

OCT 10 1990

U. S. NUCLEAR REGULATORY COMMISSION
REGION I

EA No.: 90-148

Report No.: 50-219/90-80

Docket No.: 50-219

License No.: DPR-16

Licensee: GPU Nuclear Corporation
P. O. Box 388
Forked River, New Jersey 08731

Facility Name: Oyster Creek Nuclear Generating Station

Meeting at: Region I Office, King of Prussia, Pennsylvania

Meeting Conducted: September 17, 1990

Submitted by: *Terry E. Walker* 9/26/90
T. Walker, Senior Operations Engineer
BWR Section, Division of Reactor Safety
Date

Reviewed By: *Richard J. Conte* 9/26/90
Richard J. Conte, Chief, BWR Section
Operations Branch, DRS
Date

Approved By: *Lee H. Bettenhausen* 10/13/90
Lee H. Bettenhausen, Chief
Operations Branch, DRS
Date

Summary: An Enforcement Conference was held on September 17, 1990, to discuss an apparent violation of NRC requirements as the result of incorrect grading of licensed operator written requalification examinations as documented in Inspection Report No. 50-219/90-80. The NRC staff findings, the results of the licensee's regrade of the examinations, the root causes and the contributing factors of the incorrect grading, the safety significance of the non-proficient operators who performed licensed duties, and the corrective actions planned or taken to prevent recurrence were discussed.

DETAILS

1.0 Introduction

On September 17, 1990, at the NRC Region I Office, the below listed personnel participated in an enforcement conference to discuss an apparent violation in the licensee's licensed operator requalification program.

2.0 Meeting Attendees

2.1 GPU Nuclear Corporation

P. B. Fiedler, Director, Nuclear Assurance
E. E. Fitzpatrick, Vice President and Director, Oyster Creek
R. P. Coe, Training and Education Director
M. W. Laggart, Corporate Licensing Manager
J. D. Kowalski, Manager, Plant Training
D. Barrett, Plant Operations Director
P. Scallon, Manager of Plant Operations
M. Heller, Licensing Engineer
P. Thompson, QA Auditor

2.2 U. S. Nuclear Regulatory Commission

M. W. Hedges, Director, Division of Reactor Safety (DRS)
C. W. Reed, Director, Division of Reactor Projects (DRP)
L. H. Bettenhausen, Chief, Operations Branch (OB), DRS
E. C. Wenzinger, Chief, Projects Branch 4, DRP
R. J. Conte, Chief, BWR Section, OB, DRS
T. E. Walker, Senior Operations Engineer, OB, DRS
N. F. Conicella, Senior Operations Engineer, OB, DRS
T. A. Easlick, Operations Engineer, OB, DRS
C. E. Sisco, Operations Engineer, OB, DRS
W. Oliviera, Reactor Engineer, OB, DRS
D. J. Holody, Enforcement Officer
K. Smith, Regional Counsel
A. W. Dromerick, Project Manager, NRR

3.0 Overview

The Director, Division of Reactor Safety, NRC, Region I opened the meeting and explained the purpose of the enforcement conference for the benefit of licensee management. The purpose of the meeting was for NRC staff to gain an understanding of licensee perspective on the issue of incorrect grading of licensed operator requalification examinations. This issue was documented in NRC Inspection Report No. 50-219/90-80.

The licensee was requested to address: 1) the cause of the incorrect grading, 2) the safety significance of the improper grading, and 3) corrective actions planned or taken to prevent recurrence.

4.0 Licensee Presentation

The Corporate Licensing Manager initiated the licensee's presentation. He stated that GPU Nuclear Corporation agrees that there was an unrecognized violation of Technical Specifications, section 6, the administrative controls for having licensed operators on duty and of 10 CFR 50.54, conditions of licenses. The licensee's presentation material is attached.

The Training and Education Director and the Manager of Plant Training described the events surrounding the identification of the incorrect grading of the examinations and the licensee's initial response to the events. They indicated that the Training Department had planned to perform an independent regrade of all 1989 written requalification examinations prior to the NRC's identification of the second incorrect pass/fail decision, but they had not communicated these plans to the Operations Department and the NRC. The Training and Education Director stated that they could have been more aggressive in performing a regrade of the written examinations. The Manager of Plant Training indicated that the delays in conducting the critique of the event and initiating the regrade of the examinations were due to his perception of the depth of the problem at the time. The regrade of the examinations and critique of the event were expedited after the second incorrect pass/fail decision was identified.

The licensee identified the root causes of the incorrect grading to be personnel error and inadequate procedures/documentation for the examination process. For one of the incorrect pass/fail decisions, the grader mistakenly accepted an assumption made by the examinee and believed the answer provided was correct. In the second case an oversight by the grader resulted in the examinee receiving credit for a response that did not answer the question. Misinterpretation of the Training Department's unspoken policy to not punish the student for poor questions resulted in incorrect grading by the instructors involved in the grading. Lack of a complete, valid, objective examination bank was identified as a contributing factor to the problems identified in examination grading.

The corrective actions presented by the licensee include improvements to the written examination bank, development of a comprehensive procedure for preparation, administration, and grading of examinations, and training for instructors on the event, the new procedures, and development of test questions. Modifications to the review process for examination grading including management oversight will be included in the new procedure. The licensee plans to reevaluate these modifications after two requalification cycles and committed to inform the NRC if they plan to further modify the review process.

Based on a review of the performance of the licensed operators who were involved, the licensee considered the safety significance of the particular event to be minimal. However, licensee representatives indicated that they recognized the potential for the programmatic problems that led

to the incorrect grading to have more than minor safety significance. The licensee indicated, as one of the mitigating factors of the event, that there was no careless disregard for NRC requirements.

5.0 Meeting Conclusion

Licensee management was informed that they would be notified of the results of the enforcement deliberations. Disposition of the apparent violation in this matter will be addressed in future correspondence.

Attachment: Licensee Presentation

ATTACHMENT 1

NRC RESPONSE TO QUESTIONS ON REQUAL
PROGRAM TESTING REQUIREMENTS

Public meetings were held during April, 1987, regarding the implementation of 10 CFR 55. As a result of these meetings, NUREG-1262, Answers to Questions at Public Meetings Regarding Implementation of Title 10, Code of Federal Regulation, Part 55, on Operators' Licenses, was issued in November, 1987. The answer to question 345 states:

Q. 345 "Will section 55.59(a)(2) change the policy of using a licensed SRO to write/review the written requal examination? If the written examination is given every two years, would he still fulfill the requirements of this section since technically he is not taking the exam? Similarly, will the SRO who writes the performance exam and is, thus, exempt from taking the exam for that year, comply with this requirement?"

A. Section 55.59(a)(2) will not change the policy of using a licensed SRO to write or ~~renew~~ review these examinations. However, it is the Commission's intent that all licensed operators be enrolled in the requalification program and take the requalification exams; further, an individual must take an exam that he did not write or review." (Underlining added for emphasis; typographic error corrected).

OYSTER CREEK NUCLEAR GENERATING STATION

ENFORCEMENT CONFERENCE
September 17, 1990

AGENDA

I. INTRODUCTION - M.W. LAGGART

II. DISCUSSION - R.P. COE

- EVENT DESCRIPTION/INITIAL RESPONSE
- ROOT CAUSE
- CORRECTIVE ACTIONS

III. CONCLUSION - M.W. LAGGART

- SAFETY SIGNIFICANCE
- SEVERITY LEVEL
- MITIGATING FACTORS

INTRODUCTION

- **APPARENT VIOLATION:**

"THE INADEQUACIES IN THE LICENSEE'S GRADING RESULTED IN TWO INDIVIDUALS PERFORMING LICENSED DUTIES FOR A PERIOD OF TIME IN EXCESS OF ONE YEAR WITHOUT HAVING SATISFACTORILY PASSED THE BIENNIAL WRITTEN EXAMINATION REQUIRED BY 10CFR55.59(a)(2). THE LICENSEE'S FAILURE TO IDENTIFY THE INDIVIDUALS WHO DID NOT DEMONSTRATE A SATISFACTORY LEVEL OF PROFICIENCY TO PERFORM LICENSED DUTIES IS AN APPARENT VIOLATION OF 10CFR50.54(k)".

- **GPUN AGREES THERE WAS AN UNRECOGNIZED VIOLATION OF TECHNICAL SPECIFICATION SECTION 6 (ADMINISTRATIVE CONTROLS) AND 10CFR50.54 (CONDITIONS OF LICENSES).**

EVENT DESCRIPTION/INITIAL RESPONSE

OPERATOR #1

- GRADING DISCREPANCY IDENTIFIED BY NRC ON 6/27.
- GPUN CONFIRMED FAILURE AND REMOVED FROM LICENSED DUTIES ON 6/28.
- DEVIATION REPORT WRITTEN/CRITIQUE ASSIGNED TO TRAINING DEPARTMENT ON 6/28.
- RETRIEVED ALL 1989 REQUAL EXAMS AVAILABLE ON MICROFICHE ON 6/29.
- ORDERED HARD COPY OF ALL 1989 REQUAL EXAMS FROM REMOTE RECORDS VAULT ON 6/29 (RECEIVED ON 7/2).
- OPERATOR COMMENCED ACCELERATED REQUAL PROGRAM ON 7/2 (SATISFACTORILY COMPLETED ON 8/24).

EVENT DESCRIPTION/INITIAL RESPONSE

OPERATOR #2

- GRADING DISCREPANCY IDENTIFIED BY NRC ON 7/9.
- GPUN CONFIRMED FAILURE AND REMOVED FROM LICENSED DUTIES ON 7/10.
- INDEPENDENT THIRD PARTY RE-GRADE OF EXAMS COMMENCED ON 7/10 (COMPLETED ON 7/13 - NO ADDITIONAL FAILURES).
- QA DEPARTMENT TASKED TO PERFORM AUDIT ON 7/10 (COMPLETED ON 7/23 - RESULTED IN LER).
- EXPANDED CRITIQUE TO INCLUDE SECOND DISCREPANCY ON 7/10 (COMPLETED ON 7/16).
- TRAINING DEPARTMENT COMMENCED CONCURRENT RE-GRADING OF ALL EXAMS ON 7/11 (COMPLETED 7/14 - NO ADDITIONAL FAILURES).
- OPERATOR COMMENCED ACCELERATED REQUAL PROGRAM ON 7/16 (SATISFACTORILY COMPLETED ON 8/24).

CRITIQUE RESULTS:

ROOT CAUSE

- **PERSONNEL ERROR/FAILURE TO PERFORM**
 - **INATTENTION TO DETAIL IN THE PREPARATION, ADMINISTRATION AND GRADING OF THE 1989 BIENNIAL REQUAL EXAMINATION.**

- **INADEQUATE PROCEDURE/DOCUMENTATION**
 - **LACK OF A COMPREHENSIVE PROCEDURE FOR THE ADMINISTRATION AND DOCUMENTATION OF THE EXAMINATION PROCESS.**

CRITIQUE RESULTS: (CONTINUED)

CONTRIBUTING FACTOR

- ° **LACK OF A COMPLETE, VALID, OBJECTIVE EXAMINATION BANK**
 - **LARGE PERCENTAGE OF EXAM BANK IS OF THE ESSAY OR SHORT ANSWER STYLE, WHICH INTRODUCES MORE SUBJECTIVITY DURING THE GRADING PROCESS.**
 - **NO PARTIAL CREDIT WAS IDENTIFIED FOR ESSAY OR SHORT-ANSWER STYLE QUESTIONS, EVEN THOUGH PARTIAL CREDIT WAS GIVEN.**
 - **MANY OF THE QUESTIONS WERE NOT TECHNICALLY SPECIFIC AND REQUIRED CLARIFICATION TO SOLICIT THE ANSWER AS STATED IN THE ANSWER KEY.**

CORRECTIVE ACTIONS TO PREVENT RECURRENCE

◦ **IMPROVE WRITTEN EXAM BANK AS FOLLOWS:**

- 1) **ACHIEVE \geq 80% OBJECTIVE QUESTIONS IN THE ENTIRE EXAM BANK.**
- 2) **REVALIDATE THE EXAM BANK FOR TECHNICAL/TIME ACCURACY.**
- 3) **CONDUCT INDEPENDENT REVIEW OF EXAM BANK TO IMPROVE QUESTION CLARITY.**

STATUS: COMPLETION BY 3/31/91

◦ **PROVIDE INSTRUCTOR TRAINING ON THE DEVELOPMENT OF OPEN-REFERENCE TEST ITEMS.**

STATUS: COMPLETION BY 9/30/90.

◦ **PUBLISH AN OPERATOR TRAINING EXAMINATION ADMINISTRATION PROCEDURE THAT WILL BE USED AS A BASIS FOR THE PREPARATION, ADMINISTRATION AND GRADING OF EXAMINATIONS/QUIZZES. THIS WILL INCLUDE THOROUGH DOCUMENTATION OF ALL GRADING DECISIONS THAT DEVIATE FROM ORIGINAL EXAM KEY.**

◦ **IN ADDITION, A SECOND GRADING OF ALL BIENNIAL REQUAL EXAMS AND A SECOND GRADING OF ALL QUIZZES/ EXAMS WITH SCORES WITHIN \pm 6% OF 80% WILL BE INCORPORATED.**

STATUS: COMPLETION BY 10/30/90

SAFETY SIGNIFICANCE

- DURING THE PERIOD IN QUESTION BOTH OPERATORS WERE GIVEN THE ANNUAL OPERATING EXAMINATIONS AND WERE EVALUATED AS SATISFACTORY IN BOTH JPM'S AND SIMULATOR, WITH NO MAJOR WEAKNESSES.

- DURING THE PERIOD IN QUESTION BOTH OPERATORS HAVE PARTICIPATED IN THE REQUALIFICATION PROGRAM. THE CURRICULUM HAS ADDRESSED THE IDENTIFIED WEAK AREAS OF BOTH INDIVIDUALS. THEIR WEEKLY QUIZ GRADES INDICATE AN UNDERSTANDING AND RETENTION OF THE SUBJECT AREAS.

- ONGOING OPERATIONS MANAGEMENT EVALUATION OF OPERATOR PERFORMANCE FOR NORMAL/OFF-NORMAL EVENTS WAS GOOD.

- DURING THE PERIOD IN QUESTION, THERE WERE:
 - AT LEAST 2 QUALIFIED SROs ON DUTY AT ALL TIMES.
 - 89 SHIFTS WITH LESS THAN 2 QUALIFIED ROs ON DUTY.
 - 9 SHIFTS WITH LESS THAN 1 QUALIFIED RO ON DUTY.

- THE QA AUDIT, INITIATED BY GPUN, DID NOT IDENTIFY ANY INSTANCES WHERE EQUIPMENT OPERABILITY COULD BE CONSIDERED QUESTIONABLE NOR ANY SPECIFIC PERFORMANCE DEFICIENCIES RELATED TO THE TWO OPERATORS.

BASED ON THE ABOVE, THE SAFETY SIGNIFICANCE OF THIS FINDING IS CONSIDERED MINIMAL.

10 CFR 2, APPENDIX C APPLICABILITY

SEVERITY LEVEL

- VIOLATION OF TECHNICAL SPECIFICATION SECTION 6 (ADMINISTRATIVE CONTROLS) AND 10 CFR 50.54 (CONDITIONS OF LICENSES).
- SEVERITY IV - VIOLATIONS INVOLVING (FOR EXAMPLE) THE FAILURE TO MEET A REGULATORY REQUIREMENT WITH MORE THAN MINOR SAFETY SIGNIFICANCE.

MITIGATING FACTORS

- EVENT RESULTED IN MINIMAL SAFETY SIGNIFICANCE.
- DID NOT INVOLVE CARELESS DISREGARD FOR REQUIREMENTS.
- THOROUGH AND EXTENSIVE CORRECTIVE ACTIONS TAKEN TO PREVENT RECURRENCE.
- NOT A RECURRING VIOLATION.
- NO PRIOR NOTICE OF SIMILAR EVENTS.
- LICENSEE EVENT REPORT SUBMITTED IN ACCORDANCE WITH 10 CFR 50.73.

APPENDIX

A. GPUN LETTER, P. FIEDLER TO T. MARTIN, DATED JULY 11,
1990.

B. LICENSEE EVENT REPORT 90-11 DATED AUGUST 21, 1990.

APPENDIX A

Nuclear

GPU Nuclear Corporation
One Upper Pond Road
Parsippany, New Jersey 07054
201-316-7000
TELEX 136-482
Writer's Direct Dial Number:

July 11, 1990

Mr. Thomas T. Martin, Administrator
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Dear Mr. Martin:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Operator Licensing Examinations

A telephone conference was held on July 10, 1990 between GPUN and the NRC. The purpose of the conference was to identify GPUN's corrective actions in response to an NRC finding that an operator who received a passing grade on a facility administered requalification exam in 1989 should have received a failing grade based on NRC review. This was the second operator identified, based on NRC's regrading of exams administered by GPUN in April - June 1989, who should have received a failing grade. These findings were an outcome of an NRC inspection of Oyster Creek's training programs, referred to as a NUREG 1220 Audit, conducted at Oyster Creek from June 25 to June 29, 1990.

During the conference call, GPUN agreed that the second operator should have received a failing grade and confirmed that both operators were immediately removed from licensed duties upon such determination. GPUN also committed to take the following corrective actions:

1. An independent third party re-grade (independent from the Training and Operations Departments) of all operator requalification exams administered in 1989 will be conducted by an individual who currently holds an inactive SRO license. Exams taken by operators who are currently on shift will be reviewed first. If the answer key is changed, all exams will be re-graded accordingly. This review will be completed by July 16, 1990.
2. Concurrent with the above re-grade, the Training Department will also re-grade all operator requalification exams administered in 1989. This re-grade will be completed by July 16, 1990.
3. Operations Department management will review the final grades and will determine the final status. Should additional failures result from the review, they will be removed from licensed duties to be remediated and re-examined. This review will be completed by July 16, 1990.
4. A critique will be conducted to determine the root cause of improperly graded exams in order to identify and implement corrective actions to prevent recurrence. This will be completed by July 16, 1990.

Mr. T. Martin

Page 2

5. The written exam bank will receive an independent review to improve question clarity and the bank will be technically and time revalidated by March, 1991.

If there are any questions regarding these commitments, please contact Mr. George Busch, Oyster Creek Licensing Manager, at 609-971-4663.

Very truly yours,



Peter S. Fiedler
Director Nuclear Assurance

PBF/HH:jc
OPERTNG (32-33)

cc: Marvin W. Hodges, Director
Division of Reactor Safety
Region 1
U.S. Nuclear Regulatory Commission
465 Allendale Road
King of Prussia, Pa. 19406

Mr. Kenneth E. Perkins, Chief
Operator Licensing Branch
Division of Licensee Performance & Quality Evaluation
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, DC 20555

NRC Resident Inspector, OC

APPENDIX B



GPU Nuclear Corporation
Post Office Box 388
Route 9 South
Forked River, New Jersey 08731-0388
609 971-4000
Writer's Direct Dial Number:

August 21, 1990

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

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report

This letter forwards one (1) copy of Licensee Event Report (LER) No. 90-011.

Very truly yours,

A handwritten signature in dark ink, appearing to read 'E. S. Fitzpatrick', written over the typed name and title.

E. S. Fitzpatrick
Vice President & Director
Oyster Creek

EEF:JJR
(ler/Covltrs:jc)
Enclosure

cc: Mr. Thomas Martin, Administrator
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Alexander W. Dromerick
U.S. Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

NRC Resident Inspector
Oyster Creek Nuclear Generating Station
Forked River, NJ 08731

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oyster Creek, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 1 9	PAGE (3) 1 OF 0 3
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TITLE (4) **Unqualified Operators on Shift Due to Inadequacies in Exam Process
Results in Violation of Tech Spec Shift Manning Requirements**

EVENT DATE (5)			LER NUMBER (6)		REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)			
MONTH	DAY	YEAR	SEQUENTIAL NUMBER	REVISED NUMBER	MONTH	DAY	YEAR	FACILITY NAME		DOCKET NUMBER (8)	
07	23	90	01	1						0 5 0 0 0 0	

OPERATING MODE (9) **N**

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

26.40(b)(1)	26.40(b)(2)	26.72(b)(1)(H)	73.71(b)
26.40(b)(1)(H)	26.50(b)(1)	26.72(b)(2)(H)	73.71(b)
26.40(b)(1)(H)	26.50(b)(2)	26.72(b)(2)(H)	OTHER (Specify in Abstract below and in Text, NRC Form 205A)
26.40(b)(1)(H)	<input checked="" type="checkbox"/> 26.72(b)(2)(H)	26.72(b)(2)(H)(A)	
26.40(b)(1)(H)	26.72(b)(2)(H)	26.72(b)(2)(H)(B)	
26.40(b)(1)(H)	26.72(b)(2)(H)	26.72(b)(2)(H)	

POWER LEVEL (10) **N/A**

LICENSEE CONTACT FOR THIS LER (12)

NAME Michael G. Heller	TELEPHONE NUMBER 6 0 9 9 7 1 - 4 6 8 0
----------------------------------	--

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)

NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 words; i.e., approximately 1/2 page single-spaced typewritten text) (16)

In June and July of 1990, as a result of an NRC audit of the operator training program, 1989 biennial requalification exams were found to have been incorrectly graded. A regrading effort resulted in the failure of two licensed operators. The operators were immediately removed from licensed duties and entered into an accelerated requalification program. These operators had been performing licensed duties during the period from the requal exam up to the regrading of the exam. Since these two operators were retroactively disqualified, there were 89 shifts during this period with less than two control room operators as required by technical specifications. The cause of this occurrence is attributed to personnel error as a result of programmatic inadequacies in the exam process. An investigation and critique of this incident revealed that these inadequacies led to errors in the preparation, administration and grading of the 1989 written requalification exam. These inadequacies caused the grading anomalies identified. To prevent recurrence, an examination procedure will be developed to provide guidance for the preparation, administration and grading of exams.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Oyster Creek, Unit 1	DOCKET NUMBER (2) 0 1 5 1 0 1 0 1 2 1 1 9	LER NUMBER (3)			PAGE (3) 9 0 - 0 1 1 1 - 0 1 0 0 2 OF 0 1 3
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	

TEXT IS MADE AVAILABLE IN ACCORDANCE WITH THE PROVISIONS OF NRC FORM 2054 (1/77)

DATE OF DISCOVERY

The condition being reported was discovered on June 28 and July 10, 1990, and determined reportable on July 23, 1990.

IDENTIFICATION OF OCCURRENCE

Two individuals performing licensed duties were not technically qualified to perform those duties. This resulted in not meeting the shift manning requirements of Technical Specifications. This event is considered reportable as defined in 10 CFR 50.73 (a)(2)(i)(B).

CONDITIONS PRIOR TO OCCURRENCE

The plant was operated in various modes while the above condition existed.

DESCRIPTION OF OCCURRENCE

On June 28, 1990, during a Nuclear Regulatory Commission audit of the operator training program at Oyster Creek, it was determined that a 1989 biennial requalification retake examination belonging to a licensed operator had been incorrectly graded. This operator's examination had originally been given a passing grade. However, a review by the NRC audit team (and concurred with by GPUN) indicated that the operator had in fact failed. This operator was immediately removed from licensed duties and placed in an accelerated requalification training program. Similarly, on Tuesday, July 10, 1990, another licensed operator's 1989 biennial requalification exam was reviewed and was determined to have also been a failure. The operator was also removed from licensed duties and placed in an accelerated training program.

APPARENT CAUSE OF OCCURRENCE

The cause of this occurrence is attributed to personnel error as a result of programmatic inadequacies in the examination process. An investigation and critique of this incident revealed that these inadequacies led to errors in the preparation, administration and grading of the 1989 written requalification examination. These inadequacies caused the grading anomalies identified.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Oyster Creek, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 1 9			LER NUMBER ID			PAGE ID		
	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER						
	910	011	010	013	OF	013			

TEXT IF MORE THAN 99 CHARACTERS AND EXCEEDS NRC Form 2004 (1) (17)

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

Technical Specifications require at least two licensed reactor operators on each shift. Discounting the two operators in question, 89 shifts were identified with less than two licensed reactor operators. However, only nine shifts were without one fully qualified licensed reactor operator. In addition, a licensed senior reactor operator was on shift at all times.

The 1989 licensed operator requalification process includes an operating test in addition to the written exam. The operating test consists of a dynamic simulator evaluation and a plant walk-through or job performance measure (JPM) which evaluates the operators knowledge of plant systems that are important to the safe operation of the facility. Although not technically qualified to perform licensed duties due to the written exam failure, both operators did satisfactorily demonstrate their capabilities in the operating test.

An audit was performed by the Quality Assurance Department to ascertain any impact upon plant safety and equipment operability considering the qualification status of the two operators. This audit included a review of shift coverage log sheets, control room logs, completed surveillance tests, valve lineups, equipment tagouts, licensee event reports, critiques and performance evaluations. The audit team did not identify any instances where equipment operability could be considered questionable nor any specific performance deficiencies related to the two operators.

Based upon the above, the safety significance of this event is considered minimal.

CORRECTIVE ACTIONS

1. Immediate corrective action consisted of removing the involved operators from licensed duty and placing them into an accelerated requalification program.
2. All of the 1989 requalification exams were regraded by an individual who is independent of the operations and training departments and who currently holds an inactive SRO license. Although grades did change, no additional failures were identified.
3. An audit was performed by the Quality Assurance Department to ascertain any impact upon plant safety and equipment operability considering the qualification status of the two operators. No negative impact was identified.
4. An examination procedure will be developed to provide guidance for the preparation, administration and grading of examinations.
5. Management expectations in the area of exam preparation, administration and grading will be reemphasized to all operations training personnel.

SIMILAR OCCURRENCES

None.