Communication

CROSS REFERENCE:

4.a: Communications - Clarity

SCENARIO/EVENT:

Scenario 6, Event 4: Controlling Pressurizer Level Channel LT-459 Failed Low

EXPECTED ACTION/RESPONSE:

The applicant, as Senior Reactor Operator (SRO), was expected to accurately state the status of FIC-0121 during the crew brief that was performed following plant stabilization.

APPLICANT ACTION/RESPONSE:

In response to LT-459 failing low, the applicant directed the Reactor Operator (RO) to place FIC-0121 in manual to control pressurizer level. However, approximately one minute later, the applicant stated during a crew brief that FIC-0121 was in automatic. The RO quickly corrected the communication error. The applicant was downgraded due to not clearly and accurately communicating the status of FIC-0121 to the crew.

The applicant made three non-critical errors in this rating factor; therefore, a score of "1" was assigned.

LACK OF ABILITY/KNOWLEDGE:

The applicant demonstrated a weakness in her ability to correctly communicate the status of FIC-0121 to the crew during a brief.

POTENTIAL CONSEQUENCES:

The potential consequences of not correctly communicating component status to the crew include incorrect operator actions and confusion as to actions that may be required.

K/A (SRO IMPORTANCE RATING): G2.1.17 (4.0)

It was mention more than once that the controller was in manual during this briefing. In one sentence the word "automatic" was used. This was a **briefing** and nothing was directed to be performed during the briefing. This is the example of a comment that would not have any impact. The status of the controller was discussed in the briefing and the discussion centered around the crew taking the controller back to automatic once the briefing was over.

CROSS REFERENCE:

4.a: Communications - Clarity

SCENARIO/EVENT:

Scenario 6, Event 4: Controlling Pressurizer Level Channel LT-459 Failed Low

EXPECTED ACTION/RESPONSE:

The applicant, as Senior Reactor Operator (SRO), was expected to enter the correct procedure (18001-C) and begin performing the steps to address the failure of LT-459. The applicant was not expected to direct the Unit Operator (UO) to perform Immediate Operator Actions because there were no Immediate Operator Actions associated with this failure.

APPLICANT ACTION/RESPONSE:

The applicant, in response to LT-459 failing low, directed the UO to perform Immediate Operator Actions. The UO responded that no Immediate Operator Actions existed. The applicant then proceeded to enter the correct procedure and perform steps in the correct section of that procedure. After the scenario, the applicant was asked what Immediate Operator Actions she had intended the UO to perform after the associated alarms were received. The applicant stated that she had "misspoke" when providing that direction. The applicant was downgraded in this competency because she did not communicate in a clear, accurate, and easily understood manner when she provided direction to the UO to perform Immediate Operator Actions that did not exist for the failure of LT-459.

The applicant made three non-critical errors in this rating factor; therefore, a score of "1" was assigned.

LACK OF ABILITY/KNOWLEDGE:

The applicant demonstrated a weakness in her ability to communicate in a clear, accurate, and easily understood manner when she provided direction to the UO to perform Immediate Operator Actions that did not exist.

POTENTIAL CONSEQUENCES:

The potential consequences of incorrectly directing immediate operator actions include creating confusion surrounding the correct diagnosis of plant conditions.

K/A (SRO IMPORTANCE RATING): G2.1.17 (4.0)

Directing the operator to perform Immediate Operator Actions did not in any way hinder the performance of the Abnormal Operating Procedure entry. The applicant identified that she misspoke. At no time was there any confusion as to what was expected to occur. After the correction, the correct AOP was entered and the failure was addressed. No consequences could occur, nor did this have any effect on the diagnosis of the event.

CROSS REFERENCE:

4.a: Communications - Clarity

SCENARIO/EVENT:

Scenario 7, Event 7: MFRV #3 Failed Shut Requiring Reactor Trip, Three Stuck Rods

EXPECTED ACTION/RESPONSE:

The applicant, as Reactor Operator (RO), was expected to state that pressurizer pressure was not less than 1870 psig in accordance with procedure 19000-C, "E-0 Reactor Trip or Safety Injection," Step 4 RNO.

APPLICANT ACTION/RESPONSE:

When the Senior Reactor Operator (SRO) directed the applicant to "check if SI is required," the applicant initially checked steam generator pressures, and then incorrectly informed the SRO that <u>pressurizer</u> pressures were 1020 psig and stable. The SRO did not correct the communication, nor did the applicant correct the false information. The SRO did not direct any incorrect actions based on the communication error. The applicant was downgraded in this competency because she did not communicate in an accurate manner when a determination was being made on whether safety injection was required.

The applicant made three non-critical errors in this rating factor; therefore, a score of "1" was assigned.

LACK OF ABILITY/KNOWLEDGE:

The applicant demonstrated a weakness in her ability to correctly communicate information to the SRO when checking to see if a safety injection was required.

POTENTIAL CONSEQUENCES:

The potential consequences of providing an incorrect pressurizer pressure include making the wrong decision on whether safety injection is required.

K/A (SRO IMPORTANCE RATING): G2.1.17 (4.0)

CROSS REFERENCE:

4.b: Communications - Crew & Others Informed

SCENARIO/EVENT:

Scenario 3, Event 1: Steam Generator (SG) #4 NR LT-554 Failed High

EXPECTED ACTION/RESPONSE:

The applicant, as Senior Reactor Operator (SRO), was expected to request the Shift Manager's permission prior to placing 1-FIC-540 (SG #4 FRV) back to automatic after selecting the unaffected SG level control channel. Procedure NMP-OS-007-001, Version 9.0, "Conduct of Operations Standards and Expectations," Step 6.29.2.1, states, in part, "When a system or component has been placed in manual due to a transient caused by an automatic control malfunction, SM permission is required prior to returning the system or component to automatic control following stabilization from the transient and correction of the malfunction."

APPLICANT ACTION/RESPONSE:

The applicant incorrectly directed the Unit Operator (UO) to place 1-FIC-540 back to automatic without first getting permission from the Shift Manager. After the applicant gave the direction to the UO, the Reactor Operator (RO) whispered to the applicant that she needed to get the Shift Manager's permission prior to going to automatic. The applicant then instructed the UO to wait to place 1-FIC-540 back to automatic until the Shift Manager's permission was obtained. The applicant obtained the Shift Manager's permission, and then correctly directed the UO to place 1-FCI-540 back to automatic. The applicant was downgraded due to not keeping the Shift Manager informed as required by NMP-OS-007-001. It was only the correction by the RO that allowed the communication requirement to be met.

The applicant made two non-critical errors in this rating factor; therefore, a score of "1" was assigned.

LACK OF ABILITY/KNOWLEDGE:

The applicant demonstrated a weakness in her ability to keep other crew members informed by not getting permission from the Shift Manager prior to placing 1-FIC-540 back to automatic.

POTENTIAL CONSEQUENCES:

The potential consequences of not keeping all crew members informed in accordance with plant administrative procedures is that incorrect decisions could be made, or a delay in actions or response could be incurred while that information is conveyed at a later time.

K/A (SRO IMPORTANCE RATING): G2.1.17 (4.0)

CROSS REFERENCE:

4.b: Communications - Crew & Others Informed

SCENARIO/EVENT:

Scenario 3, Event 4: Controlling Pressurizer Pressure Channel PT-455 Failed High

EXPECTED ACTION/RESPONSE:

The applicant, as Senior Reactor Operator (SRO), was expected to request the Shift Manager's permission prior to placing the pressurizer master pressure controller back to automatic following the selection of an unaffected pressurizer channel. Procedure NMP-OS-007-001, Version 9.0, "Conduct of Operations Standards and Expectations," Step 6.29.2.1, states, in part, "When a system or component has been placed in manual due to a transient caused by an automatic control malfunction, SM permission is required prior to returning the system or component to automatic control following stabilization from the transient and correction of the malfunction."

APPLICANT ACTION/RESPONSE:

The applicant incorrectly directed the Unit Operator (UO) to place the pressurizer master pressure controller back to automatic without first getting permission from the Shift Manager. The applicant was downgraded due to not keeping the Shift Manager informed as required by NMP-OS-007-001.

The applicant made two non-critical errors in this rating factor; therefore, a score of "1" was assigned.

LACK OF ABILITY/KNOWLEDGE:

The applicant demonstrated a weakness in her ability to keep other crew members informed by not getting permission from the Shift Manager prior to placing the pressurizer master pressure controller back to automatic.

POTENTIAL CONSEQUENCES:

The potential consequences of not keeping all crew members informed in accordance with plant administrative procedures is that incorrect decisions could be made, or a delay in actions or response could be incurred while that information is conveyed at a later time.

K/A (SRO IMPORTANCE RATING): G2.1.17 (4.0)

This is new standard that was recently incorporated. Two comments were identified in this area and in each comment it states that the applicant directed/instructed the Operator to place a component back in automatic. Each time the crew corrected and ensured that the SM was notified (No actions were performed). The crew is expected to function as team. If the component were placed in automatic, there are no actions that would occur that would affect the outcome of the scenario or the event.

CROSS REFERENCE:

4.c: Communications - Receive Information

SCENARIO/EVENT:

Scenario 6, Event 1: ACCW Pump #1 Locked Rotor with Failure of the Standby ACCW Pump to Automatically Start

EXPECTED ACTION/RESPONSE-

The applicant, as Senior Reactor Operator (SRO), was expected to acknowledge communication of technical data in accordance with the three-way communication standards stated in procedure 00004-C, "Plant Communications," Revision 9.5. Specifically, during this event when the Unit Operator (UO) stated that alarms were consistent with the failure of the ACCW pump malfunctions, it was expected that the applicant repeat the information and the UO complete the communication by stating that the repeated information was correct.

APPLICANT ACTION/RESPONSE:

The UO clearly stated to the applicant that the alarms were consistent with the ACCW pump malfunctions, but the applicant did not repeat the information. Also, the UO did not ensure that the SRO correctly received the information.

The applicant made one non-critical error in this rating factor; therefore, a score of "2" was assigned.

LACK OF ABILITY/KNOWLEDGE:

The applicant demonstrated a weakness in her ability to correctly receive verbal technical information.

POTENTIAL CONSEQUENCES:

The potential consequences of not receiving information in accordance with plant administrative procedures is that incorrect decisions could be made, or a delay in actions or response could be incurred while that information is conveyed at a later time.

K/A (SRO IMPORTANCE RATING): G2.1.17 (4.0)

This comment is focusing on a portion of the communications that was repeated back - Evaluator identifies the applicant doesn't repeat back that the "alarms are consistent with the failure" although it has already been identified that the pump tripped.