inspection of the 125-volt D.C. vital battery channels, it was discovered that the surveillance had not been performed within the LCO required time frequency. This rendered the vital batteries inoperable and the unit complied with LCO 3.0.3.

Conditions Prior to Occurrence:

Unit 1 in mode 1 at 100% Rx power; unit 2 in mode 1 at 75% Rx power.

Apparent Cause of Occurrence:

Investigation revealed that the late performance of the SI package was caused by personnel error in that the maintenance foreman responsible for this work had placed the SI package on his desk and forgot to take it out when it was due to be completed.

Analysis of Occurrence:

The test was required to be completed on 03/30/83. The maintenance foreman was given the surveillance package on 03/28/83 for working. The foreman was short of personnel on that day and placed the package in his desk for working the next day. Inadvertently, the foreman forgot about the package until 03/31/83.

Corrective Action:

Immediately upon discovery, the performance of the surveillance was initiated and successfully completed. The vital batteries were declared operable at 1330 CST on 03/31/83.

Maintenance personnel have been informed of the severity of this incident and instructed to ensure that SI packages are completed on time. Additionally, disciplinary action will be taken against the personnel involved.

Failure Data:

None.



TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37411

1750 Chestnut Street Tower II

LM  
4/19

April 13, 1981

000064/F04

|                |           |
|----------------|-----------|
| LER            |           |
| LER #          | 327-83043 |
| EVENT DATE     | 830331    |
| IMPO RCVD DATE | 830418    |
| NSAC RCVD DATE |           |

LMW  
JAH

Mr. James P. O'Reilly, Director  
U.S. Nuclear Regulatory Commission  
Suite 2900  
101 Marietta Street, NW  
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET  
NO. 50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE  
REPORT SORO-50-327/83043

The enclosed report provides details concerning the failure to perform  
a surveillance on the 125-volt batteries within the specified time frequency.  
This report is submitted in accordance with Sequoyah unit 1 Technical  
Specification 6.9.1.12.b.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

H. J. Green  
Director of Nuclear Power

Enclosure

cc (Enclosure):

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

Records Center  
Institute of Nuclear Power Operations  
Suite 1500  
1100 Circle 75 Parkway  
Atlanta, Georgia 30339

NRC Inspector, Sequoyah