Nebraska Public Power District

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NLS950231

November 27, 1995

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555-0001

Dear Sir:

Cooper Nuclear Station Licensee Event Report 95-016 is forwarded as an attachment to this letter.

Sincerely,

J. T. Herron
Plant Manager

CCT

Attachment

cc: L. J. Callan
G. R. Horn
J. H. Mueller
R. G. Jones
R. A. Sessoms
M. F. Peckham
R. L. Gardner
N. E. Champlin
T. N. Ferrando
INPO Records Center
NRC Resident Inspector
R. Turnbull
CNS Training
CNS Quality Assurance

NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), 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.

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	
COOPER NUCLEAR STATION	05000298	1 OF 3

TITLE (4)

Control Room Emergency Filter System Inoperable During Refueling Operations Due to Personnel Error

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	27	95	95	-- 016 --	00	11	27	95	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	20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	X 50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Calvin C. Taylor, Licensing and Compliance Specialist	(402) 825-3811

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

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)

At 0256 CST, on October 27, 1995, during a core off-load the Main Control Room Supply Fans were mistakenly shutdown while removing the nonessential Control Building HVAC system from service to support refueling outage (RE16) maintenance. This rendered the single train Control Room Emergency Filter System inoperable. The operator promptly realized his mistake and restored the Control Room ventilation after a period of nine minutes. This event would have resulted in the Control Room Emergency Ventilation System being unable to mitigate the consequences of a refueling accident as described in Chapter 14 of the SAR.

The cause of this event is Personnel Error, (NUREG 1022, Appendix B, Root Cause Code A). The Licensed Operator responsible for this event produced a Lessons Learned memo and has been counseled by his supervision on the importance of the self-checking concept of STAR (Stop, Think, Act, Review).

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL	REVISION	
COOPER NUCLEAR STATION	05000298	95	-- 016 --	00	2 OF 3

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

PLANT STATUS

Cooper Nuclear Station (CNS) was in Cold Shut Down with refueling operations in progress for the current refueling outage, (RE16). A core off load was in progress.

EVENT DESCRIPTION

At 0215 CST, on October 27, 1995, a Licensed Operator (LO) was assigned to work with the electric shop to de-energize a motor control center (MCC) [EIIS identifier - EC] to support planned maintenance on 480V breakers. At 0220 the LO discussed the job scope with the lead electrician who expressed a desire to de-energize an MCC within an hour so that preventive maintenance could be completed. The LO determined that de-energizing MCC-CA would impact operations the least. The operator researched the requirements to de-energize MCC-CA and received permission from the Shift Supervisor to proceed. The LO was qualified to perform this task and permission as an off watch operator to perform this task was also received from the Control Room Supervisor (SRO). A pre-job brief was neither required nor given due to the simplicity and routine nature of this task. The LO had a firm understanding of what was to be accomplished and had the station operating procedure 2.2.38 (Reference Use) in hand. Requirements for de-energizing MCC-CA included removing control building nonessential ventilation from service. Vertical Board "R" [ECBD], where the fan controls are located, has twelve fans with a label ending in _F-C-1A or B in an area of less than two square feet. All labels are similar except for the Component Identification Codes (CICs).

At 0256, the LO opened the switches of SF-C-1A and SF-C-1B (control room supply fans) [FAN] instead of BF-C-1A and BF-C-1B (control building recirculation fans) [FAN]. Shutting off the control room supply fans rendered the single train Control Room Emergency Ventilation System [VI] inoperable. At 0300, the LO sensed an anomaly with the control building ventilation when leaving the control room to hang clearance tags. The LO returned to the control room and informed the Shift Supervisor that the control room supply fans appeared to have been mistakenly shutdown. At 0305, the control room ventilation was restored by restarting a control room supply fan.

CAUSE

The cause of this event is Personnel Error, (NUREG 1022, Appendix B, Root Cause Code A). A review of the operating procedure found the guidance to be accurate and easily accomplished. The labeling on Control Room vertical board "R" was found to be accurate.

Contributing to this event was perceived schedule pressure and overconfidence of the LO performing this simple task.

SAFETY SIGNIFICANCE

The operator promptly realized his mistake and restored the Control Room ventilation after a period of nine minutes.

This event would have resulted in the Control Room Emergency Ventilation System being unable to mitigate the consequences of a refueling accident as described in Chapter 14 of the SAR. During refueling operations the single train Control Room Emergency Ventilation System is required to be operable per CNS Technical Specifications.

The safety significance is minimal as the probability of a refueling accident during the nine minutes the Control Room Emergency Filter System was inoperable is low and the system could have been rapidly restored to service.

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL	REVISION	
COOPER NUCLEAR STATION	05000298	95	-- 016 --	00	3 OF 3

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

CORRECTIVE ACTION

The LO responsible for this event produced a Lessons Learned memo which the LO distributed to all operators. In addition the LO has been counseled by his supervision on the importance of the self-checking concept of STAR (Stop, Think, Act, Review).

SIMILAR EVENTS

LER 93-003 documented the loss of shutdown cooling on March 6, 1993, due to inadvertently tripping the 480V feeder breaker to a safety-related MCC. The cause was identified as personnel error by a non-licensed operator due to inadequate self-checking. Meetings were held to communicate management expectations for personnel performance and the responsible operator presented a lessons learned to shift operators. Self-checking training was enhanced and additional labeling and visual identification aids were evaluated.

LER 90-004 documented an inadvertent emergency diesel generator start April 14, 1990, due to operating the incorrect breaker control switch. The cause was cognitive personnel error by licensed operators. The operator performing the evolution failed to verify that the correct breaker control switch was selected prior to its operation. The procedure used to operate the switch was reviewed as part of the procedure upgrade program and the event was included in industry events training.

LER 87-009 documented a reactor trip on February 18, 1987, due to a non-licensed operator tripping the operating Reactor Feedwater Pump. The cause was personnel error and the lack of human factors in component equipment labeling. Corrective actions were implemented to discuss the event with operations personnel and improve labeling.

Correspondence No: NLS950231

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.

COMMITMENT	COMMITTED DATE OR OUTAGE
NONE	