



Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038-0236

Nuclear Business Unit

SEP 07 1995

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

Dear Sir:

HOPE CREEK GENERATING STATION
DOCKET NO. 50-354
UNIT NO. 1
LICENSEE EVENT REPORT 94-013-02

This Supplemental Licensee Event Report is being submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B). This supplement provides additional information concerning an alleged event that is assumed to be valid and was discussed in the previous supplement. This supplement also adds a corrective action that would have precluded the need for this supplement.

Sincerely,

M. E. Reddemann
General Manager -
Hope Creek Operations

RAR/tcp

Attachment
SORC Meeting 95-085
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The power is in your hands.

95-2168 REV 8/94

LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT

FACILITY NAME (1) HOPE CREEK GENERATING STATION	DOCKET NUMBER (2) 05000354	PAGE (3) 1 OF 8
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TITLE (4)
Condition Prohibited by the Plant Technical Specifications - Noncompliance with the shift manning requirement of technical specification 6.2.2.a, shift manning requirements

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONT H	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONT H	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
9	16	94	94	013	02	9	6	95		05000
										05000

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)									
POWER LEVEL (10) 100 %	<input type="checkbox"/>	20.2201(b)	<input type="checkbox"/>	20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)	<input type="checkbox"/>	50.73(a)(2)(viii)		
	<input type="checkbox"/>	20.2203(a)(1)	<input type="checkbox"/>	20.2203(a)(3)(i)	<input type="checkbox"/>	50.73(a)(2)(ii)	<input type="checkbox"/>	50.73(a)(2)(x)		
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	<input type="checkbox"/>	20.2203(a)(2)(ii)	<input type="checkbox"/>	20.2203(a)(4)	<input type="checkbox"/>	50.73(a)(2)(iv)	<input type="checkbox"/>	OTHER		
	<input type="checkbox"/>	20.2203(a)(2)(iii)	<input type="checkbox"/>	50.36(c)(1)	<input type="checkbox"/>	50.73(a)(2)(v)	<input type="checkbox"/>	Specify in Abstract below or in NRC Form 366A		
<input type="checkbox"/>	20.2203(a)(2)(iv)	<input type="checkbox"/>	50.36(c)(2)	<input type="checkbox"/>	50.73(a)(2)(vii)	<input type="checkbox"/>				

LICENSEE CONTACT FOR THIS LER (12)

NAME W. P. O'Malley - Operations Manager	TELEPHONE NUMBER (include Area Code) (609) 339-3478
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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)		
YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/>	NO		MONT	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

This supplemental LER is being submitted to provide additional information concerning an alleged event which is assumed to be valid and was discussed in the previous supplement, and to provide an update on the corrective actions. The original LER, and the first supplement, were submitted due to occurrences of not meeting the requirements of Tech Spec 6.2.2.a. The LER is being reported under 10CFR50.73(a)(2)(i)(B). The root cause of one of the events was attributed to less than adequate administration of the guidelines contained in NUREG 1262. The root cause of the other events was attributed to personnel error as the NSS's involved allowed themselves to become distracted by other activities and inadvertently left the control room area. Corrective actions for these events include administrative procedure changes regarding proficiency requirements, a review of the NUREG with appropriate personnel, and inclusion of the requirements in operators requalification training. A mechanical restraint is currently being placed over a watchstander's security badge to prevent personnel who are meeting the control room manning requirements from carding out of the area. The Senior Nuclear Shift Supervisor and NSS's involved in these events have also been counseled and disciplined as appropriate.

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PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
No system applicable

IDENTIFICATION OF OCCURRENCE

TITLE (4): Condition prohibited by Plant Technical Specification:
non-compliance with the requirements of technical specification
6.2.2.a, shift manning requirements

Event Dates: Various
Event Discovery: Various, first event discovered on 9/16/94
Event Time: Various
This LER was initiated by Incident Report Nos. 94-153, 94-154, 94-162 and
94-241.

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation)
Reactor Power 100% of rated, 1085 MWe

DESCRIPTION OF OCCURRENCE

On September 15, 1994, during a requalification training classroom session, a discussion regarding the proficiency requirements of 10CFR55.53 was being conducted with shift personnel. As the requirements were being discussed, a Nuclear Control Operator (NCO) who had obtained his Senior Reactor Operators (SRO) license stated that he was never made aware that the SRO portion of his license would not be active unless he stood the specified number of shifts in that role during any calendar quarter. The Nuclear Control operators are typically licensed as Reactor Operators (RO) only, and as members of the bargaining unit, do not act in a supervisory or "command and control" role in the control room. The instructor immediately notified his supervisor of the discussion who also reviewed the requirements of 10CFR55.53 and NUREG 1262. Following the review of the documents, which continued into the following day, training center personnel notified the Operating Engineer (OE) that NCO's who had not stood proficiency watches under the guidelines of NUREG 1262 could not assume the command and control position in the control room. Upon being notified, the OE informed all the Senior Nuclear Shift Supervisors (SNSS - SRO licensed) of the proficiency requirements and directed a review of the watchstanding history for their respective shifts. The review revealed that on the evening of 9/15/94, an SRO licensed NCO, who had been upgraded to NSS, had been designated as the command and control SRO for several short time periods when the SNSS left the control room to perform other duties such as plant rounds. This incident created a heightened awareness of the requirements for a valid SRO to be present in the control room as

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DESCRIPTION OF OCCURRENCE

delineated by Technical Specification 6.2.2.a. The turnover process of designating a SRO as command and control when the SNSS leaves the control room was also re-emphasized via the night orders.

Despite these measures, a similar event occurred on 9/28/94, when a Nuclear Shift Supervisor (NSS - SRO licensed), who was designated as the command and control SRO, inadvertently walked out of the control room area to the adjacent work control center for approximately 18 seconds. At the time, a SRO licensed NCO was in the control room performing the NSS duties under direction of this NSS to regain his proficiency. The NCO had completed 38 hours of the required 40 under the direction of an SRO to regain his proficiency.

One additional event, which resulted from an allegation presented in a meeting with the Chief Nuclear officer, was investigated which occurred some two years prior to the events described above. On June 3, 1992, at 1338 hours, the NSS who had assumed the command and control role inadvertently left the control room. The SNSS had turned over to the NSS to attend a department staff meeting. Some time after the SNSS had left the control room, a problem was brought to the attention of the NSS regarding control room chillers. The NSS decided to go to the chillers, and contacted the Station Technical Advisor (STA - SRO licensed) to discuss the problem and to be relieved. Following this discussion, the NSS walked into the rear of the control room area to get his hard hat and safety gear while the STA returned to the work control office. Both individuals believed the other was to remain in the control room; the NSS believed he had turned over command and control while the STA believed the turnover was yet to occur. The two individuals left from different doors that are not visible from each other. The on duty NCO and a Quality Assurance (QA) engineer who were in the control room realized that no SRO was present and paged the STA. The STA returned to the control room within three minutes of the time he exited.

Interviews were conducted with personnel, following issuance of rev 0 of this LER, to determine if any other occurrences of control room manning deficiencies had occurred. A former NCO did recall an event occurring sometime in 1987 or 1988. The NCO stated that the SNSS, who was the last remaining SRO in the control room area, had carded out of the control room into the adjacent ready room area. The NCO walked to the viewing window, tapped on the glass and signaled the SNSS to return. The SNSS returned to the control room where the NCO told the SNSS that he was the only SRO in the control room and needed to remain in the area until another SRO returned. This event was confirmed by a former NSS who was not present at the time, but remembers discussing preventive measures some time after the event. The SNSS involved does not recall the specific event but does not deny the possibility of it occurring.

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DESCRIPTION OF OCCURRENCE

An alleged event was identified by an individual from a site support organization that performed training exercises one day per week in the Hope Creek Control Room. The individual can only recall that one day, while waiting for the training exercises to begin, he had looked around the Control Room and could not remember seeing an SRO. He also recalls that no NCO was in the "at the controls" area. One of the two assigned NCO's had left the Control Room, and the other NCO left the controls area to go to the back panels. The individual also reported that both NCO's returned to the "at the controls" area within a few minutes.

ANALYSIS OF OCCURRENCE

The Hope Creek Technical Specifications requires that a Senior Reactor operator shall be in the control room during OPERATIONAL CONDITION 1, 2, or 3. It also requires that when the Senior Nuclear Shift Supervisor is absent from the control room in OPERATIONAL CONDITION 1, 2, or 3, that an individual with a valid SRO license is designated to assume the command and control function in the control room. The term valid SRO requires that personnel meet the requirements of 10CFR55.53 as clarified in NUREG 1262. Additionally, one NCO is required to be "at the controls" at all times.

The events being reported all relate to not meeting the proper manning requirements of the above specification. The first event was related to proficiency, while the remaining events involve the failure to maintain a SRO present in the control room. The alleged event also involved not meeting the administrative requirement for an NCO in the "at the controls" area.

Hope Creek had previously established a program to maintain proficiency for individuals who are licensed, but are assigned to non-shift duties. Staff personnel were required to stand the required number of shifts to maintain their proficiency or perform the 40 hours of parallel duties to regain their proficiency if it had expired. Typically, all staff personnel are supervisory positions and were licensed as SRO'S. To perform their proficiency watches they are assigned to a technical specification required SRO position. Due to constraints placed on management via the collective bargaining agreement, supervisors cannot routinely fill the position of a nuclear control operator, hence the situation of standing watches in a position other than that for which an individual was licensed did not occur.

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ANALYSIS OF OCCURRENCE (Con't)

A program to upgrade reactor operators to senior reactor operators was established to ensure an adequate number of qualified individuals are available for promotion when needed. The reactor operators are typically bargaining unit personnel who, under the constraints of the collective bargaining agreement, cannot be placed in a supervisory role on a day to day basis. Likewise, additional reactor operator licenses are maintained, above the technical specification minimum, to ensure an adequate pool of individuals exists to man the control room.

In the past, some NCO's who received SRO licenses were promoted to NSS within 90 days of receipt of their SRO licenses, and thus, were considered current. When other SRO licensed NCO's were promoted to shift supervisor, they were required to stand the proficiency watches prior to assuming the duties of the new position. This was directed by the previous Operating Engineer who was aware of the proficiency requirements. The individual who was assigned command and control function prior to re-establishing his proficiency in this event had been promoted; however, the current Operating Engineer was not aware of the proficiency requirements for the position change. The individual had performed some of the shift supervisor functions under the direction of his SNSS who was attempting to orient the individual to assume the NSS duties. This orientation is common at Hope Creek and is above and beyond all formal requirements for newly licensed individuals.

As a result of the initial event, the Operating Engineer notified all SNSS's to perform a review of the watchstanding log to determine if any other similar situations existed. Additionally, the turnover process for assuring the transfer of command and control was re-emphasized. All Senior and Nuclear Shift Supervisors reviewed the proficiency requirements and understood who was qualified to assume the command and control role.

The second occurrence (event of 9/28/94) being reported was due to an individual leaving the control room after assuming the command and control role. The SNSS had formally turned over the command and control to his shift supervisor, who was also directing an individual performing his proficiency watches. The NSS was standing in the control room near the viewing windows that separate the control room from the equipment operators (EO) ready room area. The NSS was curious about the EO's moving new equipment into an adjacent room. He stepped out of the control room into the control room viewing area to question the EO's as to the source of the new equipment. As he stepped out, he realized his mistake and returned to the control room.

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ANALYSIS OF OCCURRENCE

The third occurrence (event of June 3, 1992) being reported was again due to not having a SRO in the control room. The investigation determined that in addition to the control room manning deficiency, the personnel involved did not comply with station administrative requirements to prepare an incident report. When the SNSS returned to the control room, following a staff meeting, the NSS and STA discussed the occurrence with the SNSS. The NSS described the occurrence and attributed the event to miscommunication between himself and the STA. The NSS believed the STA understood he was about to leave the control room area. The STA could not recall any transfer of command and control from the NSS. The group discussed the fact that for a period of approximately three minutes (2 minutes 56 seconds) no SRO was in the control room and recognized a technical specification violation had occurred. The individuals evaluated whether or not the reporting requirements of the Hope Creek Administrative procedure governing reportable events had been met. They believed that due to the short period of time involved that the severity of the event did not warrant the incident report. The SNSS was also informed by the NSS that a quality assurance engineer had been present during the period and was aware that no SRO was in the control room. The SNSS contacted the QA engineer and discussed the event with him. The SNSS solicited the input of the QA engineer as to the reportability of the event. The QA engineer did not state that an incident report was required, but that it was up to the SNSS to handle the situation. The SNSS inappropriately rationalized that due to the time period involved, the lack of any definitive recommendation by anyone to prepare an incident report, that the persons involved understood why the event occurred and actions could be taken within the shift to prevent recurrence of a similar event, that an incident report was not required. Reportability to the NRC was not considered or discussed.

The former NSS involved in the confirmed event identified from the LER follow-up could not recall who may have had the control room command function at the time, i.e., who had left the area last. He also could not remember if a formal turnover of the command and control responsibilities had occurred. The former NSS does recall some follow-up discussion with the supervisors on the crew; however, the date, time, subject and details of those discussion cannot be clearly remembered. He believes the discussions were limited to measures to prevent recurrence, in regard to turnover of command and control, and that the questions regarding reportability or a technical specification violation were not considered or discussed. The former NCO recalled that the SNSS was the last SRO to exit the area. He does not recall any follow-up discussion of the event with other crew members. A review of corrective actions taken for the initial LER determined that the actions taken would have been adequate to prevent this event and no further corrective actions are required.

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ANALYSIS OF OCCURRENCE

The alleged event is being treated as having occurred. The individual who presented the allegation can only recall his observation that he did not see a SRO in the Control Room, or an NCO "at the controls" for a short period of time, during a Friday morning exercise. He cannot remember the names of individuals who may have been involved, or the date or year when the event may have occurred. During preparation of the first LER update, another member of the Hope Creek staff, upon hearing the description of the event, vaguely recalls being present in the control room with the individual when the event may have occurred. Neither individual can recall checking the SNSS office or other areas of the control room that may have been out of direct visual observation. Likewise, neither person can recall confronting any crew members that can confirm or deny the allegation. The person confirming the incident allegation would not have been present during a Friday morning control room exercise. Due to the vague nature concerning the time and date involved, an exhaustive investigation would be required to determine if this event occurred. This investigation was not conducted because the benefits gained from confirming this event would not justify the expense required to conduct the investigation and because the corrective actions implemented to date should prevent this type of event.

SAFETY SIGNIFICANCE

These incidents posed minimal safety significance. In the first two cases an individual with a SRO license, who was an integral part of the shift manning, had participated in the shift turnover and was current in respect to requalification training, was present in the control room. In all events, proficient SRO's were within minutes, if not seconds, of the control room at all times. In the alleged event, involving an RO, an RO was in the Control Room at all times.

PREVIOUS OCCURRENCES

There have been no previous events of this nature at Hope Creek.

APPARENT CAUSE OF OCCURRENCE

The root cause of the initial event was a misunderstanding of the requirements for standing proficiency watches. The individuals were not aware of the interpretation of proficiency requirements described in NUREG 1262. The other events were due to personnel error. The NSS who left the control room was distracted by activities visible through the control room viewing window directly adjacent to the control room. The event of June 3, 1992, was also attributed to personnel error on the part of the NSS who left the control room after assuming command and control. Personnel error on the part of the SNSS, NSS, STA, and the QA engineer, all of whom concluded that an incident report was not warranted, resulted in a missed LER.

NRC FORM 366A
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CORRECTIVE ACTIONS

The proficiency requirements specified in NUREG 1262 have been reviewed with appropriate personnel.

Training Department has included training on the requirements of 10CFR55.53 and NUREG 1262 in requalification and initial license training. SRO and RO manning requirements and responsibilities were stressed.

Operations Department Administrative Procedure for Personnel Qualification and Training have been revised to incorporate the proficiency requirements and have been routed to all licensed individuals with a clarification of their responsibilities.

Additional training has been provided to appropriate personnel on the reporting requirements of 10CFR50.73 and NUREG 1022.

Licensed individuals involved in all events and the QA engineer have been counseled and/or disciplined as appropriate.

The individuals involved in not writing an incident report have designed an intervention method to preclude similar events.

An appropriate barrier, such as a restraining clip, that fits over an individuals security badge, is being used to prevent the command and control individual, and other required watchstanders, from carding out of the control room.

A letter expressing managements expectations for proper conduct has been issued to appropriate personnel.

Nuclear Licensing has provided guidance on the NUREG 1022 guidelines as they apply to the administrative section of technical specifications.

Licensing will develop a guideline for the development of LER's, including the requirement to solicit input from all appropriate parties involved in an investigative effort.