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Omaha NE 68102-2247

October 14, 2004
LIC-04-0105

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station P1-137
Washington, DC 20555

Reference: Docket No. 50-285

Subject: Licensee Event Report 2004-S01 Revision 0 for the Fort Calhoun Station

Please find attached Licensee Event Report 2004-S01, Revision 0, dated October 14, 2004. This report is being submitted pursuant to 10 CFR 73.71(a)(4). If you should have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "D. J. Bannister".

D. J. Bannister
Manager - Fort Calhoun Station

DJB/EPM/epm

Attachment

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: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@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. DOCKET NUMBER 05000285	3. PAGE 1 OF 4
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4. TITLE
Inadequate Security Compensatory Measures for a Security Zone

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
08	19	2004	2004	- S01 -	00	10	14	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	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input checked="" type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input checked="" type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input checked="" type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input checked="" type="checkbox"/> 73.71(a)(4)						
<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)							
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER							
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A							

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME Brian Obermeyer	TELEPHONE NUMBER (Include Area Code) (402) 533-6624
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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 <input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR

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

On Thursday, August 19, 2004, at 1259 hours, compensatory measures were incorrectly lifted per the direction of the Shift Security Supervisor (SSS). At the time the compensatory measures were lifted, work was still in progress. The oncoming SSS felt that lifting the measures was contrary to procedure. The SSS made several phone calls to 'B' shift personnel involved in the earlier decision. The Security Duty Officer (SDO), Security Operations Supervisor (SOS), and Manager - Security Services & EP were also notified. The event was determined to meet the criteria for a one hour NRC notification per 10 CFR 73.71 at 2125 hours, based on a decision by the SOS that the event was reportable. The notification to the NRC was made at 2137 hours. A search of the plant was done to verify all areas were secure and all security measures were in place.

The execution of a flawed decision and not adhering to procedural requirements is considered the root cause.

As an interim measure, the security force has implemented a process that ensures the CAS and SAS operators, the Sergeant, and the Shift Security Supervisor all concur on compensatory measures. The Security Duty Officer is contacted if there is not a consensus among this group.

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Fort Calhoun Nuclear Station	05000285	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2	OF	4
		2004	- S01	- 00			

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

EVENT DESCRIPTION:

On Thursday morning, August 19, 2004, a phone call between the Security Operations Supervisor (SOS) and the Shift Security Supervisor (SSS) took place to discuss debris removal operations planned for that day. The SOS communicated his expectations for security measures to be implemented for this activity. He specifically stated that the zone would need to be posted. Based on subsequent events later that day, it appears this statement was misunderstood.

At 1022 hours, maintenance personnel were preparing for debris removal. Compensatory measures were put in place and a Nuclear Security Officer posted (NSO1). The work continued in that area until approximately 1550 hours. At 1247 the posted officer (NSO2) was temporarily relieved by another officer (NSO3). En-route back to his post, the NSO2 met the SSS and mentioned that he was returning to his compensatory post. According to interviews with Central Alarm Station (CAS) and Secondary Alarm Station (SAS) operators and the NSO2, the SSS stated to them that the area did not need posting and that he would be removing the compensatory measure. Shortly following his return to the post, the SSS contacted the NSO2 and directed him to pull the post.

The CAS and SAS operators overheard this request. The SAS operator noted at the time of the request the zone was still in alarm. The 'B' shift CAS asked the 'B' shift SAS via intercom for verification on what he heard. SAS stated he was on the phone with the SSS to clarify what he had heard. The NSO2 contacted SAS for a time to put in the Security Compensatory Post Log (SDF-104) for removing the post. In the mean time, the SSS called CAS to inform him of the removal. CAS stated that the post could not be removed because two personnel were still in the zone. The SSS stated that a meeting was held in the morning and the post need not be compensated.

At 1259 hours, compensatory measures were lifted per the direction of the SSS and logged on the SDF-104. At the time the compensatory measures were lifted, work was still in progress. The decision was still being questioned by both the 'B' shift CAS and SAS operators but the concern was not raised above the SSS level where the decision was made. The alarm stations continued to monitor the zone via CCTV cameras.

At 1500, the 'C' shift CAS operator contacted the 'C' shift Sergeant to express concern that compensatory measures were not in place on the zone. The Sergeant forgot to follow up on the CAS operator's concerns.

At 1830 following turnover between the SSS for day and night shift, an operator wanted to go into the zone. The 'C' shift CAS operator (who also was filling in as the 'B' shift CAS at the time of the event) questioned the Sergeant whether they were to continue the practice that had been done during the day. The Sergeant remembered the CAS operator's concern from 1500 and directed the CAS operator to contact the oncoming SSS.

The oncoming SSS felt that lifting the measures was contrary to procedure. The SSS made several phone calls to 'B' shift personnel involved in the earlier decision. The Security Duty Officer (SDO), SOS, and Manager - Security Services & EP (MSSEP) were also notified. The event was determined to meet the criteria for a one hour NRC notification per 10 CFR 73.71 at 2125 hours, based on a decision by the SOS that the event was reportable. The notification to the NRC was made at 2137 hours. A search of the plant was done to verify all areas were secure and all security measures were in place.

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

Event Timeline	
Time	Event
~0800	SOS briefed SSS over the phone on the debris removal work.
~1000	Sergeant determined that posting would be required in the zone due to the work.
1022	NSO1 posted as a compensatory measure. Initialed SDF-104, compensatory log.
1057	NSO2 relieves NSO1, initialed SDF-104.
~1247	NSO3 relieves NSO2 for a break, did not initial SDF-104.
~1250	NSO2 meets SSS by service building; SSS makes decision to pull the compensatory measure.
~1250-1259	NSO2 returned and SSS radioed a request to have the compensatory measure pulled.
1259	SAS/CAS both question the pulling of the compensatory measure with personnel still working. SSS justifies the decision.
1259	Compensatory measure pulled and alarm reset.
~1300	CAS and SAS relieved
1259-1310	Alarm came back in.
1310	Alarm reset.
1310-1321	Alarm came back in.
1321	Alarm reset.
1321-1548	Alarm came back in.
~1500	CAS and SAS relieved by 'C' Shift, 'C' CAS notified 'C' Sergeant of posting practice but he forgot to pass information on.
1548	Alarm reset. Work complete. Area secured, locking mechanism installed.
~1800	Night shift SSS relieves day shift SSS.
~1830	Plant operations wanted to enter zone, 'C' shift CAS operator questioned Sergeant whether to continue the practice utilized during 'days'
~1830	Sergeant remembered, contacted SSS
+1830	SSS contacted the Security Duty Officer, SOS, Manager-Security Services & EP
~1900-2125	Contacted day shift personnel, discussion to determine if criteria met the one hour NRC notification per 10 CFR 73.71
2125	Determined one hour report was needed.
2137	One hour report was completed.

Approximate times are based on interviews, all other times were retrieved from logs.

CONCLUSION:

A root cause evaluation was conducted to determine the cause of this event so that appropriate corrective actions could be implemented. The SOS correctly determined that removing debris was going to require a compensatory posting of a security officer at the zone for the duration of the task. The area was properly posted from 1022 to 1259, but at that time it was directed by the SSS to deposit the compensatory measure. The debris removal evolution continued into the afternoon with the zone in alarm and several personnel in the area. This resulted in improper compensatory posting of the area and following an investigation required a one hour report to the NRC.

Based on interviews and all available evidence, it appears that the SSS made a flawed decision and directed actions contrary to procedure. The SSS over-ruled the questions brought forth by both the SAS and CAS operators resulting in the area not having appropriate compensatory measures in place and the zone being monitored by the CAS/SAS operators

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using only CCTV cameras. The execution of a flawed decision and not adhering to procedural requirements is considered the root cause.

A contributing cause to the event was improper application of self checking and intervention techniques during the questioning process. Questions were asked, but the concerns that remained did not get communicated high enough to be resolved.

A second contributing cause to the event was the lack of two/three way communications during the phone conversation between the SOS and the SSS which played a contributing factor in the SSS not having complete understanding of the direction given.

A third contributing cause was there were various interpretations of a long standing unwritten practice to allow Operators in a zone for less than 10 minutes without providing compensatory measures. Individuals interviewed had differing viewpoints on when a compensatory measure was needed.

SAFETY SIGNIFICANCE:

There were no challenges to nuclear safety during or as a result of this event, and no Technical Specifications were violated. The zone was monitored. An officer was present in the zone for over an hour during the time the zone was improperly compensated. The zone was cleared and the doors accessing the zone were properly secured following maintenance activities in the zone. Therefore, this event has little if any impact on the health and safety of the public.

CORRECTIVE ACTIONS:

As an interim measure, the security force has implemented a process that ensures the CAS and SAS operators, the Sergeant, and the Shift Security Supervisor all concur on compensatory measures. The Security Duty Officer is contacted if there is not a consensus among this group. A procedure change is being processed to place this change in the appropriate procedures. In addition, Security procedures were changed to require an officer to be present whenever someone needs to enter this security zone. Additional corrective actions will be implemented by the 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:

LERs 2003-S01 and 2003-S02 document similar incidents where proper compensation was not made.