PSE&G

Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038

Salem Generating Station

December 14, 1994

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

Attn: Document Control Desk

SALEM GENERATING STATION
LICENSE NO: DPR-70 and DRP-75
DOCKET NO: 50-272 and 50-311
UNIT NO: 1 and 2

LICENSEE EVENT REPORT NO. 272/94-016-00

This Licensee Event Report is being submitted pursuant to the requirements of Code of Federal Regulation 10CFR50.73(a)(2)(i)(B). Issuance of this report is required within thirty (30) days of event discovery.

Sincerely,

J. J. Hagan
General Manager -
Salem Operations

FW:vs

C Distribution
LER File

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)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Salem Generating Station - Unit 1	05000 272	1 OF 5

TITLE (4) Non-Compliance With Control Room Area Senior Reactor Operator (SRO) Manning Requirements

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
11	16	94	94	-- 16 --	00	12	16	94		05000
									FACILITY NAME	DOCKET NUMBER
										05000

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

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

	20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)
	20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
	20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER
	20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)
	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)
Frederick Wiltsee, LER Coordinator	609 339-5163

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 11/16/94 it was determined that during the last several years there were four occurrences of not meeting requirements for Control Room area Senior Reactor Operator (SRO) manning requirements. The first event was due to poor turnover of the "on duty" SRO function, resulting in the "on duty" SRO going to the Work Control Center(WCC) immediately adjacent to the Control Room area. The remaining events occured when the "on duty" SRO left the Control Room area for the WCC. These events are attributed to personnel error by the SROs allowing themselves to become distracted and leaving the Control Room area. In all cases the SROs went to the WCC immediately adjacent to the Control Room area. Corrective actions include emphasis of expectations for turnover of the "on duty" SRO function, training for appropriate personnel on reporting requirements, placing a mechanical restraint on the security badge of "on duty" SROs to prevent leaving the Control Room area, and an administrative procedure revision to clarify reportability.

Plant and System Identification:

Westinghouse - Pressurized Water Reactor

Energy Industry Identification System (EIIS) codes appear in the text as {xx}

Identification of Occurrence:

Non-compliance With Control Room area Senior Reactor Operator (SRO) Manning Requirements

Event Reportability Date: 11/16/94

Report Date: 12/16/94

This report was initiated by Incident Report No. 94-368.

Conditions at Time of Discovery:

Unit 1: Mode 1 Reactor Power 100 % Unit Load 1150 MWe

Unit 2: Mode 6 Defueled

Description of Occurrence:

As a result of Hope Creek LER 354/94-13-00 on Control Room Shift Manning, the Nuclear Safety Assessment Group (NSAG) performed an independent review to determine if instances of inadequate Control Room staffing had occurred at Salem. This review involved interviews with licensed personnel who identified four separate occurrences of not having met the requirements of Technical Specification 6.2.2.b. The review indicated the individuals were knowledgable of the "on duty" Senior Reactor Operator (SRO) responsibilities. However, they did not recognize the need for an incident report or the possible reportability until after the Hope Creek LER.

In the first occurrence the Senior Nuclear Shift Supervisor (SNSS-SRO licensed) exhibited poor transfer of the "on duty" SRO responsibilities, resulting in the Nuclear Shift Supervisor (NSS-SRO licensed) leaving the Control Room area while he had the "on duty" SRO responsibilities. In this case while the NSS was on the phone, the SNSS informed an unlicensed supervisor that he was going to a meeting and to inform the NSS that he was in charge. Prior to being notified, the NSS went to the Work Control Center (WCC), immediately adjacent to the Control Room area (see Attachment 1). Within minutes (1-2) of entering the WCC, the "on duty" SRO recognized his error and returned to the Control Room area. Operations management discussed the manning requirements and the need to be more attentive to the transfer of the "on duty" SRO responsibilities.

In the remaining three occurrences the NSSs in charge became distracted by other tasks and left the Control Room area for the WCC. Upon realizing their error the individuals immediately returned to the Control Room area. All the above information was provided by the involved licensed individuals when interviewed.

Analysis of Occurrence:

Technical Specification 6.2.2.b requires that at least one SRO shall be in the Control Room area at all times. The four occurrences being reported all relate to not meeting this manning requirement of the Technical Specification.

The first occurrence was due to not having an SRO in the Control Room area. The SNSS did not formally turn over the "on duty" SRO responsibilities to the NSS. The turnover was communicated to a third individual and had not been communicated to the NSS prior to his leaving for the WCC. Upon discovery, the manning requirements were discussed between Operations Management and involved individuals. All understood that actions had to be taken to prevent recurrence of a similar event. However, none were aware of an incident report requirement (including reportability) and all information was provided by the involved licensed individuals when interviewed.

The remaining occurrences were also due to not having an SRO in the Control Room area. However in these cases the individuals had formally received the "on duty" SRO responsibilities and inadvertently left the area for the WCC. As in the first case the individuals were not aware of an incident report requirement (including reportability) and all information was provided by the involved licensed individuals when interviewed.

Apparent Cause of Occurrence:

These events are attributed to "Personnel Error", as classified in Appendix B of NUREG-1022. A contributor to the first occurrence was poor communication of the "on duty" SRO responsibilities. The cause of the remaining occurrences are cognitive as the NSSs allowed themselves to become distracted by other activities and inadvertently left the Control Room area to go to the WCC.

All four cases involved the "on duty" SRO leaving the Control Room area for a very brief period of time. The review determined that the involved individuals did not recognize the need for an incident report due to the short time period involved, the immediate action taken to return to the area and the admistrative nature of the events. The primary causal factor was determined to be that the events were not recognized by the organization as being reportable due to their administrative nature.

Prior Similar Occurrence:

Review of prior Incident Reports and LERs did not show similar occurrences at Salem.

Safety Significance:

This is reported pursuant to the requirements of 10CFR50.73 (a)(2)(i)(B) due to shift composition being less than the minimum required in the Control Room area.

These events were of minimal safety significance since in all cases the SRO was at the WCC immediately adjacent to the Control Room area.

Corrective Action:

Management's expectations for proper turnover of the "on duty" SRO function and reporting requirements have been clarified and re-emphasized.

An appropriate barrier that fits over an individuals security badge is now being used to prevent the "on duty" individual(s) from carding out of the Control Room area.

Additional training will be provided to appropriate personnel on the reporting requirements of 10CFR50.73, NUREG 1022, and Administrative Technical Specifications.

NAP-6 will be revised for Administrative Technical Specifications, Section 6.0, events as an "Off-Normal Event" requiring an incident report.

J. J. Hagan
General Manager -
Salem Operations

FW:vs

REF: SORC Mtg. 94-094

ATTACHMENT 1