NRC-059
Submitted: August 16, 2013

August 16, 2013

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

In the Matter of	)	
	)	
CHARLISSA C. SMITH	)	Docket No. 55-23694-SP
	)	
(Denial of Senior Reactor Operator License)	)	

NRC STAFF TESTIMONY OF
MARK. A BATES, PHILLIP G. CAPEHART, AND MICHAEL K. MEEKS
IN RESPONSE TO BOARD EXHIBIT BRD-013 AND MR. LEA'S TESTIMONY

Introduction

Q.1. Please state your name, occupation, and by whom you are employed.

A.1. (MAB) My name is Mark A. Bates. Please see my full answer to this question on page 1 of Exhibit NRC-002. A statement of my professional qualifications is available as Exhibit NRC-028.

A.1. (PGC) My name is Phillip G. Capehart. Please see my full answer to this question on page 1 of Exhibit NRC-003. A statement of my professional qualifications is available as Exhibit NRC-029.

A.1. (MKM) My name is Michael K. Meeks. Please see my full answer to this question on page 1 of Exhibit NRC-006. A statement of my professional qualifications is available as Exhibit NRC-030.

Background

Q.2. Please describe the nature of your responsibilities on behalf of the U.S. Nuclear Regulatory Commission (NRC) staff (Staff).

A.2. (MAB) Please see my full answer to this question on page 2 of Exhibit NRC-002.

A.2. (PGC) Please see my full answer to this question on pages 1-2 of Exhibit NRC-003.

A.2. (MKM) Please see my full answer to this question on pages 1-2 of Exhibit NRC-006.

Q.3. Please explain what your overall duties have been in connection with the denial of the Senior Reactor Operator (SRO) license application of Charlissa C. Smith (Ms. Smith).

A.3. (MAB) Please see my full answer to this question on page 2 of Exhibit NRC-002.

A.3. (PGC) Please see my full answer to this question on page 2 of Exhibit NRC-003.

A.3. (MKM) Please see my full answer to this question on pages 2-3 of Exhibit NRC-006.

Q.4. Were you present at the evidentiary hearing in the above-captioned proceeding on July 17-18, 2013?

A.4. (MAB), (PGC), (MKM) Yes, I was present for both days of testimony.

Q.5. Did you hear the testimony offered by Edwin Lea (Mr. Lea) during that proceeding?

A.5. (MAB), (PGC), (MKM) Yes, I did.

Q.6. Have you had the opportunity to review the transcript of the evidentiary hearing?

A.6. (MAB), (PGC), (MKM) Yes, and in particular I have reviewed pages 663-712 of the transcript, which contain the testimony offered by Mr. Lea.

Q.7. Have you reviewed Board Exhibit BRD-013, which was written by Mr. Lea?

A.7. (MAB), (PGC), (MKM) Yes.

Q.8. What is the purpose of this testimony?

A.8. (MAB), (PGC), (MKM) The purpose of this testimony is to respond to BRD-013 and Mr. Lea’s testimony in support of that exhibit.

Discussion – Scenario 3, Event 5 (EHC Pump Trip)

Q.9. Please respond generally to Mr. Lea's arguments by providing a brief summary of why it was proper to assign an error to Ms. Smith with respect to her response to the tripping of an EHC pump.

A.9. (MAB), (PGC), (MKM) In summary, Ms. Smith's performance was properly downgraded because, following the trip of the running EHC pump, she incorrectly believed that the standby EHC pump had failed to automatically start when it was designed to automatically start. This incorrect belief was demonstrated by Ms. Smith's direction to Clearance & Tagging (C&T) to investigate the failure of the standby EHC pump to automatically start, despite the fact that EHC system pressure had not yet decreased to 1400 psig, which is the pressure at which the standby EHC pump would be expected to automatically start, before Ms. Smith had directed the Balance of Plant (BOP) operator to manually start the standby EHC pump. This incorrect belief was verified through post-scenario follow-up questioning during which Ms. Smith stated that the standby EHC pump should have automatically started.[1] Ms. Smith's incorrect belief amounted to a diagnosis error because she should have verified EHC system pressure before concluding that the auto-start feature of the standby EHC pump was malfunctioning. Ms. Smith could have easily done this by asking the BOP operator to report EHC system pressure or by simply walking to the control board and reading the appropriate gauge herself. For failing to ascertain EHC system pressure before concluding that the auto-start feature of the standby EHC pump was malfunctioning, Ms. Smith was properly assessed a Rating Factor (RF) 1.b. error because she made a diagnosis without collecting complete and accurate information.

[1] *See* Exhibit CCS-043, 82.

Please refer to NRC-002, question 11, for a more detailed discussion of the events surrounding this error, as well as the examiner's justification for determining that an error was made and for assigning that error to RF 1.b., "Interpretation/Diagnosis – Ensure Accuracy."[2]

Q.10. Please respond specifically to Mr. Lea's arguments that it was improper to assign an error to Ms. Smith with respect to her response to the tripping of an EHC pump.

A.10. (MAB), (PGC), (MKM) In BRD-013, Mr. Lea states,

> Which action must the applicant perform to successfully complete the task or address the event of the scenario? In one sentence we say that the applicant should start the pump after the EHC pump tripped AND pressure reached 1400 psig. In the next sentence we say that the applicant should start the pump SHORTLY after the EHC pump trips.

Mr. Lea is incorrect in implying that the expected operator actions for this event are somehow mis-written or that Ms. Smith's compliance with the expected operator actions somehow excuses her demonstration of a performance deficiency. The expected operator actions referenced by Mr. Lea provide two correct paths for Ms. Smith to take, and either path would have allowed her to display competence in Competency 1, Interpretation/Diagnosis.[3] It would have been acceptable for Ms. Smith to wait for EHC system pressure to lower to the standby pump auto-start setpoint of 1400 psig, recognize that the standby pump had not automatically started, and then direct the manual start of the standby pump and the subsequent investigation of the standby pump's automatic start feature. This performance would have demonstrated adequate diagnosis of the status of the standby EHC pump. A second, and better, correct path would have been for Ms. Smith to understand that the standby EHC pump had not yet received a demand to automatically start, and then to direct the manual start of the standby pump before EHC system pressure lowered to the standby pump auto-start setpoint. Ms. Smith followed this

[2] Exhibit NRC-002 (Bates Testimony), 20-22; NUREG-1021 (Exhibits CCS-005A, CCS-005B), ES-303, 13.

[3] *See* Exhibit CCS-048, 32-33.

second path and was not downgraded for her directions accomplishing this. Instead, she was downgraded because, after completing these actions, she made a diagnosis that the auto-start feature of the standby pump had failed without collecting the correct information on which this diagnosis could be based. Specifically, since the auto-start setpoint had not been reached, Ms. Smith could not have known whether the auto-start feature of the standby pump was malfunctioning. Therefore, the expected operator actions are properly written and the examiner's assignment of an RF 1.b. error to Ms. Smith was appropriate.

In BRD-013, Mr. Lea states,

> Applicants should be asked followup questions if they did something wrong or actions taken not identified in the event task description. Why the questions? It would appear to me that the applicant recognized that the standby pump tripped and directed actions to start the pump. We then asked a follow-up question and downgraded the applicant on the answer provided.

Mr. Lea argues that there was no reason for the examiner to ask Ms. Smith the follow-up question regarding whether the standby EHC pump should have automatically started.[4] Again, however, this argument misses the actual, documented reason Mr. Smith was downgraded. Ms. Smith specifically directed C&T to investigate a failure of the auto-start feature of the standby EHC pump.[5] However, she had not collected the correct information that would indicate that there may have been a problem with the auto-start feature because the EHC system pressure was always higher than the setpoint that would have demanded the start of the standby pump.[6] Therefore, her direction to C&T indicated that she had made a diagnosis error. In order to confirm this, Ms. Smith was asked a pointed follow-up question. Her response verified that she had made a misdiagnosis. Furthermore, Mr. Lea's incorrect statement in BRD-

[4] *See* Exhibit CCS-043, 82.

[5] *Id*.

[6] *Id*. at 78 (stating that it would take several minutes to reach this pressure but that Ms. Smith started the standby EHC pump in approximately 90 seconds).

013 that "the applicant recognized that the standby pump tripped," when it was the running pump that had tripped, indicates that Mr. Lea has a fundamental misunderstanding of both the design of this scenario event, and the performance of Ms. Smith during this scenario event.

In BRD-013, Mr. Lea states,

> We went on to say that the applicant 'incorrectly diagnosed that EHC pressure had dropped below 1400 psig, which is the standby EHC pump automatic start setpoint.' At no point in our write up did we say what EHC pressure was. What was pressure?

In Ms. Smith's ES-303, the examiner documented that EHC system pressure was greater than 1400 psig at the time that the standby EHC pump was manually started.[7] The examiner did not document the exact EHC system pressure at this time; however, such specificity was not necessary because an applicant's diagnosis that the standby EHC pump should have automatically started at any pressure above 1400 psig is indicative of a performance deficiency.

In BRD-013, Mr. Lea states,

> Did you ask the applicant to show you what the pressure was when the pump was directed to be tripped? Was the applicant who tripped to pump asked the same question? Did you ask the applicant who tripped the pump, why they tripped the pump? Based on the applicant response, was that applicant downgraded?

Again, Mr. Lea's statement demonstrates his misunderstanding of the scenario event and of Ms. Smith's performance. Forms ES-D-1 and ES-D-2 show that no applicant was ever directed to "trip" (*i.e.*, stop) an EHC pump.[8] The scenario event was designed so that the running pump would trip on its own in order to provide the applicants with an opportunity to display competence by either immediately starting the standby pump or waiting until the auto-start setpoint of the standby pump was reached, observing that the standby pump did not automatically start, and then manually starting the standby pump and investigating why its auto-

[7] *See* Exhibit CCS-045, 8.

[8] *See* Exhibit CCS-043, 78.

start feature had failed. If anything, the correct question would be, "was the applicant who started the standby pump asked the same question?" However, even this question misses the point because Ms. Smith was not downgraded for starting the standby pump before its auto-start setpoint was reached, but rather for subsequently investigating the auto-start feature of the standby pump when there had been no indication that that feature had malfunctioned.

Furthermore, it would have made no sense to question the BOP who physically started the standby EHC pump, because the BOP was a surrogate operator. Surrogate operators are used to complete an operating crew to allow the administration of a scenario.[9] Surrogate operators are not taking the test in an attempt to get a license; therefore, they are not evaluated or asked follow-up questions. Rather, surrogate operators are briefed on the scenario and their expected actions before its administration. The fact that the BOP was a surrogate should have been readily apparent to Mr. Lea since he testified that he had reviewed the docket file.[10]

Discussion – Scenario 3, Event 7 (SI/SLI Block)

Q.11. Please respond generally to Mr. Lea's arguments by providing a brief summary of why it was proper to assign an error to Ms. Smith with respect to her attempt to block low steamline pressure Safety Injection/Steamline Isolation (SI/SLI).

A.11. (MAB), (PGC), (MKM) In summary, Ms. Smith's performance was properly downgraded because she initially incorrectly interpreted that the plant conditions that would allow for SI/SLI to be blocked were satisfied. However, these plant conditions were not satisfied as demonstrated by the fact that Ms. Smith's initial attempt to block SI/SLI failed. Ms. Smith indicated in her response to post-scenario follow-up questioning that she did not ensure the accuracy of her initial interpretation by verifying the status of P-11 prior to directing that SI/SLI be blocked.[11] As explained in NRC-002, the status of P-11 is the most meaningful indication of

[9] NUREG-1021 (Exhibits CCS-005A, CCS-005B), ES-302, 4-5.

[10] *See, e.g.,* Exhibit CCS-043, 77 (examiner note stating that the BOP was a surrogate).

whether pressurizer pressure is less than 2000 psig so that SI/SLI may be blocked.[12] Additionally, NUREG-1021 requires applicants to know certain interlocks, such as P-11, from memory.[13] Therefore, Ms. Smith was properly assessed an RF 1.b error because she did not collect complete and accurate information on which to base a diagnosis that the conditions required to permit the blocking of SI/SLI (*i.e.*, that pressurizer pressure was less than 2000 psig as indicated by P-11) were satisfied.

Please refer to NRC-002, question 12, for a more detailed discussion of the events surrounding the error, as well as the examiner's justification for determining that an error was made and for assigning the error to RF 1.b, "Interpretation/Diagnosis – Ensure Accuracy."[14]

Q.12. Please respond specifically to Mr. Lea's arguments that it was improper to assign an error to Ms. Smith with respect to her attempt to block SI/SLI.

A.12. (MAB), (PGC), (MKM) In BRD-013, Mr. Lea states, "[n]ote the procedure did not say as indicated by P-11 status lights." This fact does not excuse Ms. Smith's failure to collect complete and accurate information before directing the block of SI/SLI. Licensed operators are expected to understand and comply with the intent of procedure steps and not to blindly follow them or to satisfy them in an improper manner. The proper manner to satisfy the intent of the procedural step stating "PZR pressure – LESS THAN 2000 PISG" is to verify that pressurizer pressure is less than 2000 psig so that SI/SLI may be blocked. An individual with an adequate understanding of the plant would know that the appropriate indication for whether pressurizer pressure is less than 2000 psig so that SI/SLI may be blocked is the P-11 permissive, because the ability to block SI/SLI is based upon whether this permissive is met. However, Mr. Lea

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[11] *See* Exhibit CCS-043, 81.

[12] Exhibit NRC-002 (Bates Testimony), 22-25.

[13] *Id*. at 24.

[14] Exhibit NRC-002 (Bates Testimony), 22-25; NUREG-1021 (Exhibits CCS-005A, CCS-005B), ES-303, 13.

interprets the procedural language to mean that an SI/SLI block may be attempted when any indication of pressurizer pressure is less than 2000 psig. Thus, he maintains that Ms. Smith's attempt to block SI/SLI based only on reading that one of the four pressurizer pressure instruments indicated less than 2000 psig, and without referring to the status of P-11, was sufficient. This interpretation represents a misunderstanding of how operators are supposed to perform procedural steps.

In BRD-013, Mr. Lea states,

> The block was successfully completed a few minutes later. You also state that the applicant thought pressurizer pressure was 1998 psig and this is why she directed that SI/SLI be blocked. If she thought that pressure was 1998 psig, she was right in directing the action according to procedure because a setpoint was reached.

Mr. Lea is correct in stating that SI/SLI was successfully blocked a few minutes later and that Ms. Smith initially thought that pressurizer pressure was 1998 psig.[15] However, the reason why SI/SLI was successfully blocked a few minutes later was that the simulator provided feedback that informed the crew that blocking was not initially successful and that P-11 was not met prior to the first unsuccessful blocking attempt. Ms. Smith did eventually perform the block properly by waiting for P-11 to be met and then directing the block of SI/SLI, but this was not until after she had already displayed weakness in collecting complete and accurate information for pressurizer pressure by not observing the status of the P-11 interlock. Just because Ms. Smith "thought" that pressurizer pressure was 1998 psig was not sufficient to demonstrate her competency. She was expected to understand that the task of verifying pressurizer pressure less than 2000 psig in order to block SI/SLI meant verifying the status of P-11 and thus she was expected to collect the information appropriate to verify this.

[15] *See* Exhibit NRC-043, 81.

In his testimony, Mr. Lea attempted to justify the fact that Ms. Smith attempted to block SI/SLI without sufficient information by stating that she had only had one indication of pressurizer pressure easily visible to her and that it was difficult for her to determine exactly when pressurizer pressure was less than 2000 psig.[16] Specifically, he stated that Ms. Smith may have been reading a digital indication of pressurizer pressure and that the other gauges indicating pressurizer pressure may have been so far away from Ms. Smith that their increments would be difficult to read.[17] This testimony demonstrates Mr. Lea's misunderstanding of the purpose and location of the P-11 status lights. Ms. Smith's performance was not downgraded because she did not read all of the pressurizer pressure gauges; it was downgraded because she did not verify the status of P-11. This status is indicated by "status lights" readily apparent to an individual in Ms. Smith's position and is not based on gauges with small increments that may be difficult to see. Another consideration that Mr. Lea fails to mention is that it is routine for a Control Room Supervisor (CRS) to request that the board operators provide reports of plant parameters that may not be visible from the CRS's location. Ms. Smith did not request that the board operator report the status of P-11, nor did she personally verify P-11, either of which she could have easily done from her location, prior to the failed block attempt.

Mr. Lea also demonstrates a misunderstanding of how P-11 is designed to work. He discusses "inhibiting" P-11, which does not make sense for a Steam Generator Tube Rupture (SGTR) event.[18] During a SGTR event, SI/SLI is supposed to be blocked so that the condenser remains available for cooling the steam generators and thereby the reactor coolant system. In order to block SI/SLI, P-11 must be actuated, not inhibited.

[16] Transcript of Evidentiary Hearing in the matter of Charlissa C. Smith at 706-07 (July 17-18, 2013) ("Tr.").

[17] *Id*.

[18] *Id*.

Discussion – Scenario 7, Event 6 (RWST Leak)

Q.13. Please respond generally to Mr. Lea's arguments by providing a brief summary of why it was proper to assign an error to Ms. Smith with respect to the Refueling Water Storage Tank (RWST) leak.

A.13. (MAB), (PGC), (MKM) In summary, Ms. Smith's performance was properly downgraded because she demonstrated that she did not know that switches and indications for the sludge mixing isolation valves were located in the main control room. Ms. Smith, along with the rest of her crew, allowed the RWST to drain for 19 minutes (from the alarm at 94% capacity to 86.3% capacity)[19] without anyone from the crew approaching the location of these switches and indications. Ms. Smith had an opportunity to exhibit competence because she was involved in conversations with the crew discussing that these valves should have closed.[20] She was also aware of the information reported to the control room from the field operators that the leak was downstream of the sludge mixing isolation valves.[21] The examiner testimony and notes indicate that, even with all of this information, neither Ms. Smith nor the other members of her crew suggested that the valve positions should be manually verified by looking at the switches and indications in the control room.[22] This verification of the valve positions would have taken just a few seconds and it would have confirmed the crew's knowledge of the cause of the leak (*i.e.*, that the leak was progressing because the sludge mixing isolation valves did not automatically shut). Furthermore, although Ms. Smith was responsible for monitoring the reactor, the reactor was stable and no control manipulations were needed during this casualty.[23] In conclusion, Ms. Smith was presented with the opportunity to exhibit competence, but failed to speak up

[19] Exhibit CCS-047, 76-77.

[20] *Id*.

[21] *Id*.

[22] *Id*.

[23] Tr. at 323.

regarding the location of the switches and indications, demonstrating to the examiner that Ms. Smith did not know the location of the switches and indications and, therefore, should properly be assessed an RF 3.a. error.

The factual dispute between the Region II examiners and the crew members, as made clear during the evidentiary hearing,[24] is whether, during this 19 minute delay, the crew members actually knew the location of the switches and indications in the control room. The examiners inferred that the crew members did not know this since none of the crew members went to, or recommended going to, the location of the switches and indications to verify their belief that the RWST was leaking because the sludge mixing isolating valves had failed to automatically shut until the CRS pointed to this location on the piping and instrumentation diagram (P&ID).[25] The crew members maintain that they always knew the location of the switches and indications but did not go to this location until they had found the appropriate procedure that would allow them to operate the switches.[26]

Please refer to NRC-002, question 18, for a more detailed discussion of the events surrounding the error, as well as the examiner's justification for determining that an error was made and for assigning the error to RF 3.a, "Control Board Operations – Locate & Manipulate."[27]

Q.14. Please respond specifically to Mr. Lea's arguments that it was improper to assign an error to Ms. Smith with respect to the RWST leak.

A.14. (MAB), (PGC), (MKM) In BRD-013, Mr. Lea states,

> You say that the applicant as the RO was not expected to leave the control board, therefore not expected to go and locate the

[24] *Compare* Tr. at 322-347 *with* Exhibit NRC-002, 41-44.

[25] *See* Exhibits CCS-045, 20; NRC-002, 42.

[26] See*, e.g.*, Tr. at 328-29.

[27] Exhibit NRC-002 (Bates Testimony), 41-44; NUREG-1021 (Exhibits CCS-005A, CCS-005B), ES-303, 13.

> valves …….If the BOP pulled the ARP, then the BOP should have read the actions identified in the ARP and performed the actions not the applicant. She is not expected to know the actions of the ARP form [sic] memory."

Ms. Smith's performance was downgraded because the examiner believed that her failure to tell the other crew members the location of the switches and indications for the sludge mixing isolation valves when it appeared that they were looking for these switches and indications indicated that she did not know this information. Ms. Smith was not expected to leave her position and place her hands on the switches and indications; she was only expected to inform the other crew members that the switches and indications were located in the control room on a back panel. Ms. Smith was not downgraded on the use of procedures because she was not responsible for reading and carrying out the procedures. Ms. Smith's assigned error had nothing to do with not knowing procedure actions from memory.

In BRD-013, Mr. Lea states,

> I looked at the Event Sheet and it said this was a CC for the BOP and the SS and a TS for the SS. The applicant should not have been downgraded in this area. Also look [sic] take a look at the writeup for the BOP. Write-up is not very good. It said that the crew took 19 minutes to take actions. What were they doing during the 19 minutes?

It is true that the Forms ES-D-1 and ES-D-2 indicate that it was expected that the BOP (also known as the Unit Operator (UO)) would most likely take the verifiable action of isolating the leak.[28] However, these forms do not limit the opportunities for other applicants to exhibit competence in various RFs. According to the examiner testimony, during the 19 minutes of the RWST leak, the crew was looking at P&IDs without once physically verifying in the control room the position of the valves that would have isolated the leak had they been closed.[29] It was not until the CRS pointed at the designation for panel QPCP on the P&ID that he finally directed the

[28] Exhibit CCS-047, 2, 32-33.

[29] Exhibit NRC-002, 42.

BOP operator to verify the location of the switches for the isolation valves.[30] This indicated to the examiner that, during this 19-minute period, the crew members did not know the location of the switches, despite their later testimony to the contrary.

Finally, in his direct testimony, Mr. Lea stated that Ms. Smith should not have been downgraded because she was assigned to monitor reactivity.[31] However, at this time the reactor was stable and no control manipulations were needed.[32] Ms. Smith was downgraded for demonstrating that she did not know the location of the switches in the control room by not providing this information to her fellow crew members who the examiner believed were actively looking for these switches. She was not downgraded for failing to do something that would have been prohibited by her monitoring the reactivity of a stable plant. Rather, as testified to by Mr. Tucker, it was expected that Ms. Smith, even while monitoring reactivity, would "speak up and offer comments and input."[33]

Conclusion

Q.15. What is your overall evaluation of Mr. Lea's arguments that Ms. Smith was improperly assigned errors?

A.15. (MAB), (PGC), (MKM) In my professional opinion, BRD-013 and Mr. Lea's testimony in support of that exhibit demonstrate that Mr. Lea does not have a solid grasp of the events in question or Ms. Smith's performance during these events. Mr. Lea's arguments do not affect my professional opinion that Ms. Smith's simulator test was graded properly and that the NRC made the proper determination, based on this grade, to deny Ms. Smith's SRO license application.

[30] *Id*.

[31] Tr. at 705.

[32] *Id*. at 323.

[33] *Id*. at 305.

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BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

In the Matter of	)	
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CHARLISSA C. SMITH	)	Docket No. 55-23694-SP
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(Denial of Senior	)	
Reactor Operator License)	)	

AFFIDAVIT OF MARK A. BATES

I, Mark A. Bates, do hereby declare under penalty of perjury that my statements in the foregoing testimony are true and correct to the best of my knowledge and belief.

Executed in Accord with 10 C.F.R. § 2.304(d)

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Executed in Rockville, Maryland
this 16th day of August, 2013

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

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CHARLISSA C. SMITH	)	Docket No. 55-23694-SP
	)	
(Denial of Senior Reactor Operator License)	)	

AFFIDAVIT OF PHILLIP G. CAPEHART

I, Phillip G. Capehart, do hereby declare under penalty of perjury that my statements in the foregoing testimony are true and correct to the best of my knowledge and belief.

Executed in Accord with 10 C.F.R. § 2.304(d)

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Executed in Rockville, Maryland
this 16th day of August, 2013

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AFFIDAVIT OF MICHAEL K. MEEKS

I, Michael K. Meeks, do hereby declare under penalty of perjury that my statements in the foregoing testimony are true and correct to the best of my knowledge and belief.

Executed in Accord with 10 C.F.R. § 2.304(d)

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Executed in Rockville, Maryland
this 16th day of August, 2013