



# Nebraska Public Power District

COOPER NUCLEAR STATION  
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CNSS913052

February 1, 1991

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

Dear Sir:

Cooper Nuclear Station Licensee Event Report 91-001, Revision 0, is being forwarded as an attachment to this letter.

Sincerely,

J. M. Meacham  
Division Manager of  
Nuclear Operations  
Cooper Nuclear Station

JMM:bjs

Attachment

cc: R. D. Martin  
G. R. Horn  
R. E. Wilbur  
V. L. Wolstenholm  
D. A. Whitman  
INPO Records Center  
ANI Library  
NRC Resident Inspector  
R. J. Singer  
CNS Training  
CNS Quality Assurance

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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST, 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-330), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) DOCKET NUMBER (2) PAGE (3)

Cooper Nuclear Station

050002198 1 OF 03

TITLE (4) Unplanned Actuation of Group VI Isolation During Surveillance Testing Due to Personnel Error

EVENT DATE (5)			LPI NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
01	07	91	91	001	00	02	01	91		05000
										05000

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)									
POWER LEVEL (10) 100	20.402(b)		20.405(e)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)		73.71(b)			
	20.405(a)(1)(i)		50.36(a)(1)		50.73(a)(2)(v)		73.71(c)			
	20.405(a)(1)(ii)		50.36(a)(2)		50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
	20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(vii)(A)					
	20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(vii)(B)					
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)					

LICENSEE CONTACT FOR THIS LER (12)

NAME: Donald L. Reeves, Jr. TELEPHONE NUMBER: 402 825-3811

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if yes, complete EXPECTED SUBMISSION DATE)  NO  X

EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space lines) (16)

On January 7, 1991, at 1:38 pm, with the plant in operation at full power, an unplanned actuation of the Group VI Isolation logic occurred, resulting in isolation of the Secondary Containment and initiation of the Standby Gas Treatment (SGT) System. The actuation occurred due to incorrect placement of a jumper during performance of Surveillance Procedure 6.3.7.5, Reactor Building Ventilation Radiation Monitor Source Check, which was being performed by I&C trainees, under the supervision of qualified I&C Technicians. The procedure was being conducted as a regularly scheduled surveillance test and as an On-the-Job Training (CJT) exercise.

The cause of the unplanned actuation was the failure of both the qualified Technician, acting as an OJT instructor, and the trainee to refer to the procedure step prior to installation of the jumper.

Corrective action taken included test termination, jumper removal, reset of the Group VI Isolation, and restoration of Reactor Building ventilation to normal. The procedure was reviewed and determined to be satisfactory from a content and human factors standpoint. Both the qualified I&C Technician and the trainee were counseled. Further corrective action to be taken includes incorporation of this event in Industry Events training for I&C Technicians.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-820), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20586, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)  Cooper Nuclear Station	DOCKET NUMBER (2)  0 5 0 0 0 2 9 8	LER NUMBER (6)			PAGE (3)		
		YEAR 9 1	SEQUENTIAL NUMBER 0 0 1	REVISION NUMBER 0 0	0 2	OF	0 3

TEXT (if more space is required, use additional NRC Form 386A's) (17)

A. Event Description

On January 7, 1991, at 1:38 pm, an unplanned Group VI Isolation occurred while performing surveillance testing. Surveillance Procedure 6.3.7.5, Reactor Building Ventilation Radiation Monitor Source Check, was being performed as a regularly scheduled surveillance test and as an On-the-Job Training (OJT) exercise. The test had proceeded to the point where the first of the two monitors had been successfully tested, and the trainees had been reassigned to new "stations". In setting up for the test of the second monitor, RMP-RM-452B, the trainee in the Control Room was instructed to install a jumper at the location pointed out to him by the qualified Technician. However, neither the qualified Technician nor the trainee referred to the procedure step, nor rechecked their work, to ensure jumper location was correct. In fact, the jumper was installed where it had previously been installed during testing of RMP-RM-452A. Consequently, several steps later in the procedure, when monitor RMP-RM-452B was exposed to the source, a trip signal was generated in the Group VI ESF logic, resulting in isolation of Secondary Containment and initiation of the Standby Gas Treatment (SGT) System.

B. Plant Status

The plant was in normal operation at full power.

C. Basis for Report

An unplanned actuation of an ESF (Group VI Isolation), reportable in accordance with 10CFR50.73 (a)(2)(iv).

D. Cause

Personnel. Neither the qualified I&C Technician nor the trainee consulted the procedure step for exact jumper placement, nor rechecked their work after placement, to ensure its installation in the correct location.

E. Safety Significance

No significant effect. Other than isolation of the Secondary Containment and startup of the SGT System, plant operation was unaffected. The Group VI Isolation ESF functioned as designed.

F. Safety Implications

Upon Secondary Containment isolation, ventilation to the Reactor Recirculation Pump Motor Generator (RRMG) Sets is lost. If ventilation is not immediately restored, the RRMG Sets may trip due to high winding temperatures, resulting in loss of the Reactor Recirc (RR) Pumps. This consideration has a high probability of occurrence during hot weather conditions with the plant at full power. Upon loss of the RR Pumps, a plant trip may result. Regardless, plant recovery will require that the plant be shut down.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 30.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530) U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20585, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104) OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)  Cooper Nuclear Station	DOCKET NUMBER (2)  0   5   0   0   0   2   9   8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (if more space is required, use additional NRC Form 386A (2/117))

G. Corrective Action

The surveillance test was terminated, the jumper removed, the isolation signal was reset, and normal Reactor Building ventilation was restored. The procedure was reviewed and determined to be satisfactory from a content and human factors standpoint. Following confirmation of the cause of the trip and review of the procedure, the surveillance test was satisfactorily completed. Both the qualified Technician and the trainee were counseled regarding their failures to implement procedural requirements. Further corrective actions to be taken includes incorporating this event in Industry Events training for I&C Technicians.

H. Similar Events

88-017      Unplanned Automatic Actuation of Engineered Safety Features Due to Human Error During Surveillance Testing.