ENERGY NORTHWEST

P.O. Box 968 ■ Richland, Washington 99352-0968

October 1, 1999
GO2-99-177

Docket No. 50-397

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Gentlemen:

Subject: **WNP-2, OPERATING LICENSE NPF-21**
LICENSEE EVENT REPORT NO. 1999-S01-00

Transmitted herewith is Licensee Event Report No. 1999-S01-00 for WNP-2. This report is submitted pursuant to 10 CFR 73.71 and discusses the items of reportability, corrective action taken, and action to preclude recurrence.

Should you have any questions or desire additional information pertaining to this report, please call me or PJ Inserra at (509) 377-4147.

Respectfully,

RL Webring
Vice President, Operations Support/PIO
Mail Drop PE08

Attachment

cc: EW Merschoff - NRC RIV
JS Cushing - NRC NRR
INPO Records Center
NRC Senior Resident Inspector - 927N (2)
DL Williams - BPA/1399
TC Poindexter - Winston & Strawn

IE74

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
WNP- 2	50-397	1 OF 3

TITLE (4) FAILURE TO TAKE COMPENSATORY MEASURE WITHIN REQUIRED TIME UPON FAILURE OF AN ISOLATION ZONE MICROWAVE UNIT

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
09	03	1999	1999	S01	00	10	01	1999	FACILITY NAME	DOCKET NUMBER

OPERATING MODE		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
	1		20.402(b)		20.405(c)		50.73(a)(2)(iv)	X	73.71(b)
POWER LEVEL			20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
	78		20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER
			20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
			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	TELEPHONE NUMBER (Include Area Code)
RN Sherman, Licensing Engineer	(509) 377-8616

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED	MONTH	DAY	YEAR
YES (If yes, completed EXPECTED SUBMISSION DATE).	X	NO				

ABSTRACT:

On September 3, 1999, with the plant operating at 78 percent power, an intrusion alarm was received in the Central Alarm Station (CAS) from a microwave unit monitoring a section of the plant protected area isolation zone. The CAS operator, as well as the operator in the Secondary Alarm Station (SAS), acknowledged the alarm and surveyed the alarmed area using the associated closed circuit television (CCTV). However, the operators did not immediately recognize the need for a compensatory measure. In addition, the operators did not continuously monitor the affected microwave zone using the CCTV. Approximately 26 minutes later the SAS operator noted that the microwave alarm was in constant alarm and notified the CAS operator. The CAS operator dispatched a security patrol officer to the affected isolation zone and monitored the zone using the CCTV until the patrol officer arrived. The patrol officer assessed the microwave zone as clear. The patrol officer inspected the microwave zone and noted an accumulation of spider webs. The patrol officer cleared the spider webs from the microwave unit and conducted several walk-through operability tests of the microwave zone. The microwave unit was then declared operational.

The root cause of this event is personnel error. Corrective actions include providing refresher training on compensatory measures and conducting periodic performance assessments with personnel involved in the event.

No intrusion occurred and compensatory measures were in place within approximately 26 minutes. Therefore, the safety consequences of this event are minimal.

LICENSEE EVENT REPORT (LER)

FAILURE TO TAKE COMPENSATORY MEASURE, WITHIN REQUIRED TIME, UPON FAILURE OF ISOLATION ZONE MICROWAVE UNIT

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
WNP-2	50-397	1999	S01	00	2 OF 3

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

Event Description

On September 3, 1999, at approximately 1513 hours, with the plant operating at 78 percent power, an intrusion alarm was received from a microwave unit that was monitoring a section of the plant protected area isolation zone. The CAS operator acknowledged the alarm and surveyed the alarmed area using the associated CCTV. The CAS operator annotated the alarm on the alarm summary as a "false alarm/CCTV shows area clear." The CAS operator did not notice that the microwave unit was in constant alarm. This situation requires continuous monitoring using the CCTV or compensatory posting by a security patrol officer. However, the CAS operator did not monitor the affected microwave zone continuously nor dispatch a security patrol officer within ten minutes pursuant to the Security Plan implementing procedure requirements.

Coincident with the actions of the CAS operator, the officer in SAS heard the original alarm when it sounded, checked the alarm summary to confirm the alarm, and surveyed the associated area using the CCTV for any potential signs of intrusion into the microwave zone. The SAS operator did not continuously monitor the affected microwave zone.

Approximately 26 minutes later (1539 hours), the SAS operator noted that the microwave unit was in constant alarm and notified the CAS operator. The CAS operator immediately dispatched a security patrol officer to the affected microwave zone and monitored the zone using the CCTV until the patrol officer arrived. The patrol officer assessed the microwave zone as clear. The patrol officer inspected the microwave unit and found an accumulation of spider webs blocking the microwave unit head. The patrol officer removed the spider webs and conducted several walk-through operability tests of the microwave zone. The microwave unit returned to normal and was then declared operational.

Telephone notification was made on September 3, 1999, at approximately 1639 hours, to the NRC Operations Center persuant to 10CFR73.71 Appendix G (I) which requires NRC notification within one hour for events of this type.

Immediate Corrective Action

A Problem Evaluation Request was initiated to document the failure to post the required compensatory measure within ten minutes.

Risk Determination

This event has been determined to present no or low risk to the plant safety systems necessary to protect the public health and safety. This determination is based on the following:

1. This event had a low risk of radiological sabotage.
2. This event was not predictable or easily exploitable.
3. This is the first event of this nature to occur within the past 12 months.

Root Cause

This event involved the failure to post a security officer within a required time limit. The root cause for the failure to implement the compensatory measure within ten minutes was personnel error. The CAS operator did not recognize the constant intrusion alarm and, therefore, did not dispatch an officer for compensatory posting. The SAS operator did not check his alarm summary to make sure the CAS operator had taken the proper actions.

Further Corrective Actions

Refresher training on compensatory measures for microwave intrusion alarms will be completed with the CAS/SAS operators involved.

The CAS/SAS operators involved will receive periodic performance assessments while on duty in CAS/SAS during the next three months.

Nuclear Security Officers will receive a training time-out session on preventing security events due to human error.

The Security force completed a time-out session on this event to reinforce procedure compliance.

Security force CAS/SAS operators will participate in a targeted drill pertaining to this incident.

Appropriate disciplinary action will be taken with the officers involved in the event.

Assessment of Safety Consequences

No unauthorized intrusion occurred. No signs of unauthorized entry were detected when the patrol officer arrived. The cause of the alarm was apparent and corrected. Therefore, the safety consequences associated with this event are minimal.

Similar Events

Licensee Event Report 97-S01-00 reported an event that involved an intrusion alarm that was acknowledged and assessed. However, the CAS and SAS operators did not recognize the alarm was in a constant alarm state and did not take actions to post a security officer as a compensatory measure.