

444 South 16th Street Mall Omaha, NE 68102-2247

LIC-11-0024 April 5, 2011

U.S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, DC 20555-0001

Reference:

Docket No. 50-285

Subject:

Licensee Event Report 2011-004, Revision 0, for the Fort Calhoun

Station

Please find attached Licensee Event Report 2011-004, Revision 0, dated, April 5, 2011. This report is being submitted pursuant to 10CFR50.73(a)(2)(v)(B). If you should have any questions, please contact me.

Sincerel

Jeffrey Reinhart Site Vice President

JAR/epm

Attachment

c: E. E. Collins, Jr., NRC Regional Administrator, Region IV

L. E. Wilkins, NRC Project Manager

J. C. Kirkland, NRC Senior Resident Inspector

INPO Records Center

	NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION APPROVED BY OMB: NO. 3150-0104 EXPIRES: 10/31/2013																
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)								Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.									
1. FACILITY NAME Fort Calhoun Station						2	2. DOCKET NUMBER 3. PAGE 05000285 1 OF 4										
Isolation of Both Trains of Safety Related Auxiliary Feedwater																	
						FACILITI	LITIES INVOLVED										
MONTH	DAY	YEAR	YEAR SEQUENTIAL NUMBER NO.		V MON			YEAR	FACILITY NAME				DOCKET NUMBER 05000				
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On February 5, 2011, during plant startup activities, operations personnel initiated a transition from auxiliary feedwater (AFW) to main feedwater (MFW) while in Mode 2 (Hot Standby Condition). During the transition, AFW was being supplied by a safety-related motor-driven AFW pump (FW-6) through the AFW nozzles (HCV-1107A/B and HCV-1108A/B). With MFW aligned and feeding both steam generators, the control room operator was directed to shut down FW-6 and return the system to its normal alignment. During this activity the control room operator placed both inboard isolation valves, as directed by procedure, HCV-1107A and HCV-1108A, into their closed position. This action defeated automatic initiation via an auxiliary feedwater actuation signal to open the valves, rendering both trains of AFW inoperable. A root cause analysis is in progress. The results of the analysis will be reported in a revision to this LER. The condition was recognized and the control switches were placed in "Auto" restoring both trains to operable.																	

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LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

U.S. NUCLEAR REGULATORY COMMISSION

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE		
Fort Calbour Station	05000395	YEAR	SEQUENTIAL NUMBER	REV NO.	2	OF	4
Fort Calhoun Station	05000285	2011	- 004 -	0			4

NARRATIVE

BACKGROUND

Fort Calhoun Station (FCS) is a two-loop Combustion Engineering (CE) design reactor coolant system (RCS). Each loop has one steam generator (SG) and two reactor coolant pumps (RCPs). Each SG has one main feedwater (MFW) nozzle and one auxiliary feedwater (AFW) nozzle. The MFW nozzle is the normal path for feeding the SGs.

The AFW system is provided for storage, pumping and delivery of makeup water to the SGs in order to remove decay heat if the MFW system is not available. The AFW system consists of one emergency feedwater storage tank; one safety-related motor-driven AFW pump (FW-6), one safety-related turbine-driven AFW pump (FW-10); one non-safety-related, diesel-driven AFW pump (FW-54); one non-safety-related diesel fuel oil transfer pump with a day tank; non-safety-related fuel oil piping and valves; remotely operated flow control valves; interconnecting piping to the MFW system and piping to the AFW nozzles on the SGs.

The AFW line to each SG has an isolation valve on the inside of containment (the 'A' valves) and one on the outside of containment (the 'B' valves). The HCV-1107A/B valves are the isolation valves for the 'A' SG. The HCV-1108A/B valves are the isolation valves for the 'B' SG. The AFW isolation valves are 3-inch, pneumatically operated globe valves. These valves are air to close and spring to open.

FW-54 is the startup AFW pump. FW-54 takes its suction from the condensate storage tank and discharges to the normal feedwater header. FW-54 and its associated equipment are not safety-related.

The AFW system provides a redundant means of supplying one or both SGs with feedwater. Operation of the safety-related portion of the AFW system is automatically initiated on a low SG water level or manually initiated as follows:

- Automatic initiation via an auxiliary feedwater actuation signal (AFAS).
- Automatic start signals to the safety-related pumps (FW-6 and FW-10).
- Manual initiation from the control room.
- Manual initiation from alternate shutdown panel for FW-10 and the AFW injection valves and locally for FW-6.

The system is designed to add feedwater to either or both SGs under any condition, including the loss of all electrical power along with the loss of the MFW system and the loss of the main steam piping downstream of the main steam isolation valves. The AFW system fulfills both safety-related and non-safety-related functions.

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NARRATIVE

Technical Specification (TS) 2.5, "Steam and Feedwater Systems," states, in part:

- (1) Two AFW trains shall be OPERABLE when Toold is above 300°F.
 - A. With one steam supply to the turbine driven AFW pump inoperable, restore the steam supply to OPERABLE status within 7 days and within 8 days from discovery of failure to meet the LCO.
 - B. With one AFW train inoperable for reasons other than condition A, restore the AFW train to OPERABLE status within 24 hours.
 - C. If the required action and associated completion times of condition A or B are not met, then the unit shall be placed in MODE 2 in 6 hours, in MODE 3 in the next 6 hours, and less than 300°F without reliance on the steam generators for decay heat removal within the next 18 hours.
 - D. With both AFW trains inoperable, then initiate actions to restore one AFW train to OPERABLE status immediately. Technical Specification (TS) 2.0.1 and all TS actions requiring MODE changes are suspended until one AFW train is restored to OPERABLE status.

EVENT DESCRIPTION

On February 5, 2011, during plant startup activities, operations personnel initiated a transition from AFW to MFW while in Mode 2, power operations. During the transition, AFW was being supplied by FW-6 through the AFW nozzles via HCV-1107A/B and HCV-1108A/B. With MFW aligned and feeding both steam generators, the control room operator was directed to shut down FW-6 and return the system to its normal alignment. During this activity, the control room operator, as directed by procedure, placed both HCV-1107A and HCV-1108A into their closed position. This action defeated the AFAS ability to open the valves, rendering both trains of AFW inoperable. The condition was subsequently recognized as inappropriate for the current plant mode and the control switches for HCV-1107A and HCV-1108A were placed in "Auto" restoring both trains to operable status. The condition represented a violation of Technical Specification 2.5(1)D. This condition existed for approximately three minutes. On February 6, 2011, an eight (8) hour report was made under 10 CFR 50.72 (b)(3)(v)(B) to the NRC Headquarters Operation Office (HOO) at 0237 CST. This report is being made per 10 CFR 50.73(a)(2)(v)(B).

CONCLUSION

A root cause analysis is in progress. The results of the analysis will be reported in a revision to this LER.

CORRECTIVE ACTIONS

As previously noted, the condition was recognized and the control switches were placed in "Auto" restoring both trains to operable.

SAFETY SIGNIFICANCE

The safety significance of this event will be assessed in detail on completion of the root cause analysis.

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NARRATIVE

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This event does result in a safety system functional failure in accordance with NEI-99-02.

PREVIOUS EVENTS

LERs 2010-003, 2008-003 and 2006-002 report similar events.