

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Fort Calhoun Station, Unit No. 1										DOCKET NUMBER (2) 0 5 0 0 0 2 8 5				PAGE 13 1 OF 0 2		
TITLE (4) VIAS Actuation																
EVENT DATE (6)			LER NUMBER (8)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (9)						
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES N				DOCKET NUMBER(S) 0 5 0 0 0			
0 8	2 3	8 5	8 5	0 0 5	0 0	0 9	1 9	8 5					0 5 0 0 0			
OPERATING MODE (8) 1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)														
POWER LEVEL (10) 1 0 0		20.402(b)				20.408(a)				<input checked="" type="checkbox"/> 80.73(a)(2)(iv)		73.71(b)				
		20.408(a)(1)(i)				80.36(a)(1)				<input type="checkbox"/> 80.73(a)(2)(v)		73.71(a)				
		20.408(a)(1)(ii)				80.36(a)(2)				<input type="checkbox"/> 80.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)				
		20.408(a)(1)(iii)				80.73(a)(2)(i)				<input type="checkbox"/> 80.73(a)(2)(viii)(A)						
		20.408(a)(1)(iv)				80.73(a)(2)(ii)				<input type="checkbox"/> 80.73(a)(2)(viii)(B)						
		20.408(a)(1)(v)				80.73(a)(2)(iii)				<input type="checkbox"/> 80.73(a)(2)(ix)						
LICENSEE CONTACT FOR THIS LER (12)																
NAME Lawrence T. Kusek, Supervisor-Operations Fort Calhoun Station, Unit No. 1										TELEPHONE NUMBER AREA CODE 4 0 2 4 2 6 1 - 4 0 1 1						
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC						
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO				

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

During normal plant operation at 100% power with a containment pressure reduction in progress, an unplanned actuation of the Ventilation Isolation Actuation System (VIAS) occurred at 0912 on August 23, 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 I&C technician error. The actuation occurred while the technician was checking the inversion setpoints on the ventilation discharge duct monitor, RM-061. When the low/high setpoint selector switch was repositioned, RM-061 momentarily went into high alarm and initiated VIAS. The "reset" pushbutton is normally depressed during this switching operation to avoid spurious actuation due to instrument spike. If the technician had depressed the "reset" pushbutton, the VIAS actuation would not have occurred.

As soon as the VIAS actuation occurred, the monitor was returned to normal, VIAS was reset and the containment pressure reduction was restarted. 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, I&C technicians will be made aware of this incident and reformed on the proper methods of monitor operation through training.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (8)			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 5	— 0 0	0 2	OF	0 2

TEXT (If more space is required, use additional NRC Form 368A's) (17)

During normal plant operation at 100% power with a containment pressure reduction in progress, an unplanned actuation of the Ventilation Isolation Actuation System (VIAS) occurred at 0912 on August 23, 1985. The actuation of the VIAS signal [an Engineered Safety Feature (ESF)] was caused by I&C technician error. The actuation occurred while the technician was checking the inversion setpoints on the ventilation discharge duct monitor, RM-061. When the low/high setpoint selector switch was repositioned, RM-061 momentarily went into high alarm and initiated VIAS. The "reset" pushbutton is normally depressed during this switching operation to avoid spurious actuation due to instrument spike. If the technician had depressed the "reset" pushbutton, the VIAS actuation would not have occurred.

VIAS, as described in the USAR, is designed to mitigate a release of significant radio-iodine 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, the I&C technicians will be made aware of this incident and reformed 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, 85-003 and 85-004.

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

September 18, 1985  
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LIC-85-428

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

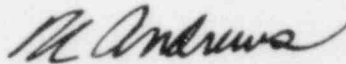
Reference: Docket No. 50-285

Gentlemen:

Licensee Event Report for the  
Fort Calhoun Station

Please find attached Licensee Event Report 85-005 dated August 23, 1985.  
This report is being submitted per requirements of 10 CFR 50.73.

Sincerely,



R. L. Andrews  
Division Manager  
Nuclear Production

RLA/AB/rs-W

Attachment

cc: Mr. E. H. Johnson, Chief  
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Mr. L. A. Yandell, Senior Resident Inspector  
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Fort Calhoun File (2)

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