

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 2 3 4 5 6

(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME

LICENSE NUMBER

LICENSE TYPE

EVENT TYPE

01 N E F C S 1 0 0 - 0 0 0 0 0 - 0 0 4 1 1 1 1 0 1

01 CONT T L 0 5 0 - 0 2 8 5 0 8 0 1 7 6 0 8 0 4 7 6

EVENT DESCRIPTION

02 From 1006 to 1143 hours on August 1, 1976, a waste liquid release was conducted with
03 the waste liquid process radiation monitor inoperable. The operator conducting the
04 release failed to return the monitor to an operable status after testing. This moni-
05 tor serves as a backup to monitor tank analysis to prevent release of liquids in
06 excess of 10CFR20 limits. (LER 50-285/76-24)

07 M A A I N S T R U A V 1 1 5 Y

CAUSE DESCRIPTION

08 The operator failed to return the monitor to the OPERATE position from the CALIBRATE
09 position after testing the control functions of the monitor prior to initiating the
10 release. Operator involved was orally reprimanded. (con't in Additional Factors)

11 E 0 9 7 NA B During daily surveillance test

12 L M 2.828E-03 curies total Circulating Water Discharge Tunnel

PERSONNEL EXPOSURES

13 0 0 0 Z NA

PERSONNEL INJURIES

14 0 0 0 NA

OFFSITE CONSEQUENCES

15 Liquid release was made within 10CFR20 limits.

LOSS OR DAMAGE TO FACILITY

16 Z NA

PUBLICITY

17 NA

8403230201 760804
PDR ADOCK 05000285
S PDR

ADDITIONAL FACTORS

18 Cause Description (con't): Procedure changes have been implemented to require step-by-
19 step sign-off control of monitor testing prior to conducting waste releases. Attach.)

NAME: W. Dermeyer/R. Andrews

PHONE: 402-426-4011

ATTACHMENT NO. 1

Safety Analysis/Analysis of Occurrence

At 0610 hours on August 2, 1976, while performing daily process radiation monitor checks, Waste Liquid Process Radiation Monitor RM-055 was found to be in the CALIBRATE position. Further investigation revealed that the monitor had been in this condition since 1006 hours on August 1, 1976, and that a waste liquid release had been conducted during this period. (This was ascertained by reviewing the process radiation monitor recorder charts - point #7 (RM-055) read zero which is characteristic of a monitor in the CALIBRATE position.) This release had therefore violated Technical Specification 2.9(1)e(ii) and (iii) in that the monitor (when in the CALIBRATE position) could not monitor the release or control automatic liquid release control valves. The release did not affect the health and safety of the public since the release rate was within the recommended amount (this was ascertained by the waste liquid flow recorder strip chart) and resulted in a concentration in the circulating water discharge tunnel of $4.51\text{E-}09$ micro-curies per milliliter (this is a small fraction ($2.02\text{E-}03$) of the unrestricted area MPC).

Operator error caused the incident. Plant procedures require a functional test of RM-055 prior to initiating a waste liquid release. This check involves placing the monitor in the CALIBRATE position; verifying that the monitor reading comes up to the "CAL" point; then quickly placing the monitor in the OPERATE position and observing that the monitor automatically closes the automatic liquid release control valves. The procedure then specifies that the RESET pushbutton be depressed and the automatic control valves reopened (in fact, the automatic control valves cannot be reopened unless the RESET pushbutton is depressed or the monitor is placed in the CALIBRATE position). Correct operation of the automatic liquid release control valves was verified, however, the operator inadvertently placed the monitor back in the CALIBRATE position instead of leaving the monitor in the OPERATE position and depressing the RESET pushbutton.

During the waste liquid release of B Monitor Tank conducted on August 1, 1976, from 1006 to 1143 hours, RM-055 was inoperable. B Monitor Tank contents were sampled and analyzed prior to actual release to the circulating water discharge tunnel via RM-055. Therefore, RM-055 serves as a backup to sample analysis to ensure liquid releases are not in excess of 10CFR20 limits. During the release on August 1, 1976, this backup capability was not available.

ATTACHMENT NO. 2

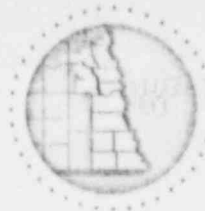
Corrective Action

1. The operator involved in the incident was orally reprimanded by the Manager-Fort Calhoun Station and Operations Supervisor.
2. The waste liquid release procedure was revised to require step-by-step sign-off administrative control of monitor testing.
3. Other waste release procedures were reviewed to ensure that monitor testing was properly controlled. Procedure changes were required to the waste gas release procedure as a result of the review.

ATTACHMENT NO. 3

Failure Data

This is the second time a waste liquid release was conducted with an inoperable effluent control monitor. The first incident was a result of a defective reset switch and resulted in loss of monitor control function only (the monitoring function was not lost in the first incident).



Omaha Public Power District

1623 HARNEY ■ OMAHA, NEBRASKA 68102 ■ TELEPHONE 536-4000 AREA CODE 402

August 4, 1976
FC-239-76

Mr. E. Morris Howard
U. S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive
Suite 1000
Arlington, TX 76012

Dear Mr. Howard:

Reference: Fort Calhoun Station Unit No. 1
Docket No. 50-285

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 the following licensee event report 50-285/76-24 to satisfy the requirements of Regulatory Guide 1.16.

Sincerely,

W. C. Jones
W. C. Jones
Section Manager
Operations

WCJ/WDD:rge

Enclosure

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)

Mr. L. C. Shalla
SARC Chairman
PRC Chairman
Fort Calhoun File (2)

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