



**Nebraska Public Power District**

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NLS2004022  
March 12, 2004

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

**Subject:** Reply to Preliminary White Finding Regarding NRC Inspection Report  
05000298/2004-009

**Reference:** Letter to Randall K. Edington (NPPD) from Dwight D. Chamberlain (USNRC)  
dated February 11, 2004, "NRC Inspection Report 05000298/2004-009 Biennial  
Licensed Operator Requalification Inspection - Preliminary White Finding"

The purpose of this letter is to submit Nebraska Public Power District's (NPPD) position on a preliminary finding discussed in the referenced letter. The Nuclear Regulatory Commission (NRC) cited an apparent violation and provided NPPD an opportunity to discuss its position in a regulatory conference or in writing. As discussed with Tony Gody (USNRC Region IV) in a phone call with Paul Fleming (NPPD) and Jerry Roberts (NPPD) on February 20, 2004, NPPD is not requesting a regulatory conference.

The referenced letter discusses a preliminary finding that is categorized as having low to moderate safety significance (i.e., White). During the biennial Licensed Operator Requalification (LOR) cycle, seventeen of forty-six operators (36 percent) failed the biennial written examination. The letter states that these results fail to demonstrate satisfactory licensed operator requalification program performance as described in NUREG-1021, "Operator Licensing Examination Standards for Power Reactors," Revision 8, Supplement 1, Examination Standard 601, Section E.3.a(1).

It is NPPD's position that it is inappropriate to conclude, as the NRC did in Aspect 2 of their evaluation, that the operator requalification program is unsatisfactory and then use that perceived problem to execute the Significance Determination Process (SDP) flowchart provided in Manual Chapter 0609, Appendix I, "Operator Requalification Human Performance SDP." The SDP flowchart should be navigated with a problem or issue statement (i.e., 36 percent failure on the written portion of the examination) to proceed to a conclusion regarding the significance of the specific issue. It is our understanding that the NRC is addressing concerns with this SDP based on an internal feedback form.

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NPPD assessed the significance of the finding using NRC Manual Chapter 0609, Appendix I, "Operator Requalification Human Performance Significance Determination Process (SDP)" using the 36 percent failure rate as the problem statement and arrived at a Green terminus. We arrived at this conclusion using the generally accepted standards for flowpath use.

As a result of the extent of condition review for the condition report written to address the issue, an additional failure was discovered. The individual has been removed from the shift until remedial action can be taken.

During the week of November 17, 2003, two NRC inspectors assessed various aspects of NPPD's licensed operator requalification program. No programmatic issues were identified during the conduct of the NRC's inspection per Inspection Procedure 71111.11, nor were there any performance issues other than those noted with the written examination pass rate. No evidence of an unsatisfactory program was noted by the inspectors. This information should be considered in the NRC's processing of the final significance determination of this finding.

If the NRC's final determination assesses this finding as a "White," then, as discussed in a telephone call with NRC Region IV personnel, NPPD would expect an NRC inspection using the guidance of Inspection Procedure 95001. As described in Inspection Manual Chapter 2515, Appendix B, this supplemental inspection would consist of a review of NPPD's evaluation of root cause, extent of condition, and proposed corrective actions. Attachment 1 to this letter provides a summary of NPPD's evaluation of the licensed operator requalification written examination failures.

If you have any questions please contact Mr. Paul Fleming, Licensing and Regulatory Affairs Manager at (402) 825-2774.

Sincerely,



Randall K. Edington  
Vice President - Nuclear and  
Chief Nuclear Officer

/dwv

Attachment

cc: Regional Administrator w/attachment  
USNRC - Region IV

Senior Project Manager w/attachment  
USNRC - NRR Project Directorate IV-1

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Senior Resident Inspector w/attachment  
USNRC

NPG Distribution w/attachment

Records w/attachment

## ATTACHMENT 1

### SUMMARY OF NEBRASKA PUBLIC POWER DISTRICT'S EVALUATION OF LICENSED OPERATOR REQUALIFICATION WRITTEN EXAMINATION FAILURE

#### PROBLEM STATEMENT

A high percentage of Cooper Nuclear Station (CNS) licensed operators, 17 of 46, failed their initial 2003 comprehensive written examination that was administered between November 11 and December 22, 2003.

**Note** - The root cause and contributing causes were developed using "Why Staircase" and validated with "Taproot."

#### ROOT CAUSE

Several organizational and process breakdowns occurred over the two-year cycle that contributed to the written examination failures noted. The common tie among all of these issues is fundamental managerial oversight of the training and LOR written examination processes.

#### CONTRIBUTING CAUSES

Contributing Cause #1: Based on the identified performance issues, training needs and limitation of a 32-hour LOR training week, a portion of the standard core topics were replaced with specialized subject matter. The result was a sample plan and subsequent written examination that did not have the normal balance of core topics to specialized topics. Based on interviews, this focus on specialized topics resulted in what is perceived to be a more challenging examination.

Contributing Cause #2: Training supervision and management during the development phase of the written examination was limited. The reason for this limited oversight appears to be related to Exam Security. This was evidenced by: expectations not being communicated to the examination team; interface with management during examination development was lacking; and intrusive feedback on examination problems being insufficient due to a reluctance to confront examination team.

Contributing Cause #3: Inadequate change management planning as evidenced by:

1. The first time use of electronic references during a biennial written examination .
2. The transition of Operations Training Supervision.
3. The then existing CNS Training Manager not having experience with LOR Biennial written examinations.
4. The first time involvement in this process for both the Operations Supervisor and Manager.
5. A new person performing the Operations approval.

Contributing Cause #4: Operator cycle examinations (i.e., weekly or periodic during the cycle) were not written to the same cognitive order/level of difficulty as the biennial written examination. This situation created unfavorable examination dynamics that inhibited chances of success.

Contributing Cause #5: Marginal performers in LOR training were not identified using any mechanism other than a passing rate; therefore, operators consistently having low passing grades were not being identified and having action taken in response to their being marginal performers.

Contributing Cause #6: Environmental factors:

1. End of year (higher than typical holidays & vacation).
2. Week 4 of the exams, which exhibited a high failure, was administered after forced outage and holiday.
3. Written examination given in same week as operating examination.
4. Written examination was given in the morning of the first day of the cycle.
5. Up to fifteen examinees in the single exam room (i.e., week 4).

#### EXTENT OF CONDITION

Internal operating experience revealed that Significant Condition Report (SCR) 2001-1495 dealt with operator written examinations. The evaluation was concerned with examination problem statements and the potential of examination compromise. SCR 2001-1495 was determined to not be relevant to this issue of examination failures. No other condition evaluations dealt specifically with high examination failures.

The INPO database was examined using the following key words: Requal, Examination, Tests, Failure. No similar conditions were found in the INPO database.

Internal operating experience was reviewed in the Entergy fleet. A similar occurrence was experienced at Indian Point 2 in 2000. It was determined that although the occurrences were similar, the cause was different.

