



444 South 16th Street Mall
Omaha NE 68102-2247

January 8, 2004
LIC-04-0002

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

Reference: Docket No. 50-285

Subject: Licensee Event Report 2003-S02 Revision 0 for the Fort Calhoun Station

Please find attached Licensee Event Report 2003-S02, Revision 0, dated January 8, 2004. This report is being submitted pursuant to 10 CFR 73.71. If you should have any questions, please contact me.

Sincerely,



R. T. Ridenoure
Vice President
RTR/EPM/epm
Attachment

- c: B. S. Mallett, NRC Regional Administrator, Region IV
- A. B. Wang, NRC Project Manager
- J. G. Kramer, NRC Senior Resident Inspector
- INPO Records Center

JE74

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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 bj1@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.

1. FACILITY NAME Fort Calhoun Nuclear Station Unit Number 1	2. DOCKET NUMBER 05000285	3. PAGE 1 OF 2
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4. TITLE
Lack of Proper Compensation for a Security Zone.

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
12	10	2003	2003	S02	00	01	08	2004	FACILITY NAME	DOCKET NUMBER
										05000
										05000

9. OPERATING MODE	1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)								
10. POWER LEVEL	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)	73.71(a)(4)					
		20.2203(a)(2)(i)	50.36(c)(1)(ii)(A)	50.73(a)(2)(v)(A)	X 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)(i)(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)						

12. LICENSEE CONTACT FOR THIS LER

NAME Erick Matzke, Station Licensing Engineer	TELEPHONE NUMBER (Include Area Code) 402-533-6855
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

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

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

On December 10, 2003, the security force was asked to allow access to one of the plant security zones to permit maintenance on plant equipment. The maintenance required that the affected zone and an adjacent door be placed in access mode. About 4.5 hours after the start of the maintenance the compensatory post was moved to a different door. The first door was placed back in the secure mode and the door to be used was placed in access. About 1.5 hours later maintenance was completed, and the compensatory post at the second door was secured. The second door was placed in the secure mode. About two hours after securing the second door, the security force discovered the security zone that was initially placed in access was still in access and was not being properly compensated. The zone had not been properly compensated for 2 hours and 9 minutes.

The root causes are as follows:

1. Performance expectations are not clearly established or effectively monitored, and
2. Multi-barrier compensation situations are not clearly addressed by procedural guidance.

Immediate corrective actions were implemented to prevent recurrence. Long term corrective actions to address the causes of this event are being developed and will be implemented using the station's corrective action system.

LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE	
Fort Calhoun Nuclear Station Unit Number 1	05000285	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2	OF 2
		2003	- S02	- 00		

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

EVENT DESCRIPTION

On December 10, 2003, during normal plant operations the security force was asked to allow access to one of the plant security zones to permit maintenance on plant equipment. The maintenance required that the affected zone and an adjacent door be placed in access mode to allow compensatory measures to be instituted. About three hours later an adjacent barrier was placed in access, compensated, and removed from access after about a five minute period. About 4.5 hours after the start of the maintenance, the compensatory post was moved to a different door. The first door was placed back in the secure mode and the second door to be used was placed in access. About 1.5 hours later, maintenance was completed, and the compensatory post at the second door was secured. At that time, the second door was placed in the secure mode. About two hours after securing the second door, the security force discovered the security zone that was initially placed in access was still in access and was not being properly compensated. The zone had not been properly compensated for 2 hours and 9 minutes. Station management determined that the event was reportable per 10CFR73.71 on December 10, 2003. A one hour report was made to the NRC Operations Center on December 10, 2003. This event is being reported per 10CFR73.71.

SAFETY SIGNIFICANCE

During the time the zone was not in the secure mode there were other barriers and intrusion detection equipment in place to prevent unauthorized access to the plant. In this incident, several barriers had to fail for the event to occur, therefore, it was not predictable. Looking at the zone, one would not be able to tell that the zone was in an unsecured mode. Therefore, it was not identifiable. And last, because of the negative responses to the first two questions, the situation was not exploitable. And last, because of the negative responses to the first two questions, the situation was not exploitable and did not result in a loss or degradation of safeguards effectiveness. Therefore, this event had no impact on public health or safety.

CONCLUSION

A root cause analysis was conducted to determine the causes of the event. The root causes are as follows:

1. Performance expectations are not clearly established or effectively monitored, and
2. Multi-barrier compensation situations are not clearly addressed by procedural guidance.

CORRECTIVE ACTIONS

Two short term corrective actions were implemented to preclude a repeat of this problem until long term corrective actions could be constructed and implemented.

1. The security computer operators are required to determine the security zones that are not in a secure mode using the plant security computer each time they assume that station.
2. The shift security supervisor is required to personally verify that the security zones are placed in the proper state prior to releasing any compensatory security officers from their posts.

Long term corrective actions to address the causes of this event are being developed and will be implemented using the station's corrective action system.

SAFETY SYSTEM FUNCTIONAL FAILURE

This event did not result in a safety system functional failure in accordance with NEI 99-02.

PREVIOUS SIMILAR EVENTS

LER 2003-S01 documented an event similar to the one described in this report.