



Nebraska Public Power District
Nebraska's Energy Leader

NLS2001049
April 26, 2001

U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D.C. 20555-0001

Gentlemen:

Subject: Safeguards Licensee Event Report No. 2001-S01-00
Cooper Nuclear Station, NRC Docket 50-298, DPR-46

The subject Safeguards Event Report is forwarded as an enclosure to this letter. No safeguards information is contained within this document.

Sincerely,



J. A. McDonald
Plant Manager

/dvw
Enclosure

cc: Regional Administrator
USNRC - Region IV

Senior Project Manager
USNRC - NRR Project Directorate IV-1

Senior Resident Inspector
USNRC

NPG Distribution

INPO Records Center

W. Leech
MidAmerican Energy

CNS Records

JENH

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|---|---|---|--------------------------|
| NRC FORM 366 (1-2001) | U.S. NUCLEAR REGULATORY COMMISSION | APPROVED BY OMB NO. 3150-0104 Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@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 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. | EXPIRES 6-30-2001 |
| LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block) | | | |

| | | |
|--|--------------------------------------|---------------------------|
| FACILITY NAME (1) Cooper Nuclear Station | DOCKET NUMBER (2) 05000298 | PAGE (3) 1 OF 4 |
|--|--------------------------------------|---------------------------|

TITLE (4)
Personnel Error Results in Uncompensated Loss of Ability to Monitor Vital Alarms

| EVENT DATE (5) | | | LER NUMBER (6) | | | REPORT DATE (7) | | | OTHER FACILITIES INVOLVED (8) | |
|----------------|-----|------|----------------|-------------------|--------|-----------------|-----|------|-------------------------------|---------------|
| MO | DAY | YEAR | YEAR | SEQUENTIAL NUMBER | REV NO | MO | DAY | YEAR | FACILITY NAME | DOCKET NUMBER |
| 03 | 30 | 2001 | 2001 | S01 | 00 | 04 | 26 | 2001 | FACILITY NAME | DOCKET NUMBER |
| | | | | | | | | | | 05000 |
| | | | | | | | | | | 05000 |

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|---------------------------|-----|---|--------------------|--|--------------------|----------------------|--|----------------------|--|--------------------|---|
| OPERATING MODE (9) | 1 | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11) | | | | | | | | | |
| POWER LEVEL (10) | 100 | 20.2201(b) | | | 20.2203(a)(3)(ii) | | | 50.73(a)(2)(ii)(B) | | 50.73(a)(2)(ix)(A) | |
| | | 20.2201(d) | | | 20.2203(a)(4) | | | 50.73(a)(2)(iii) | | 50.73(a)(2)(x) | |
| | | 20.2203(a)(1) | | | 50.36(c)(1)(i)(A) | | | 50.73(a)(2)(iv)(A) | | x | 73.71(a)(4) |
| | | 20.2203(a)(2)(i) | | | 50.36(c)(1)(ii)(A) | | | 50.73(a)(2)(v)(A) | | | 73.71(a)(5) |
| | | 20.2203(a)(2)(ii) | | | 50.36(c)(2) | | | 50.73(a)(2)(v)(B) | | | OTHER Specify in Abstract below or in NRC Form 366A |
| | | 20.2203(a)(2)(iii) | | | 50.46(a)(3)(ii) | | | 50.73(a)(2)(v)(C) | | | |
| | | 20.2203(a)(2)(iv) | | | 50.73(a)(2)(i)(A) | | | 50.73(a)(2)(v)(D) | | | |
| | | 20.2203(a)(2)(v) | | | 50.73(a)(2)(ii)(B) | | | 50.73(a)(2)(vii) | | | |
| | | 20.2203(a)(2)(vi) | | | 50.73(a)(2)(i)(C) | | | 50.73(a)(2)(viii)(A) | | | |
| 20.2203(a)(3)(i) | | | 50.73(a)(2)(ii)(A) | | | 50.73(a)(2)(viii)(B) | | | | | |

LICENSEE CONTACT FOR THIS LER (12)

| | |
|---|--|
| NAME Mike Boyce, Risk and Regulatory Affairs Manager | TELEPHONE NUMBER (Include Area Code) 402-825-3811 |
|---|--|

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX |
|-------|--------|-----------|--------------|--------------------|-------|--------|-----------|--------------|--------------------|
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|---|---|-----------|--|--------------------------------------|--|--|
| SUPPLEMENTAL REPORT EXPECTED (14) | | | | EXPECTED SUBMISSION DATE (15) | | |
| YES (If yes, complete EXPECTED SUBMISSION DATE). | X | NO | | | | |

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)(16)

At 18:16 Central Standard Time (CST) on March 30, 2001 it was identified that both the Central Alarm Station (CAS) and Secondary Alarm Station (SAS) consoles had locked up due to a simultaneous test of the station duress alarms. This resulted in both CAS and SAS consoles being disabled and the inability to monitor the alarm systems from either station. The Specialists in the alarm stations and the responding Security Shift Supervisor did not immediately recognize that the consoles locking up prevented the monitoring of the alarms. At 18:33 CST it was recognized that alarm monitoring was lost.

Required compensatory actions were initiated at 18:35 CST and completed by 18:45 CST. The total time the alarms were not monitored was 29 minutes. Consoles and Alarm monitoring capabilities were restored and compensatory actions were terminated by 20:21 CST on March 30, 2001. The root cause of this event was personnel error due to lack of training.

LICENSEE EVENT REPORT (LER)

| FACILITY NAME (1) | DOCKET (2) | LER NUMBER (6) | | | PAGE (3) | |
|------------------------|------------|----------------|-------------------|-----------------|----------|--|
| Cooper Nuclear Station | 05000298 | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | 2 OF 4 | |
| | | 2001 | -- S01 | -- 00 | | |

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

The text below specifically addresses the information requests of Regulatory Guide 5.62, Revision 1, Section 3.2. There is no Safeguards Information in the text below.

PLANT STATUS

The plant was operating at approximately 100% steady state power when the event occurred.

BACKGROUND

Security consoles are part of the security computer used for command and control of the intrusion detection systems. Dual consoles are located in both the Central Alarm Station (CAS) and Secondary Alarm Station (SAS). A new system was installed and security personnel were trained in November of 2000.

The Duress Test is conducted on Saturdays as part of the Weekly Alarm Station Console Check and documented on the Daily Security Log. The test is intended to be a coordinated test and conducted by pressing two keys on the Alarm Station Console keyboard. Once these two keys are pressed, the associated Alarm Station Console is locked out. To enable the console a different set of keys on the keyboard are pressed. A verification request message is sent to the other Alarm Station asking for concurrence to enable the Alarm Station. Once this verification is concurred with the locked Alarm Station is then enabled. This test is conducted to verify that an alarm station can send a duress message to the other Alarm Station and that the consoles are locked out to prevent unauthorized access to the Security System in the event of an emergency. Communications for conducting this test are typically conducted over the intercom system between Alarm Stations.

The new Security System Duress system is activated differently than the old security system push button. Training on the new security system was provided on two different occasions, by the vendor, for Alarm Station Specialists, Team Leaders and Security Shift Supervisors.

The security force is proprietary.

EVENT DESCRIPTION

At 18:16 Central Standard Time (CST) on March 30, 2001 it was identified that both the CAS and SAS consoles had locked up due to a simultaneous test of the station duress alarms. The SAS Specialist had asked the CAS Specialist if he was ready to conduct the weekly duress alarm. The CAS Specialist acknowledged that he was and immediately initiated the duress command. The SAS Specialist understood the acknowledgment to mean that CAS was ready for him to conduct the alarm and also initiated the duress command. This resulted in both CAS and SAS consoles being disabled and the inability to monitor the alarm systems from either station. The Protected area and Vital areas required posting within the following 10 minutes according to CNS Security Procedure 2.14. The Specialists in the alarm stations and the responding Security Shift Supervisor did not recognize that the consoles locking up prevented the monitoring of the alarms and initiated actions to recover the use of the consoles. At 18:33 CST Security shift personnel attempted to alarm the Vital door at CAS. When this attempted alarm did not display on the consoles it was then recognized that alarm monitoring was lost. Required compensatory actions were initiated at 18:35 CST and completed by 18:45 CST. The total time the alarms were not monitored was 29 minutes, which was in excess of the 10 minute posting requirement.

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Contact was made with Nuclear Information Services personnel who then provided instructions to recover consoles and monitoring capabilities via the Administrator terminal located in the computer room. Consoles and Alarm monitoring capabilities were restored and compensatory actions were terminated by 20:21 CST on March 30, 2001.

On March 31, 2001, the Day Shift Security Shift Supervisor was reviewing the events from the previous shift and determined the event was not compensated for in the required time because the loss of alarm monitoring should have been discovered upon occurrence. The Control Room was notified and a 1-hour report was completed to the NRC per 10 CFR 73.71(b)(1) at 09:17 CST on March 31, 2001.

BASIS FOR REPORT

This event is being reported under the requirements of 10CFR73.71, Appendix G, (I)(c). This event consisted of the uncompensated loss of ability to monitor vital alarms through the loss of both Central and Secondary alarm stations capability to monitor alarms, in combination with a failure to provide proper compensation within 10 minutes of occurrence. The initial notification incorrectly identified that compensatory measures were in place by 18:35 CST, they were in place by 18:45 CST.

CAUSE

The root cause of this event was personnel error due to lack of training. Alarm Station Specialists, Team Leaders, and Security Shift Supervisors were initially provided two classroom training sessions on how the new system works. However, the training did not analyze and therefore did not provide learning objectives on the fact that 1) both CAS and SAS consoles could be locked up at the same time and 2) when the consoles were locked up, alarm monitoring capabilities were lost.

SAFETY SIGNIFICANCE

There is no safety significance associated with this event. There were no safety systems affected or threatened, directly or indirectly. There was no intrusion during the event.

CORRECTIVE ACTIONS

Immediate Actions

Upon discovery compensatory actions were implemented in accordance with security procedure 2.14.

The Control Room was notified on March 31, 2001 by the on-duty-Security Shift Supervisor and a one-hour notification was made to the NRC.

Contacted security team supervisory personnel and confirmed they were knowledgeable of the loss of monitoring capabilities, when CAS and SAS consoles are disabled.

Advised security force personnel that the intercom will not be used to conduct business unless there is an event/emergency and the phones are not working.

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Long Term Actions

Implement an initial/requalification training lesson module for team supervisors and specialists that identifies security system software alarms/failure messages and the associated known losses that result.

Develop and train security shift supervisory personnel on NRC reportability criteria.

Revise Daily Security Log to separate the line entry for the Weekly Console Test of CAS/SAS to be conducted separate from each other.

PREVIOUS EVENTS

There was one similar event in the last three years. On November 6, 2000 proper compensatory actions for a microwave zone were not implemented within 10 minutes. Root cause was personnel error due to miscommunications. (LER 2000-S01).

KNOWLEDGEABLE CONTACT

Michael Hamm
Security Operations Supervisor
402-825-5337

ATTACHMENT 3 LIST OF REGULATORY COMMITMENTS

Correspondence Number: NLS2001049

The following table identifies those actions committed to by the District in this document. Any other actions discussed in the submittal represent intended or planned actions by the District. They are described for information only and are not regulatory commitments. Please notify the NL&S Manager at Cooper Nuclear Station of any questions regarding this document or any associated regulatory commitments.

| COMMITMENT | COMMITTED DATE OR OUTAGE |
|--|--------------------------|
| Implement an initial/requalification training lesson module for Team Supervisors and Specialists that identifies security system software alarms/failure messages and the associated known losses that result. | N/A |
| Develop and train Security Shift Supervisory personnel on NRC reportability criteria. | N/A |
| Revise Daily Security Log to separate the line entry for the weekly console test of CAS/SAS to be conducted separate from each other. | N/A |
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