



Nebraska Public Power District

COOPER NUCLEAR STATION
P.O. BOX 98, BROWNVILLE, NEBRASKA 68321
TELEPHONE (402) 825-3811

NLS940129

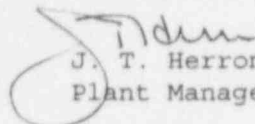
December 12, 1994

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

Dear Sir:

Cooper Nuclear Station Licensee Event Report 94-030 is forwarded as an attachment to this letter.

Sincerely,


J. T. Herron
Plant Manager

/nr

Attachment

cc: L. J. Callan
G. R. Horn
J. H. Mueller
R. G. Jones
R. A. Sessoms
K. C. Walden
INPO Records Center
NRC Resident Inspector
R. J. Singer
CNS Training
CNS Quality Assurance

cert # P103 998671
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NRC FORM 366 (5-92)		U.S. NUCLEAR REGULATORY COMMISSION			APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95					
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)								ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, 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) 05000298		PAGE (3) 1 OF 3			
TITLE (4) Failure to properly satisfy Technical Specification requirement for fire barrier inspection due to inspection by an uncertified inspector.										
EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	10	94	94	--030--	00	12	12	94	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9)		N		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)						
POWER LEVEL (10)		0		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)
				20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
				20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER
				20.405(a)(1)(iii)		X 50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)
				20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
				20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		
LICENSEE CONTACT FOR THIS LER (12)										
NAME Alan J. Horn Staff Support Engineer, Nuclear Licensing and Safety								TELEPHONE NUMBER (Include Area Code) (402) 825-3811		
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURE R	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
N/A	N/A	N/A	N/A	N						
SUPPLEMENTAL REPORT EXPECTED (14)						EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).				X NO						
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16) On October 10, 1994, the ceiling plugs in the Service Water (SW) pump room were reinstalled as part of maintenance activities. Technical Specifications require a visual inspection to verify fire barriers are functional following maintenance. A utility person signed the inspection procedure which subsequently led to securing the fire watch in the room (established because the Halon system is inoperable with the ceiling plugs removed). About twelve hours later it was determined that the inspection was invalid since the person was not QC certified for this inspection. The ceiling plugs were inspected by a QC certified inspector and signed-off as functional. No additional work on the ceiling plugs was performed during that twelve hour period. Because the barrier was subsequently shown to be functional this event was not originally determined to be reportable. Upon review of this event on November 11, 1994, it was determined to be reportable due to the non-QC certified inspection not satisfying Technical Specification requirements. The cause of this event was personnel error (NUREG-1022, Cause Code A) due to inadequate interface between the Control Room and maintenance supervision in identifying the QC certification of the person doing the original inspection. Corrective action consisted of the Maintenance Manager issuing instructions to assure maintenance personnel are aware of their QC certifications and to assure the Control Room notifies maintenance shop supervision when support for non-emergency work is required. In addition, monthly QC certification reports will be provided to maintenance shops until a computerized tracking system provides real time certification information.										

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
COOPER NUCLEAR STATION	05000298	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		94	-- 030 --	00	

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

Plant Status

On October 11, 1994, when this condition was discovered, the plant was in cold shutdown at approximately 110 degrees Fahrenheit with the Residual Heat Removal system providing shutdown cooling.

Event Description

On October 10, 1994, as part of maintenance activities on a Service Water (SW) pump (EIIIS: P), the SW pump room ceiling plugs were reinstalled. Surveillance Procedure (SP) 6.4.5.16.2, "Fire Barrier/Fire Wall Visual Inspection," provides the Technical Specification required visual inspection prior to declaring a fire barrier functional in order to secure the compensatory fire watch which was established when the plugs were removed. This fire watch was established due to the plug removal making the Halon system (EIIIS: KP) inoperable.

The person called upon by the Control Room to do the inspection of the ceiling plugs was uncertain if he was Quality Control (QC) certified for this inspection, nor did the Control Room know if he was QC certified to perform the inspection. The person was qualified to perform Technical Specification fire door inspections and considered inspecting the ceiling plugs essentially the same. The individual performed the inspection and signed-off in SP 6.4.5.16.2 that the ceiling plug installation was satisfactory. The Halon system was declared operable by the Control Room and the fire watch was secured.

About twelve hours later, on October 11, 1994, it was determined that the person who signed the SP was not properly certified as a QC inspector for this inspection as required by the procedure. A certified QC inspector immediately reinspected the ceiling plugs and satisfactorily completed the SP. There was no additional work performed on the ceiling plugs from the time of reinstallation to the time the QC inspection was performed. The functionality of the ceiling plugs was considered satisfactory from the time of reinstallation.

Subsequently, on November 11, 1994, upon review of this event, it was determined to be reportable since the inspection performed by the non-QC certified person was not acceptable for the visual inspection prior to declaring the fire barrier functional following repairs or maintenance as required by the Technical Specifications. This determination was not made earlier because it was considered a procedure deviation that did not affect the physical condition of the plant.

Safety Significance

This event was not safety significant because the ceiling plugs were installed properly and the fire barrier was determined to be functional by the QC certified inspector.

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

Cause

The root cause of this condition was personnel error due to inadequate interface between the Control Room and maintenance supervision. This resulted in not properly recognizing or verifying the QC certification of the person asked to perform the inspection. This situation was unclear to personnel involved since the person who was asked to perform the inspection was qualified to perform Technical Specification fire door inspections and the ceiling plug inspection was considered similar.

Corrective Action

1. The Maintenance Manager issued a memo to the maintenance shops emphasizing that all maintenance personnel shall be aware of the tasks they are QC certified to perform and the steps they are to take if they are uncertain of their QC certifications.
2. The Maintenance Manager issued a memo to the Operations Manager for distribution to the shift supervisors and maintenance personnel to emphasize that maintenance shop supervisors should be notified when maintenance support for non-emergency work is required so that similar instances do not occur.
3. The Maintenance Department will generate a QC Certification Report on a monthly basis. This report will be distributed to the shops and used by shop supervision and craftsmen to verify QC certifications prior to performing inspections. The first report will be issued prior to December 31, 1994. This is an interim measure until this information can be provided on a real time basis with the computerized Training Tracking System.

Similar Events

LER 93-036, Rev. 1 Inoperable Technical Specification Fire Doors Without Appropriate Fire Watches Resulting From Personnel Error, Training, and Procedure and Administrative Control Deficiencies.

Correspondence No: NLS940129

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 to the NRC for the NRC's information and are not regulatory commitments. Please notify the Licensing Manager at Cooper Nuclear Station of any questions regarding this document or any associated regulatory commitments.

[illegible]