

# LICENSEE EVENT REPORT (LER)

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

APPROVED BY OMB NO. 3150-0104 EXPIRES 06/30/2001

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the 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. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)  Cook Nuclear Plant Unit 1	DOCKET NUMBER (2)  05000-315.	PAGE (3)  1 OF 3
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TITLE (4)  Nonconforming Vital Area Barriers
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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
04	30	1999	1999	S003	00	06	01	1999	Cook Nuclear Plant Unit 2	05000-316
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)  5	POWER LEVEL (10)  0%	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)							
		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)		X 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)		50.73(a)(2)(vii)			

LICENSEE CONTACT FOR THIS LER (12)	
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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, complete EXPECTED SUBMISSION DATE).	X	NO					

## ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On April 30, 1999, at approximately 0900 hours EDT, with both units in Mode 5, a vital area (VA) barrier degradation was discovered in a penetration in the floor of the common hallway of the Auxilliary Feed Pump Rooms for Units 1 and 2. This consisted of missing and corroded fasteners on a penetration barrier. At 0910 hours EDT, it was determined that this was reportable as a safeguards event pursuant to the requirements of 10CFR73, Appendix G, paragraph I(c) and 10CFR73.71(b)(1). An Emergency Notification System (ENS) report was made to NRC at 0956 hours EDT on April 30, 1999. The apparent cause for this event was inadequate inspection and maintenance of the VA barrier.

On May 14, 1999, at approximately 1200 hours EDT, with both units in Mode 5, VA barrier nonconformances were discovered in cable tray openings between the Unit 1 and Unit 2 4 KV Rooms and their respective Reactor Cable Tunnels. These consisted of openings which did not meet NUREG 0908 criteria. At 1227 hours EDT, it was determined that this event was reportable pursuant to the same criteria as above. An ENS update report was made to NRC at 1326 hours EDT on May 14, 1999. The apparent cause for this second event was inadequate plant design.

Each of the above barrier degradations and nonconformances were identified during a Security Restart Readiness Self-Assessment team inspection. Upon identification, security compensatory measures were promptly implemented to prevent unauthorized access. Repairs or modifications will be made to the barriers to eliminate the degraded or nonconforming conditions. Compensatory measures will remain in place until the vital area barriers are restored to conforming conditions. Follow-up investigations provided reasonable assurance that these vital areas had not been compromised. Therefore, there were minimal implications to the health and safety of the public as a result of these events.

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**LICENSEE EVENT REPORT (LER)**  
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		1999	S003	00	

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

**Conditions Prior To Event**

Unit 1 Mode 5 in Cold Shutdown

Unit 2 Mode 5 in Cold Shutdown

**Description Of The Event**

On April 30, 1999, at approximately 0900 hours EDT, a vital area (VA) barrier degradation was discovered in a penetration in the floor of the common hallway of the Auxiliary Feed Pump Rooms for Units 1 and 2 during a Security Restart Readiness Self-Assessment walkdown inspection. This consisted of missing and corroded fasteners on a penetration barrier. With the barrier removed, the penetration did not meet NUREG 0908 size criteria. At 0910 hours EDT, it was determined that this nonconformance constituted a discovered vulnerability in a safeguard system that could allow unauthorized or undetected access to a VA for which compensatory measures have not been employed.

On May 14, 1999, at approximately 1200 hours EDT, VA barrier nonconformances were discovered in cable tray openings between the Unit 1 and Unit 2 4 KV Rooms and their respective Reactor Cable Tunnels. These consisted of openings which did not meet NUREG 0908 size criteria. This determination was made after the openings had been measured and a review of engineering drawings confirmed that there were no additional barriers within the fire barrier material located within the opening. At 1227 hours EDT, it was determined that this nonconformance also constituted a discovered vulnerability in a safeguard system that could allow unauthorized or undetected access to a VA for which compensatory measures have not been employed.

**Cause Of The Event**

The apparent cause for the April 30, 1999 event was inadequate inspection and maintenance of the VA barrier. The penetration involved is an opening in the floor of the common hallway of the Auxiliary Feed Pump Rooms for Units 1 and 2. The investigation determined that the opening was identified some time in the past as requiring a security barrier. A barrier was installed, attached to the concrete by bolted clamps. When this barrier was inspected to insure barrier compliance, it was found that one mounting nut/clamp was missing and the remaining mounting bolts were rusted away.

The apparent cause for the May 14, 1999 event was inadequate plant design. Evaluation of the openings for the cable tray wall penetrations between the Unit 1 and Unit 2 4 KV Rooms and their respective Reactor Cable Tunnels identified that the these opening were not in conformance with the requirements of NUREG 0908. The nonconformance of the cable tray penetrations was not readily visible due to fire barrier materials in the openings.

**Analysis of the Event**

At approximately 0910 hours EDT April 30, 1999, with Unit 1 and Unit 2 both in Mode 5, a VA barrier in a penetration in the floor of the common hallway of the Auxiliary Feed Pump Rooms for Units 1 and 2 was identified as nonconforming and vulnerable to possible compromise. The identified conditions constituted a failure, degradation or discovered vulnerability in a safeguard system that could allow unauthorized access to a protected area, material access area, controlled access area, VA or transport for with compensatory measures have not been employed. This event was reported as a safeguards event pursuant to the requirements of 10CFR73, Appendix G, paragraph I(c) and 10CFR73.71(b)(1) (1 hour ENS report). An ENS report was made to the NRC Operations Center at 0956 hours EDT on April 30, 1999.

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

At approximately 1227 hours EDT May 14, 1999, with Unit 1 and Unit 2 both in Mode 5, VA barriers were identified as nonconforming and vulnerable to possible compromise. The identified conditions constituted a failure, degradation or discovered vulnerability in a safeguard system that could allow unauthorized access to a protected area, material access area, controlled access area, VA or transport for with compensatory measures have not been employed. This event was reported as a safeguards event pursuant to the requirements of 10CFR73, Appendix G, paragraph I(c) and 10CFR73.71(b)(1) (1 hour ENS report). An ENS report was made to the NRC Operations Center at 1326 hours EDT on May 14, 1999.

This report, which addresses both of the above events, is being made pursuant to the requirements of 10CFR73, Appendix G, paragraph I(c) and 10CFR73.71(d) (30 day report).

Compensatory measures were established by security upon identification of the VA barrier vulnerabilities. Follow-up investigations provided reasonable assurance that these VA barriers had not been compromised. Therefore, there were minimal implications to the health and safety of the public as a result of these events.

**CORRECTIVE ACTIONS**

Compensatory measures were established by security upon identification of the VA barrier vulnerabilities. These actions included immediately posting an armed security officer upon discovery.

Temporary repairs were completed on the barrier for the opening in the floor of the common hallway of the Auxiliary Feed Pump Rooms at 1115 hours EDT on April 28, 1999, with permanent repairs scheduled for implementation. This secured the barrier sufficiently to allow reduction of compensatory measures to periodic patrols by security personnel.

The openings for the cable tray wall penetrations between the Unit 1 and Unit 2 4 KV Rooms and the Unit 1 and 2 Reactor Cable Tunnels will be modified to ensure compliance with NUREG 0908. Compensatory measures will remain in place until the VA barriers are restored to conforming conditions.

The ongoing Security Restart Readiness Self-Assessment team inspections will address the identification and correction of existing VA area barrier vulnerabilities due to design, materiel deficiencies or other causes prior to restart from the current outages of both units.

Security will prepare and implement a procedure for future refueling outages to inspect VA barriers to identify and correct degraded and nonconforming conditions.

**SIMILAR EVENTS**

315/99-S001-00

315/99-S002-00