NRC FORM 366

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

LICENSEE CODE		LICENSE NUMBER		LICENSE TYPE		CAT	
N E F C S 1	(2)	0 0 0 0 0 - 0 0 0 0 0	(3)	4 1 1 1 1	(4)		(5)

REPORT SOURCE		DOCKET NUMBER		EVENT DATE		REPORT DATE	
L	(6)	0 5 0 0 0 2 8 5	(7)	0 3 0 7 8 3	(8)	0 3 2 2 8 3	(9)

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 accomodate maintenance on CEDM'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)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	–	0 0 2	/	0 3	L	–	0

ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS	(22)	ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
A	(18)	G	(19)	Z	(20)	Z	(21)	0 0 0 0 0		Y	(23)	N	(24)	A	(25)	B 2 0 9	(26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

SIS-134 was removed from its station while the core was off-loaded. Reloading of the core began at 1830 on 3-4-83 and was completed at 2030 on 3-7-83. The snubber was reinstalled at 2230 on 3-8-83.

FACILITY STATUS		% POWER		OTHER STATUS	(30)	METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	(32)
H	(28)	0 0 0	(29)	NA		A	(31)	Supervisory Observation	

ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY	(35)	LOCATION OF RELEASE	(36)
Z	(33)	Z	(34)	NA		NA	

PERSONNEL EXPOSURES

NUMBER		TYPE		DESCRIPTION	(39)
0 0 0	(37)	Z	(38)	NA	

PERSONNEL INJURIES

NUMBER		DESCRIPTION	(41)
0 0 0	(40)	NA	

LOSS OF OR DAMAGE TO FACILITY (43)

TYPE		DESCRIPTION
Z	(42)	NA

PUBLICITY

ISSUED		DESCRIPTION	(45)
N	(44)	NA	

NRC USE ONLY

NAME OF PREPARER M. G. Burggraf

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
Docket No. 0500028S

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

285-83002
RLW 830307
ADR 830413 ltr

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

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 2.1a) to satisfy requirements of Regulatory Guide 1.16.

Sincerely,

R L Gamble 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. D. C. Andrews
NRC Chairman
NRC Chairman
FC Calhoun File (2)
Mr. Lawrence A. Yandell
NRC Senior Resident Inspector

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (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 (3) | 4 1 1 1 1 (4) | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 3 2 7 (7) | 0 3 3 1 8 3 (8) | 0 4 1 3 8 3 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 With unit 1 in mode 1 (100% Rx power) at 1200 CST on 03/31/83, all four 125 volt
0 3 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
0 5 with LCO 3.0.3. There was no effect upon public health and safety. Previous
0 6 occurrences - none.
0 7
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	E C (11)	A (12)	C (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 4 3	/	0 1	T	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	X (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Investigation revealed that the late performance of SI-100.1 for weekly inspection
1 1 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 instruction
1 3 (SI) package in his desk and forgot to take it out when it was due. Upon discovery,
1 4 the performance of the test was completed successfully.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	1 0 0 (29)	NA	B (31)	Review of surveillance test

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)
2 0	N (44)	NA

NRC USE ONLY

Name of Preparer: H. R. Rogers /M. R. Harding Phone: (615) 870-6422

Sequoyah Nuclear Plant

LER SUPPLEMENTAL INFORMATION

SQRO-50-327/83043 **Technical Specification Involved:** 3.8.2.3

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 37401

1750 Chestnut Street Tower II

2nr 4/19

April 13, 1983

0005 4/F04

LER

LER # 327-83043

EVENT DATE 830331

HPO RCVD DATE 830418

NSAC RCVD DATE _____

RMW JDH

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