NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Fort Calhoun Station, Unit No. 1	0 5 0 0 0 2 8 5	1 OF 0 2

TITLE (4)
VIAS Actuation

EVENT DATE (5)			LER NUMBER (6)					REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR		SEQUENTIAL NUMBER		REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 6	2 0	8 5	8 5	—	0 0 4	—	0 0	0 7	2 0	8 5	N	0 5 0 0 0
												0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
1	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
1 0 0	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	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	TELEPHONE NUMBER
Lawrence T. Kusek, Supervisor-Operations Fort Calhoun Station, Unit No. 1	AREA CODE 4 0 2 — 4 2 6 - 4 0 1 1

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)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

During normal plant operation at 100% power, an unplanned actuation of the Ventilation Isolation Actuation System (VIAS) occurred at 1121 on June 20, 1985. The actuation of the VIAS signal [an Engineered Safety Feature (ESF)] was not initiated to mitigate an event as described in the USAR. The actuation was caused by operator error. The actuation occurred while the operator was returning RM-062 to "operate" from "calibrate" after the chemist had taken a sample of RM-061 filter paper. The "calibrate" position is higher than the trip setpoint of RM-062. The operator released the "reset" pushbutton before the meter dropped below the trip setpoint. If the "reset" pushbutton had been depressed long enough, the VIAS actuation would not have occurred.

As soon as the VIAS actuation occurred, the monitor was returned to normal and VIAS was reset. All Engineered Safeguards 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 clarified if necessary. The operators will be made aware of this incident and reinformed on the proper methods of monitor operation through training.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Fort Calhoun Station, Unit No. 1	0 5 0 0 0 2 8 5	8 5	— 0 0 4	— 0 0	0 2 OF 0 2

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

During normal plant operation at 100% power, an unplanned actuation of the Ventilation Isolation Actuation System (VIAS) occurred at 1121 on June 20, 1985. The actuation of the VIAS signal [an Engineered Safety Feature (ESF)] was caused by operator error. This VIAS actuation occurred while the operator was placing the ventilation discharge duct monitors, RM-061 and RM-062, back in service following a sample clipping by the shift chemist of RM-061's filter paper. RM-061 and RM-062 share the same sample pump so both monitors had to be placed in "calibrate" to prevent spiking of the RM-061 and RM-062 monitors when the sample pump was restarted. The "calibrate" position on the scale of RM-062 is higher than the trip setpoint. When returning a monitor to service from the "calibrate" mode, the "reset" pushbutton must be held in until the meter indication drops below the trip setpoint; otherwise, the monitor will trip and initiate VIAS. In this case, the operator released the "reset" pushbutton too early and RM-062 tripped into high alarm. This causes the Containment Radiation High Signal (CRHS) relay to actuate due to the 1-out-of-5 logic, causing the VIAS relay to actuate.

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.
4. Closes the containment air sampling valves.
5. Opens the inlet and outlet vents to the safety injection pump rooms and the spent regenerant tank room.
6. Limits the control room air conditioning units to single operation and places the control room ventilation system in a filtered air makeup mode.
7. Closes the waste gas header release valve to the stack.
8. Places the containment cooling and filtering units in the filtered mode.

To prevent future unplanned VIAS actuations of this nature, applicable plant procedures will be reviewed and clarified if necessary. The operators will be made aware of this incident and reinformed on the proper methods of monitor operation through training.

Other VIAS actuations that have occurred since the new LER rule went into effect on January 1, 1984, were reported in LER's 84-005, 84-007, 84-006, 84-014, 84-017, 84-018, 84-019, 84-023, 84-024, 84-025, 85-001, 85-002 and 85-003.

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

July 19, 1985
FC-284-85
LIC-85-337

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 85-004 dated June 20, 1985. This report is being submitted per requirements of 10 CFR 50.73.

Sincerely,

R. L. Andrews
Division Manager
Nuclear Production

RLA/DJM/rh-W

Attachment

cc: Mr. Dorwin R. Hunter, Chief
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SARC Chairman
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Fort Calhoun File (2)

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