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JUL 20 1988

Docket Nos. 50-250 and 50-251
License Nos. DPR-31 and DPR-41
EA 87-85

Florida Power and Light Company
ATTN: Mr. W. F. Conway
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Gentlemen:

Enclosed is the synopsis of NRC Office of Investigation Report 2-87-016 which was issued April 21, 1988. This investigation examined the circumstances surrounding the occurrence on September 13, 1987 of an unauthorized manipulation of the Unit 3 reactivity controls by an unlicensed individual. The investigation concluded that a violation of NRC requirements occurred and that the licensed operator involved did not know that he was violating NRC requirements or plant procedures when he improperly allowed a shift technician to manipulate reactivity controls. As stated in a letter to Florida Power and Light Company (FP&L) dated March 17, 1988, the NRC staff considered that the Order issued October 19, 1987 adequately required FP&L to review and correct problems such as this as part of the Independent Management Appraisal. Therefore, further enforcement action against FP&L for the above violation is unnecessary.

Though the investigation report synopsis concludes that this problem was an isolated incident, FP&L should not interpret such a statement too broadly. The manipulation of controls by an unauthorized person was of significant concern. The act itself and the attitude expressed by the FP&L that this was of no safety significance are indicative of the less than formal operating ethic that existed at Turkey Point and which, in part, necessitated the October 19, 1987 Order.

The synopsis makes reference to the notes kept by one member of your management-on-shift (MOS) program and indicates those notes contained inaccuracies. The staff recognizes that this individual's notes reflected personal opinion and were not intended to be subjected to the scrutiny of an investigation. Nevertheless, the notes were helpful in resolving the matter, despite the concerns raised in the synopsis. Also, we have commended site management for having instituted the MOS program and the individual for his critical observations.

Sincerely,

ORIGINAL SIGNED BY:
J. NELSON GRACE

J. Nelson Grace
Regional Administrator

Inc
ACT-4

Enclosure: (see page 2)

IE01

Enclosure:
OI synopsis

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SYNOPSIS

JUL 20 1988

This investigation was initiated after the U.S. Nuclear Regulatory Commission (NRC), Region II staff learned that an NRC licensed Reactor Control Operator (RCO) at the Florida Power and Light Company's (FP&L) Turkey Point Nuclear Station (TPNS), Florida City, Florida, the licensee, had permitted an unlicensed Shift Technician (ST) to operate the Dilution Flow Start Switch (DFSS) during the September 13, 1987, midnight shift. The action of the RCO in permitting the ST to activate the DFSS violated regulatory requirements set forth in 10 CFR Parts 50 and 55 inasmuch as the ST, who was unlicensed and was also not in a license training status, performed an evolution which changed reactivity and/or the power level of the reactor. Additionally, it was learned by the NRC that the licensee had delayed significantly the investigation and resolution of the DFSS event for no apparent reasons. In view of this disclosure and due to the circumstances of the DFSS event the NRC Office of Investigations (OI) was requested by members of the NRC, Region II staff to determine whether the regulatory violation by the RCO was a deliberate, intentional act; if it was symptomatic of widespread deficiencies in operator professionalism; and the factors which caused the licensee to delay the resolution of the incident. For the purpose of this investigation the term operator professionalism is totally unrelated to any technical, mechanical, scientific, and/or engineering aspects of reactor operations but has direct reference to the conduct, behavior and attitude of TPNS licensed operators as they perform their control room duties and responsibilities.

The DFSS event occurred during a period when a reactor core physics exercise was in progress and the RCO was attempting to maintain a constant reactor coolant water temperature by frequently diluting from the Volume Control Tank. The dilutions were being controlled by the flow start switch on the main control room panel. The RCO acknowledged, under oath, that he permitted the ST to activate the start switch on two occasions during a three minute period of time during the September 13, 1987, midnight shift. The ST confirmed the action of the RCO and both categorically denied they intentionally violated 10 CFR requirements. The RCO offered that he believed he was performing within the limits of his NRC license when he allowed the ST to activate the start switch.

Following the interviews of the RCO and the ST, other TPNS personnel assigned to control room duties during the DFSS event provided substantive information regarding the purpose of the investigation. The Plant Supervisor-Nuclear (PSN) reported he did not learn of the incident until September 14, 1987, and that both participants were counselled by him on the following midnight shift regarding the impropriety of their actions. The PSN opined that the action of the RCO and the ST was an inadvertent mistake and a lapse in sound judgment rather than a willful, deliberate violation of 10 CFR regulations. The PSN and four other individuals, all of whom are currently licensed by the NRC, vouched for the professionalism of licensed operators at the TPNS facility and claimed no knowledge of other regulatory violations by any of these individuals.

The Management-On-Shift (MOS) program, consisting of two-man teams of site managers, was implemented at the TPNS facility in August 1987 to observe, assist, and provide guidance during the backshift (2200 to 0700) hours. The two MOS personnel on duty in the control room when the DFSS event occurred were

interviewed. One MOS official recalled that he witnessed the DFSS event as it was related by both of the participants. The second MOS official concurred with the observations of his counterpart, even though copious personal handwritten notes prepared immediately following his tour of duty contained significant indications of regulatory violations, unprofessional behavior by operators and improper control room demeanor and conduct. During a lengthy interview the second MOS official acknowledged that more than ninety percent of all the remarks contained in his personal notes were speculation, conjecture and supposition and that many statements are inaccurate and incorrect. He related that in his opinion NRC licensed TPNS Operations personnel are performing at an acceptable level and in accordance with regulatory and procedural requirements. A copy of the notes of this MOS official was provided to members of the NRC Region II staff and a special inspection was initiated at the TPNS facility to review each item listed therein. The inspection results are documented in an NRC Region II Inspection Report labelled 50-250, 251/87-44.

The engineer performing the core physics exercise during the DFSS event was interviewed and essentially corroborated the testimonies of the two participants and the MOS officials. He steadfastly maintained that, except for the DFSS event, he has never known of any regulatory violations by NRC licensed control room personnel. Eleven additional shift personnel who are assigned license duties and responsibilities in the TPNS control room were queried extensively regarding general operator professionalism and their knowledge of the DFSS incident. Each opined unequivocally that the DFSS event was an isolated occurrence and is not indicative of the manner in which licensed personnel perform their duties. The comments of all of these individuals was essentially favorable regarding control room behavior and conduct of licensed operators. Seven additional ST's were interviewed to obtain their views regarding operator professionalism and each provided favorable responses to questions concerning this matter. Four ST's reported that they have silenced annunciators alarms for operators but only after the operators observed the causes of the alarms and performed necessary corrective actions. All categorically denied that they had ever asked or been permitted to manipulate any control mechanisms of either TPNS reactor.

Interviews of three TPNS site managers who have operations responsibilities were conducted to obtain information concerning the DFSS event and the reason(s) it was not immediately investigated and resolved by the licensee. The Operations Supervisor acknowledged he failed to immediately inform his superintendent of the incident and further, that he was remiss for delaying the investigation and resolution of that issue. He offered that his failure to initially recognize the DFSS event as a regulatory violation and expeditiously conclude the matter, was because of another priority incident (unrelated reactor trip) and his off site training immediately following the incident. The Operations Superintendent and the Plant Manager concurred with the remarks of the Operations Supervisor and acknowledged that the delay in concluding the DFSS event was unreasonable in view of the importance of operator professionalism. Each denied that the delay in resolving the DFSS event was based upon improper motives and they categorically maintained they are unaware of other regulatory violations by personnel who perform license duties. The Plant Manager acknowledged that operator professionalism has long been a concern of the licensee and that extensive efforts were underway when the DFSS event occurred to elevate this aspect of operations at the TPNS facility.

Following these interviews Corporate licensee officials, including the Site Vice-President, the Vice-President for Nuclear Operations and the Group Vice-President were contacted regarding the purpose of the investigation. Each provided a chronology of their participation and involvement in the investigation and resolution activities of the DFSS incident. The consensus of these interviewees was that the licensee's delay in concluding the DFSS event was inordinate, although their eventual inquiries into this matter revealed it to be an isolated incident rather than an example of widespread or severe deficiencies in operator professionalism. They acknowledged that the delay in resolving the DFSS incident was due to circumstantial matters rather than an intent to conceal the event or minimize its importance. Each regarded operator professionalism as an issue of high concern by the licensee and identified current efforts to improve this element in the ranks of licensed personnel. Numerous licensee records, memoranda, logs, and MOS reports were reviewed during the course of the investigation. Various documents addressed the DFSS event and the licensee's awareness regarding compliance with regulatory requirements. Additionally, licensee Quality Assurance and Operations Department reports regarding the DFSS incident indicate it was an isolated event rather than a common occurrence.

In conclusion, the investigation revealed that the DFSS event appears to be an isolated matter precipitated by a temporary lapse of judgement on the part of the participants. Although the RCO willfully permitted the ST to manipulate the DFSS, it does not appear that he knew he was violating a specific provision of the 10 CFR regulations and a plant procedure. There was no evidence developed to indicate that other regulatory violations had been committed by any licensed operators at the TPNS facility. All responsible licensee officials acknowledged that their delay in investigating and resolving the DFSS event was inexcusable and demonstrates poor judgment by the licensee. Finally, the investigation did not reveal an apparent, deliberate, intentional attempt by any licensee official to conceal the event or to minimize its significance.