NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), 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.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Dresden Nuclear Power Station, Unit 2	05000237	1 OF 5

TITLE (4)
Inadvertent Exit From the Main Control Room due to SRO Loss of Focus Resulted in Inadequate Control Room Staffing

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	17	97	97	-- 014 --	00	09	12	97	Dresden, Unit 3	05000249
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1 (1)
POWER LEVEL (10)	100 (100)

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(3)(i)		50.73(a)(2)(iii)		73.71(b)
	20.2203(a)(1)		20.2203(a)(3)(ii)		50.73(a)(2)(iv)		73.71(c)
	20.2203(a)(2)(i)		20.2203(a)(4)		50.73(a)(2)(v)		OTHER
	20.2203(a)(2)(ii)		50.36(c)(1)		50.73(a)(2)(vii)		(Specify in Abstract below and in Text, NRC Form 366A)
	20.2203(a)(2)(iii)		50.36(c)(2)		50.73(a)(2)(viii)(A)		
	20.2203(a)(2)(iv)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(B)		
	20.2203(a)(2)(v)		50.73(a)(2)(ii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Sherry L. Butterfield, Trends Analyst Ext. 2652	(815) 942-2920

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)			EXPECTED SUBMISSION DATE (15)	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 August 17, 1997, the Shift Manager provided the Unit 2 Unit Supervisor with an interim relief from the Control Room. When the Unit Supervisor returned to the Control Room from his break, he found that his interim relief had exited the Control Room resulting in a Technical Specification non-compliance for adequate Control Room Staffing. The duration of the non-compliance was verified to be one (1) minute in length, based on the elapsed time from the Shift Manager's exit until the return of the Unit Supervisor. The cause of the event was determined to be a Loss of Focus by the Shift Manager, evident by his failing to remember his interim relief responsibilities. Corrective actions include counseling of the individuals, Revision to station procedures (DAP 07-02) to formalize usage of badge clips to prevent inadvertent Control Room exit, elimination of the practice of allowing the Shift Manager to perform interim relief, and submittal of a supplemental LER to rescind corrective actions of LER 2-97-006.

PLANT AND SYSTEM IDENTIFICATION:

General Electric - boiling water reactor - 2527 MWt rated core thermal power.

Energy Industry Identification System (EIIS) codes are identified in the text as (XX) and are obtained from IEEE Standard 805-1984, IEEE Recommendation Practice for System Identification in Nuclear Power Plants and Related Facilities.

EVENT IDENTIFICATION:

Inadvertent Exit From the Main Control Room due to SRO Loss of Focus Resulted in Inadequate Control Room Staffing

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2(3) Event Date: August 17, 1997 Event Time: 1342

Reactor Mode: 1(1) Mode Name: Run(Run) Power Level: 100(100)

Reactor Coolant System Pressure: 1000(1000) psig

B. DESCRIPTION OF EVENT:

On August 17, 1997 at approximately 1336 hours, the Unit 2 Unit Supervisor [Licensed Senior Reactor Operator] requested an interim relief from the Shift Manager [Licensed Senior Reactor Operator]. The Shift Manager, who was on the phone discussing a concern regarding a Unit 1 Power Center, briefly set aside his conversation to perform the interim turnover. The interim turnover was performed between both parties, limited to acknowledgment that no current activities were in progress on Unit 2. As a result of the failure by the Shift Manager and Unit Supervisor to announce completion of turnover, the balance of the Control Room Operating Team remained unaware of the change in Command and Control for Unit 2. Upon completion of the turnover, the Shift Manager resumed his phone conversation.

As a result of an inadequate control room staffing event in February 1997, it had become an accepted practice to place a clip on the security badge of the SRO in command and control as a reminder of his responsibility and prevent inadvertent exit from the main control room. The clip was used numerous times during the shift by the Unit Supervisor and Shift Manager. Yet, the Shift Manager failed to place a clip on his badge and the Unit 2 Unit Supervisor did not ensure that clip was on the relief's badge as part of turnover for this event.

The Shift Manager concluded his phone conversation at 1341 hours and proceeded to exit the Control Room. His failure to remember acceptance of Unit Supervisor interim responsibility and subsequent exit from the Control Room resulted in leaving only one Unit Supervisor (SRO) within the Control Room, in non-compliance with Technical Specification 6.2.B.2.

The Unit 2 Unit Supervisor returned to the Control Room at 1342 hours and discovered that the Shift Manager was not present in the Control Room. He immediately accepted command and control of Unit 2, and attempted to locate the Shift Manager by phone. The Unit Supervisor found that the Shift Manager's phone was busy and surmised that Shift Manager was in his office. Unit 2 Unit Supervisor referenced Technical Specification 6.2.B.2, verifying that minimal control room manning was not met and referenced the Reportability Manual (SAF 1.15) to determine the reportability requirements.

Shortly thereafter the Shift Manager was contacted and requested to return to the Control Room. Upon his return, interim turnover to the Unit Supervisor was completed and a discussion was held regarding the noncompliance to the Technical Specification. The Unit 2 Unit Supervisor logged the event in the Unit Supervisor Log and completed the required notifications.

The Unit 3 Unit Supervisor obtained a computer printout of the Control Room Access Card Reader from Security and determined that Control Room staffing was in noncompliance with Technical Specifications for one minute. Upon completion of their shift, the Shift Manager and Unit 2 Unit Supervisor were removed from license duties pending further investigation.

This event is reportable per 10CFR 50.73(a)(2)(i)(B), any operation or condition prohibited by the plant's Technical Specifications.

B2. LER/Docket Number 97-006/5000237

In February of 1997, a similar event occurred with the same primary cause of loss of focus by the SRO. For this event, non-compliance to the Technical Specification minimum Control Room staffing requirements was not met, a result of an inadvertent exit of the Main Control after accepting interim command and control responsibility.

Review of the Corrective Actions to prevent recurrence for the February 1997 event determined them to be untimely, as only one of the corrective actions has been completed to date.

In addition to the immediate corrective action of counseling the individuals for the February event, Control Room supervisors employed usage of clips on their security badges, but this practice was in limited use and not proceduralized. Performance of clip placement by the Control Room supervisors, as a reminder of command and control responsibilities, was intended for their short-term use, awaiting implementation of Corrective Actions from the LER. The Operating Department's failure to proceduralize this process for proper implementation resulted in inconsistent operator performance of the action and its ultimate failure to prevent recurrence.

C. CAUSE OF EVENT:

The primary cause was determined to be a cognitive personnel performance error (NRC Cause Code A) by the Shift Manager for his loss of focus of Unit Supervisor responsibilities during the interim turnover in the Control Room, resulting in his exit from the Main Control Room prior to being relieved by the Unit 2 Unit Supervisor. His action of exiting the Control Room to return to his office resulted in non-compliance to Technical Specification 6.2.B.2.

Contributing to the event was the inadequate interim turnover performance by the Shift Manager and the Unit Supervisor. Neither individual demonstrated a questioning attitude and practiced STAR. More importantly, because the Shift Manager is ultimately responsible for Station compliance to the Technical Specifications, his action of exiting the Control Room without adequate manning is in non-compliance with Department Standards. All operator actions involving turnovers of command and control are required to be announced to the Operating Team. There was no announcement of the interim turnover between the Shift Manager and Unit Supervisor. Announcement of turnovers in the Main Control Room communicates to everyone cognizance of who retains command and control within the Main Control Room at all times. The lack of adherence to the interim turnover requirements is in non-compliance of DAP 07-02, Conduct of Shift Operations.

Also a contributing factor was the failure to proceduralize placement of the clip on supervisor security badges when in command and control of the units. Though long term corrective actions were created from the February event, no documented interim actions were put into place until completion of the long term actions.

The corrective actions from the February 1997 LER were aimed at assuring Technical Specification manning compliance through Control Room access control. The decision to utilize such a complex control mechanism resulted in a delayed implementation date, in addition to event recurrence.

D. SAFETY ANALYSIS:

This event had minimal effect on plant or public safety since during the short absence of a licensed SRO from the MCR, the other Unit SRO remained available within the Control Room to perform SRO related duties. Both units remained at steady power during this event, and as a result, the safety significance of this event is considered minimal.

E. CORRECTIVE ACTIONS:

The Operations Department took immediate action to address the Technical Specification noncompliance by performing an Operations standdown with each of the oncoming shifts. During this time, recent operational errors were discussed and reinforcement of Operations Standards for error free reactor operations was performed. (Complete)

The Shift Manager and Unit Supervisor understand their responsibility to adequately self check their actions, the requirement for procedural compliance, and understand how their actions resulted in non-compliance to the Technical Specifications. Operations has taken the appropriate disciplinary actions in accordance with station policy. (Complete)

Operations has revised DAP 07-02, Conduct of Shift Operations, amending the Shift Manager's duties by not allowing him to perform routine interim relief to the Unit Supervisor, except under specific conditions. This is intended to assure that the Shift Manager remains in his primary role and not routinely relieving the Unit Supervisor. DAP 07-02 was additionally revised to provide a more formal step-by-step turnover process, which includes; announcement of all completed turnovers, logging of all turnovers and the requirement for usage of a security badge clip. Implementation of the use of a badge clip indicates when a SRO is in command and control of a unit as well as providing a physical barrier which prevents their security badge from being placed into the card reader. (Complete)

Operations Staff will submit a supplemental LER to rescind the inappropriately selected corrective actions stated in LER 97-006/C5000237. (2371809701401)

F. PREVIOUS OCCURRENCES:

LER/Docket Number	Title
95-007/05000237	SRO Absent From the Main Control Room Due To Judgement Error in Badge Usage

This event was found to differ in the methodology which resulted in the non-compliance to the Control Room manning requirement. For this event, the individual did not utilize his security badge with the intent of exiting the Control Room, instead he opened the door to pass station documents to Work Execution Center personnel. Personnel from this event remained cognizant of their Control Room responsibilities at all times, but having utilized their security badge to attain successful and documented Control Room exit, Dresden decided to (conservatively) report the event.

97-006/05000237	SRO Absent From the Main Control Room Due to Loss of Focus on Interim Duties

This event has the same primary cause which was the loss of focus to interim responsibilities which resulted in exiting of the Control Room and noncompliance to Technical Specification 6.2.B.2. Lack of corrective action timeliness, as a result of their complexity, resulted in untimely action to prevent recurrence.

G. COMPONENT FAILURE DATA:

None