PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-IV-96-004

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region IV staff in Arlington, Texas on this date.

Facility
Nebraska Public Power District
Cooper 1
Brownville, Nebraska
Dockets: 50-298

Licensee Emergency Classification
Notification of Unusual Event
Alert
Site Area Emergency
General Emergency
X Not Applicable

Subject: TERMINATION OF LICENSED OPERATORS

On January 13, 1996, the licensee informed the NRC that two licensed operators (a senior reactor operator and a reactor operator) were suspended without pay pending termination on January 19. The action was taken for gross misconduct on the part of the operators. The specific reasons for the terminations were: (1) failure to correctly implement instructions from the Shift Supervisor (SS), (2) knowingly withholding information from the Control Room Supervisor (CRS) and SS, and (3) taking corrective actions on their own, contrary to procedure, which had the potential to put the reactor core at risk.

On January 7, 1996, at 99 percent power, reactor recirculation Pump A tripped, and the plant responded as expected. The SS contacted the reactor engineer (RE) at home who gave instructions to insert control rods using the reverse order reflected in the control rod sequence and movement control procedure. The SS gave these instructions to the two operators assigned to rod movement. The operators mistakenly inserted rods beginning with the wrong rod group. Realizing their error, the operators began inserting additional control rods in the correct sequence. After inserting one rod group in the correct order, the operators noted that they were still at the 106 percent rod line (which they considered to be high) and began inserting emergency insertion (CRAM) rods. Upon his arrival, the operators informed the RE of the rod insertion error. The RE assessed the situation and preliminarily determined that no thermal limits were exceeded. When rod movement was halted (to accommodate removal of a reactor feed pump from service), the operators discussed their error with the RE, who confirmed that this could be viewed as a reactivity mismanagement event. At that time, the RE determined that the operators had not informed the SS or CRS and suggested they do so. At his recommendation, the operators then informed the CRS and SS of the sequence error. The SS informed the Plant Manager and the Operations Manager, and the Site Manager was contacted. Licensee management responded to the control room to ensure the mispositioning incident was properly handled.

On January 8, 1996, during investigation of the event, licensee management determined that the operators did not immediately inform the SS or CRS of the out-of-sequence rod insertion and began to correct their error without the authorization required by the rod sequence procedure. Licensee management immediately removed the shift crew from duty.

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The licensee formed an independent assessment team, led by the Quality Assurance Division Manager and augmented by senior industry personnel to evaluate the actions taken by the operations shift crew. The assessment team presented its findings to the Vice President, Nuclear on January 13, 1996. After reviewing the assessment team's findings and directly interviewing the individuals involved, senior licensee management took the personnel actions previously stated. Licensee management discussed the reasons for the terminations with the entire operations staff and all management and supervisory personnel on January 13, 1996. On January 14, 1996, the supervisors and managers discussed the event with their staff.

Region IV dispatched a senior inspector from the Division of Reactor Safety to obtain a comprehensive understanding of the events that took place and ensure that the licensee's followup actions are appropriate.

The states of Missouri and Nebraska were not notified.

Region IV received notification of the terminations from the Resident Inspector at 4 p.m. (CST), on January 13, 1996.

The information herein has been discussed with the licensee and is current as of January 17, 1996.

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