



Omaha Public Power District  
444 South 16th Street Mall  
Omaha NE 68102-2247

September 26, 1997  
LIC-97-0154

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 97-014 Revision 0 for the Fort Calhoun  
Station

Please find attached Licensee Event Report 97-014 Revision 0 dated  
September 26, 1997. This report is being submitted pursuant to  
10CFR73.71. If you should have any questions, please contact me.

Sincerely,

S. K. Gambhir  
Division Manager  
Engineering & Operation Support

EPM/epm

Attachment

c: Winston and Strawn  
E. W. Merschoff, NRC Regional Administrator, Region IV  
L. R. Wharton, NRC Project Manager  
W. C. Walker, NRC Senior Resident Inspector  
INPO Records Center

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NRC FORM 366 (4-95)		U.I. NUCLEAR REGULATORY COMMISSION			APPROVED BY OMB NO. 3150-0104 EXPIRES 4/30/98					
<b>LICENSEE EVENT REPORT (LER)</b>										
* (See reverse for required number of digits/characters for each block)										
FACILITY NAME (1) Fort Calhoun Station Unit No. 1					DOCKET NUMBER (2) 05000285			PAGE (3) 1 OF 4		
TITLE (4) Uncompensated Loss of a Single Security Alarm Intrusion Zone										
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
08	31	97	97	-- 014 --	00	09	26	97		05000
OPERATING MODE (9) 1										
POWER LEVEL (10) 100										
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§ (Check one or more) (11)										
			20.2201(b)			20.2203(a)(2)(v)			50.73(a)(2)(i)	
			20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)	
			20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii) X	
			20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)	
			20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)	
			20.2203(a)(2)(iv)			50.36(c)(2)			50.73(a)(2)(vii)	
OTHER										
Specify in Abstract below or in NRC Form 366A										
LICENSEE CONTACT FOR THIS LER (12)										
NAME Ben L. Kindred, Supervisor Nuclear Security Operations							TELEPHONE NUMBER (include Area Code) 402-533-6604			
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)										
YES (If yes, complete EXPECTED SUBMISSION DATE)					X NO					
								EXPECTED SUBMISSION DATE (15)		
								MONTH	DAY	YEAR
ABSTRACT (Limit to 1400 spaces i.e., approximately 15 single-spaced typewritten lines) (16)										
<p>At 0645 hours on August 31, 1997, a perimeter microwave intrusion alarm on Zone 2 was received in the security alarm stations. The Central Alarm Station (CAS) Operator, who is primarily responsible for the alarm, assessed the alarm with the Closed Circuit Television (CCTV) system and determined the cause of the alarm to be birds in the zone. The CAS Operator then acknowledged the alarm, and monitored the zone, but failed to reset the alarm. Concurrently, the Secondary Alarm Station (SAS) Operator received the intrusion alarm and also observed the birds in the zone, but failed to realize that the CAS Operator had not reset the alarm. At 0656 hours the night shift CAS Operator was relieved by the day shift CAS Operator. At 0659 hours the new CAS Operator discovered that an alarm on Zone 2 was pending. At 0700 the CAS Operator reset the intrusion alarm. Approximately fifteen minutes elapsed from the time the alarm was received, to when it was reset.</p> <p>The root cause of this event is attributed to a lack of attention to detail on behalf of both the CAS and SAS Operators, which allowed the alarm stations to leave Zone 2 in alarm beyond the 10 minute criteria.</p> <p>Corrective actions include the re-emphasis of the responsibilities of alarm station operators concerning the resetting of alarms and a review of the event with the security personnel.</p>										

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
Fort Calhoun Station Unit No. 1	05000265	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 4
		97	- 014 -	00	

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

**BACKGROUND**

The Fort Calhoun Station (FCS) Site Security Plan, Section 8.4.1 states, in part, that the Central Alarm Station (CAS) Operator is responsible for the processing and logging of alarms and is the coordinating point for response actions. Section 8.4.2 of the Plan states that for any reason the CAS Operator is not responding to an alarm, the Secondary Alarm Station (SAS) Operator will take over the CAS Operator's responsibilities. Security Operational Procedure (SECOP) 3A, "CAS/SAS Operating Procedure," Section 2.2.4.A.1 states that the CAS Operator shall respond to Protected Area Perimeter Alarms as follows:

"The CAS Operator will initially assess the alarm using the Closed Circuit Television (CCTV) alarm monitors. If a reason for the alarm is immediately observed by CCTV assessment and is such that a Nuclear Officer response is not required (i.e., animal in zone) and the alarm has returned to normal, the CAS Operator may acknowledge and reset the alarm using "CCTV" for the dispatch code and the appropriate cause code."

SECOP 3A, Section 2.3.5, requires the SAS Operator to identify each alarm received and verify that the correct response has been initiated.

Security Contingency Procedures (SCP) 04, "Compensatory Measures," Section 2.2.6, states that compensatory measures for unplanned losses and degradations will be in place within 10 minutes of the discovery.

Security Administrative Procedure (SAP) 35, Attachment 1, Reporting of Safeguards Events (Examples of Safeguards Events to Be Reported Within 1 Hour), #18, states, "Loss of ability to detect within one or more intrusion detection zones, unless compensated within 10 minutes" is reportable.

**EVENT DESCRIPTION**

At 0645 Central Daylight Time (CDT) on August 31, 1997, a perimeter microwave intrusion alarm was received on Zone 2 in the security alarm stations. The CAS Operator assessed the alarm with the CCTV system and determined the cause of the alarm to be birds in the zone. The CAS Operator then acknowledged the alarm and began monitoring the zone.

Concurrently, the SAS Operator received the intrusion alarm in SAS and also observed birds in Zone 2 with the CCTV system. The SAS Operator observed the CAS Operator acknowledge the intrusion alarm on Zone 2. During this period, the SAS Operator was occupied with communication checks and monitoring, as well as, discussions with the Shift Security Supervisor (also in the SAS) on the activity of fog in the area.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
Fort Calhoun Station Unit No. 1	05000285	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 4
		97	- 014 -	00	

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

The CAS Operator lost track of the time and allowed the intrusion alarm to go uncompensated, and the alarm not to be reset for over 10 minutes.

At 0656, the night shift CAS Operator was relieved by the day shift CAS Operator. At 0659, the new CAS operator discovered that an alarm on Zone 2 was pending. At 0700, the CAS Operator reset the intrusion alarm on Zone 2. The CAS Operator notified the on duty Shift Security Supervisor of the discrepancy. After investigating and discussing the event with the security duty supervisor, it was determined to be a recordable event. A search was conducted of the Protected and Vital Areas with negative results. Alarm histories of other perimeter alarms and vital area doors revealed no unusual activities during or after the event. At 1000 CDT on August 31, 1997, it was determined on review that this event was reportable. At 1024 CDT on August 31, 1997, the NRC Operation Center was notified of this event per 10 CFR 73.71(b)(1). This report is being submitted pursuant to 10CFR73.71(b)(2).

SAFETY SIGNIFICANCE

The event, as described, has no impact on nuclear safety. There were no violations of the Updated Safety Analysis Report (USAR) or Technical Specifications. The loss of alarming capabilities of the perimeter intrusion detection system has no direct impact on plant reliability, availability or personnel safety.

A search of the Protected and Vital Areas was completed once the significance of the event was determined. No discrepancies were noted from the search. The computer record of protected and vital area alarms was reviewed and revealed no unusual activities during or after this event. This indicates that there was no security threat from the event.

CONCLUSIONS

The root cause of this event is attributed to a lack of attention to detail on behalf of both the CAS and SAS Operators, which allowed the alarm stations to leave Zone 2 in alarm beyond the 10 minute criteria. The CAS Operator's primary function during the event was to monitor the alarm and reset it as soon as possible. The SAS Operator's function was to provide backup support to the CAS in the event CAS failed to perform its required duties.

A contributing cause for this event is the lack of communication between the CAS and SAS Operators on the status of the alarm in Zone 2. Had effective communication been established on the status of the alarm and the approaching time limitation, the event could have been circumvented.

A second contributing cause is the failure of the CAS Operator to implement the

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Fort Calhoun Station Unit No. 1	05000285	97	- 014 -	00	4 OF 4

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

fitness for duty policy by not notifying security supervision concerning his health during the shift. The CAS Operator indicated during interviews that he was not feeling well due to the effects from a cold. It is general knowledge that security management will provide a relief for officers who are not feeling well during their shift.

A third contributing cause is the distractions placed upon the SAS Operator (fog, oncoming shift radio checks, and camera assessments directed by the Shift Security Supervisor). Because of these distractions, the SAS Operator failed to provide the necessary backup support to the CAS Operator.

## CORRECTIVE ACTIONS

The following corrective actions have been completed.

1. The alarm station operators involved with this event were retrained on their duties and responsibilities.
2. On August 31, 1997, a memorandum was issued to Sergeants and alarm station operators reviewing the event and reiterating expectations concerning the monitoring and the resetting of alarms, particularly during shift changes.
3. The security event and the Root Cause Analysis (RCA) were reviewed with security personnel during general security force meetings.
4. A letter was issued to security personnel reviewing Fitness for Duty requirements emphasizing the importance of informing supervision of illnesses that would inhibit them from performing their assigned duties.
5. A Security Training Information Notice was issued to review procedures governing response time to alarms and primary responsibilities of the CAS and SAS Operators.
6. Alarm station operators and the Shift Security Supervisor involved in this event received appropriate disciplinary action.
7. Shift Security Supervisory personnel received training on management expectations concerning supervisor oversight of shift activities, identifying and eliminating distractions that occur in the alarm stations.

## PREVIOUS/SIMILAR EVENTS

LER 91-S02 documented a similar previous uncompensated loss of a microwave zone.