March 12, 1996

MEMORANDUM TO: Curtis W. Rapp, Reactor Engineer
Division of Reactor Safety

FROM: Albert F. Gibson, Director (ORIGINAL SIGNED BY
Division of Reactor Safety ALBERT F. GIBSON)

SUBJECT: YOUR CONCURRENCE ON CRYSTAL RIVER INSPECTION REPORT 95-22

Jon Johnson informed me yesterday that you said that you did not concur with the findings in Crystal River Inspection Report 95-22. I was not aware of this disagreement. Based upon your written concurrence and discussions that we have had on these matters, I thought that you agreed with the findings regarding operator performance and with the apparent violations identified in this report.

Please provide a written response to this memo specifically describing how your personal views differ from the findings and apparent violations described in report 95-22. I have attached a draft notice of violation, based in part on the findings in report 95-22, which will serve as a basis for discussions during upcoming enforcement conference with Crystal River operators. I understand that you have reviewed this notice of violation and that your comments have been incorporated. In response to this memo, please state whether or not you concur with this draft notice of violation and the basis for any disagreement you may have. Please respond before next Thursday, March 21, 1996, so that your comments can be considered during the enforcement conference planning meeting scheduled for that date.

Attachment: Draft Notice of Violation

Distribution:
S. Ebneter, RA w/att
J. Johnson, DRP w/att

SEND TO PUBLIC DOCUMENT ROOM? YES (NO)						
OFFICE	RII:DRS					
SIGNATURE						
NAME	AGibson:obw					
DATE	03/12/96	03/ /96	03/ /96	03/ /96	03/ /96	03/ /96
COPY?	YES / NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: G:\MEMO\DD\RAPP.4

ATTACHMENT 9

EICS rewrite 3/4/96
50.59 + Procedures

DRAFT NOV FOR CRYSTAL RIVER OPERATORS

License [__(#)__] issued on [__DATE__] to [__NAME__] required, in part, that while performing licensed duties, [NAME] shall observe the operating procedures and other conditions specified in the facility license which authorizes operation of the facility.

Condition 1.C of the Crystal River Unit 3 Operating License No. DPR-72 requires the facility to be operated in conformity with the application, as amended, the provisions of the Act, and the rules and regulations of the Commission.

10 CFR 50.59, Changes, Tests, and Experiments, in part, allows the licensed facility to conduct tests not described in the safety analysis report (SAR), unless the proposed test involves an unreviewed safety question. A proposed test shall be deemed to involve an unreviewed safety question if the probability of occurrence or the consequences of an accident or malfunction of equipment important to safety previously evaluated in the SAR may be increased. The licensee shall maintain records of tests carried out pursuant to this section, including a written safety evaluation which provides the basis for the determination that the test does not involve an unreviewed safety question.

Crystal River 3 Technical Specification 5.6.1.1 requires, in part, that procedures be implemented covering activities as recommended in Regulatory Guide 1.33, Revision 2, Appendix A, of February 1978. Appendix A recommends procedures for operation of the reactor coolant system makeup system.

Crystal River 3 procedure AI-500, Conduct of Operations, Rev. 80, stated that it is the duty of every member of the Crystal River Plant work force to comply with procedures. Procedure OP-402, Makeup and Purification System, Rev. ??, required that operators ensure that the make-up tank pressure limits of OP-103B, Curve 8, are not exceeded when adding hydrogen to the make-up tank by manually bypassing the 15 psig hydrogen regulator. Procedure OP-103B, Curve 8, Maximum Make-up Tank Overpressure, Rev. 12, defined the acceptable make-up tank pressure versus level operating region. Procedure AR-403, PSA H Annunciator Response, Rev. 22, required operators to take action to reduce make-up tank pressure to within the limits of OP-103B, Curve 8, when a valid alarm is received.

Contrary to the above, on September 4 and 5, 1994, [__NAME__] deliberately violated Crystal River 3 procedures and other conditions specified in the facility license which authorizes operation of the facility when [HE, SHE] conducted tests not described in the SAR, without written safety evaluations which provided the basis for the determination that the tests did not involve an unreviewed safety question. Specifically, [NAME] conducted tests, not required by plant conditions, to collect data involving reactor coolant sysytem make-up tank pressure and level. During the tests, [NAME] failed to meet the requirements of AI-500 to comply with the following Crystal River 3 procedures:

a. OP-402, Step ???, was not met on September 4 and 5, 1994, in that the make-up tank pressure exceeded the limits of OP-103B, Curve 8, while

Attachment

adding hydrogen to the make-up tank by manually bypassing the 15 psig hydrogen regulator.

b. The limits of OP-103B on acceptable make-up tank pressure were exceeded on September 4, 1994, for approximately 43 minutes, from approximately 4:24 a.m. to 5:06 a.m. and on September 5, 1994 for approximately 37 minutes continuously from approximately 4:45 a.m. to 5:21 a.m.

c. AR-403, Step ???, was not met on September 4 and 5, 1994, in that timely action was not taken to reduce make-up tank pressure to within the limits of OP-103B, Curve 8, when a valid alarm was received.

BACKGROUND

Unreviewed Safety Question

The test did involve an unreviewed safety question in that make-up tank design basis limits of OP-103B, Curve 8, were exceeded. Curve 8 had been calculated to provide a margin of about 0.8 pounds per square inch (psig) to prevent potential make-up pump gas binding during an accident. The September 4 test exceeded Curve 8 limits by as much as 2.36 psig. The September 5 test exceeded Curve 8 limits by as much as 1.71 psig. Under these conditions, one postulated accident scenario, a Loss of Coolant Accident with a core flood line break and a concurrent emergency diesel generator failure, could result in the loss of all high pressure and low pressure injection flow to the nuclear reactor.

Alarm Response

With regard to the alarm response, Curve 8 was exceeded, and the alarm was in, for approximately 43 minutes on September 4 and 37 minutes on September 5, continuously. In response to the alarm, instead of reducing make-up tank pressure to within the limits of Curve 8, the operators lowered make-up tank level which caused make-up tank pressure to exceed Curve 8 by an increasing amount.

DRS original VIOL.
3/1/96 50.59 + Procedure

DRAFT NOV FOR CRYSTAL RIVER OPERATORS

License [__(#)__] issued on [__DATE__] to [__NAME__] required that while performing licensed duties, [HE, SHE] shall observe the operating procedures and other conditions specified in the facility license which authorizes operation of the facility.

10 CFR 50.5, Deliberate Misconduct, in part, prohibits facility licensee employees from engaging in deliberate misconduct that causes a licensee to be in violation of a condition of any license issued by the Commission. Deliberate misconduct is defined as an intentional act or omission that the person knows would cause a licensee to be in violation of any regulation issued by the Commission or that constitutes a violation of a procedure of a licensee.

10 CFR 50.59; Changes, Tests, and Experiments; in part, allows the licensed facility to conduct tests not described in the safety analysis report (SAR), unless the proposed test involves an unreviewed safety question. A proposed test shall be deemed to involve an unreviewed safety question if the probability of occurrence or the consequences of an accident or malfunction of equipment important to safety previously evaluated in the SAR may be increased. The licensee shall maintain records of tests carried out pursuant to this section, including a written safety evaluation which provides the basis for the determination that the test does not involve an unreviewed safety question.

Crystal River 3 Technical Specification 5.6.1.1 requires, in part, that procedures be implemented covering activities as recommended in Regulatory Guide 1.33, Revision 2, Appendix A, of February 1978. Appendix A recommends procedures for operation of the reactor coolant system makeup system.

Crystal River 3 procedure AI-500, Conduct of Operations, Rev. 80, stated that it is the duty of every member of the Crystal River Plant work force to comply with procedures. Procedure OP-402, Makeup and Purification System, required that operators ensure that the make-up tank pressure limits of OP-103B, Curve 8, are not exceeded when adding hydrogen to the make-up tank by manually bypassing the 15 psig hydrogen regulator. Procedure OP-103B, Curve 8, Maximum Make-up Tank Overpressure, Rev. 12, defined the acceptable make-up tank pressure versus level operating region. Procedure AR-403, PSA H Annunciator Response, Rev. 22, required operators to take action to reduce make-up tank pressure to within the limits of OP-103B, Curve 8, when a valid alarm is received.

Contrary to the above:

1. [__NAME__] engaged in deliberate misconduct in that [HE, SHE] intentionally caused Crystal River 3 to be in violation of a regulation issued by the Commission when [HE, SHE]:

   a. Intentionally violated 10 CFR 50.59 by conducting a test not described in the SAR on September 4, 1994, without a written safety evaluation which provided the basis for the determination that the test did not involve an unreviewed safety question. [HE,

SHE] conducted a test in that [HE, SHE] conducted an evolution involving make-up tank pressure and level, not required by plant conditions, to collect data, and which involved violation of Crystal River 3 procedures. The test did involve an unreviewed safety question in that make-up tank design basis limits of OP-103B, Curve 8, were exceeded. Curve 8 had been calculated to provide a margin of about 0.8 psig to prevent potential make-up pump gas binding during an accident, and the September 4 test exceeded Curve 8 limits by as much as 2.36 psig. Under these conditions, one postulated accident scenario, a Loss of Coolant Accident with a core flood line break and a concurrent emergency diesel generator failure, could result in the loss of all high pressure and low pressure injection flow to the nuclear reactor.

b. Intentionally violated 10 CFR 50.59 by conducting a test not described in the SAR on September 5, 1994, without a written safety evaluation which provided the basis for the determination that the test did not involve an unreviewed safety question. [HE, SHE] conducted a test in that [HE, SHE] conducted an evolution involving make-up tank pressure and level, not required by plant conditions, to collect data, and which involved violation of Crystal River 3 procedures. The test did involve an unreviewed safety question in that make-up tank design basis limits of OP-103B, Curve 8, were exceeded. Curve 8 had been calculated to provide a margin of about 0.8 psig to prevent potential make-up pump gas binding during an accident, and the September 5 test exceeded Curve 8 limits by as much as 1.71 psig. Under these conditions, one postulated accident scenario, a Loss of Coolant Accident with a core flood line break and a concurrent emergency diesel generator failure, could result in the loss of all high pressure and low pressure injection flow to the nuclear reactor.

2. [___NAME___] engaged in deliberate misconduct in that [HE, SHE] intentionally violated [AND DIRECTED LICENSED OPERATORS TO VIOLATE] Crystal River 3 procedures AI-500, OP-402, OP-103B, and AR-403 when [HE, SHE]:

a. Intentionally violated OP-402 on September 4, 1994, in that [HE, SHE] allowed the make-up tank pressure to exceed the limits of OP-103B, Curve 8, while adding hydrogen to the make-up tank by manually bypassing the 15 psig hydrogen regulator.

b. Intentionally violated AR-403 on September 4, 1994, in that [HE, SHE] failed to take timely action to reduce make-up tank pressure to within the limits of OP-103B, Curve 8, when a valid alarm was received. Curve 8 was exceeded, and the alarm was in, for approximately 43 minutes continuously. In response to the alarm, instead of reducing make-up tank pressure to within the limits of Curve 8, [HE, SHE] lowered make-up tank level which caused make-up tank pressure to exceed Curve 8 by an increasing amount.

c. Intentionally violated OP-103B on September 4, 1994, in that [HE, SHE] exceeded the limits of Curve 8 on acceptable make-up tank pressure for approximately 43 minutes continuously, from

approximately 4:24 a.m. to 5:06 am.

d. Intentionally violated OP-402 on September 5, 1994, in that [HE, SHE] allowed the make-up tank pressure to exceed the limits of OP-103B, Curve B, while adding hydrogen to the make-up tank by manually bypassing the 15 psig hydrogen regulator.

e. Intentionally violated AR-403 on September 4, 1994, in that [HE, SHE] failed to take timely action to reduce make-up tank pressure to within the limits of OP-103B, Curve B, when a valid alarm was received. Curve B was exceeded, and the alarm was in, for approximately 37 minutes continuously. In response to the alarm, instead of reducing make-up tank pressure to within the limits of Curve B, [HE, SHE] lowered make-up tank level which caused make-up tank pressure to exceed Curve B by an increasing amount.

f. Intentionally violated OP-103B on September 4, 1994, in that [HE, SHE] exceeded the limits of Curve B on acceptable make-up tank pressure for approximately 37 minutes continuously, from approximately 4:45 a.m. to 5:21 am.

EICS rewrite 5/1/96
50.59

DRAFT NOV FOP CRYSTAL RIVER OPERATORS

License [__(#)__] issued on [__DATE__] to [__NAME__] required that while performing licensed duties, [HE, SHE] shall observe the operating procedures and other conditions specified in the facility license which authorizes operation of the facility.

Condition 1.C of the Crystal River Unit 3 Operating License No. DPR-72 requires the facility to operate in conformity with the application, as amended, the provisions of the Act, and the rules and regulations of the Commission.

10 CFR 50.59, Changes, Tests, and Experiments, in part, allows the licensed facility to conduct tests not described in the safety analysis report (SAR), unless the proposed test involves an unreviewed safety question. A proposed test shall be deemed to involve an unreviewed safety question if the probability of occurrence or the consequences of an accident or malfunction of equipment important to safety previously evaluated in the SAR may be increased. The licensee shall maintain records of tests carried out pursuant to this section, including a written safety evaluation which provides the basis for the determination that the test does not involve an unreviewed safety question.

Contrary to the above, [___NAME___] failed to observe the operating procedures and other conditions specified in the facility license which authorizes operation of the facility when [HE, SHE]:

a. Deliberately violated 10 CFR 50.59 by conducting a test not described in the SAR on September 4, 1994, without a written safety evaluation which provided the basis for the determination that the test did not involve an unreviewed safety question. [HE, SHE] conducted a test in that [HE, SHE] conducted an evolution involving make-up tank pressure and level, not required by plant conditions, to collect data, and which involved violation of Crystal River 3 procedures. The test did involve an unreviewed safety question in that make-up tank design basis limits of OP-103B, Curve 8, were exceeded. Curve 8 had been calculated to provide a margin of about 0.8 pounds per square inch (psig) to prevent potential make-up pump gas binding during an accident, and the September 4 test exceeded Curve 8 limits by as much as 2.36 psig. Under these conditions, one postulated accident scenario, a Loss of Coolant Accident with a core flood line break and a concurrent emergency diesel generator failure, could result in the loss of all high pressure and low pressure injection flow to the nuclear reactor.

b. Deliberately violated 10 CFR 50.59 by conducting a test not described in the SAR on September 5, 1994, without a written safety evaluation which provided the basis for the determination that the test did not involve an unreviewed safety question. [HE, SHE] conducted a test in that [HE, SHE] conducted an evolution involving make-up tank pressure and level, not required by plant conditions, to collect data, and which involved violation of Crystal River 3 procedures. The test did involve an unreviewed safety question in that make-up tank design basis limits of OP-103B, Curve 8, were exceeded. Curve 8 had been calculated to provide

a margin of about 0.8 psig to prevent potential make-up pump gas binding during an accident, and the September 5 test exceeded Curve B limits by as much as 1.71 psig. Under these conditions, one postulated accident scenario, a Loss of Coolant Accident with a core flood line break and a concurrent emergency diesel generator failure, could result in the loss of all high pressure and low pressure injection flow to the nuclear reactor.

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

March 20, 1996

MEMORANDUM TO: Albert F. Gibson, Director
Division of Reactor Safety

FROM: Curtis W. Rapp, Senior Reactor Inspector
Division of Reactor Safety

SUBJECT: RESPONSE TO YOUR MARCH 12, 1996 MEMORANDUM CONCERNING PROPOSED NOTICE OF VIOLATION FOR CRYSTAL RIVER OPERATORS

As directed by the above subject memorandum, I am providing a detailed explanation of my professional objection to the proposed procedural violations. However, I take exception to several statements in the subject memorandum.

Your characterization that I did not concur with IR 95-22 is inaccurate; I did and still do concur with the IR 95-22. What I told Mr. Johnson was that I do not agree that procedural violations occurred, but these procedural issues need to be discussed. The enforcement conferences with the operators will provide that opportunity. Additionally, both IR 95-22 and the subject memorandum refer to these procedural violations as "apparent violations." As I understand, this means no decision has been made to actually cite the operators for these violations. If this decision has already been made, I was not included in this process.

You state that you were not aware of my professional objection to these proposed procedural violations. I have expressed my professional objection during meetings on 7/6/95, 7/11/95, 10/17/95, 10/23/95, 12/5/95, 12/20/95, 1/9/96, 1/24/96, and 1/26/96 where either you or other Regional senior managers were present. In particular, during the meeting on 10/23/95 you said that I may not be the right individual to send back to Crystal River with OI ". . . given my personal views." Furthermore, I described my professional objection and associated reasoning in a memorandum to Ellis W. Merschoff dated July 27, 1995 of which you received a copy.

I did review and comment on the proposed notice of violation (NOV). However, again I was excluded when the proposed NOV was drafted. I requested to review the proposed NOV only after being asked specific questions about correct procedural revision numbers. I provided my comments to the EICS staff member assigned to the enforcement actions. Based on my review of the proposed NOV attached to the subject memorandum, not all my comments were incorporated. I also requested that I be included on distribution for any future revisions to the proposed NOVs. Only through my efforts have I been afforded the opportunity to review and comment on the proposed NOV.

ATTACHMENT 10

A. F. Gibson

As stated above, I clearly stated my professional objection to the proposed procedural violations in my memorandum of July, 27, 1995. A copy is provided as an attachment to this memorandum. However, as directed by the subject memorandum,

> **I DO NOT concur with the inclusion of procedural violations in the draft notice of violation.**

As stated above, I clearly stated my reasoning why I disagreed with the proposed procedural violations. However, as directed by the subject memorandum, I have provided detailed explanations why the proposed procedural violations have no merit.

> Item a. of the proposed NOV states the operators violated procedure OP-402 by exceeding the allowable pressure limit when adding hydrogen. I reviewed the plant conditions for September 4 and 5, 1994 as described in IR 95-22 and plotted these conditions on a copy of Curve 8. I found the make-up tank pressure was within the allowable limit given by Curve 8 on both September 4 and 5, 1994. If the make-up tank pressure limit was exceeded, it was exceeded by substantially less than the 0.5 psig criteria applied to determine if other instances were a violation of the allowable pressure limit.
>
> Item b. of the proposed NOV states the limit on acceptable make-up tank pressure was exceeded for a substantial time on both September 4 and 5, 1994. As stated in my July 27, 1995 memorandum, OP-103B is not a procedure but contains the administrative operating limits. Therefore, exceeding the acceptable make-up tank pressure must be cited in the context of a procedural requirement. Procedure OP-402 only referenced this limit when adding hydrogen; not when make-up level was changed. Also, as identified in IR 95-22, there was no precaution or limitation in OP-402 that references acceptable make-up tank pressure limit. Since OP-402 was not violated when make-up tank pressure was increased and maintaining make-up pressure was not procedural required when changing make-up tank level, OP-402 cannot be used to cite a violation of OP-103B. The only place where compliance with administrative limits is mentioned is AI-500 as an operator responsibility. However, this is not included in the proposed NOV provided with the subject memorandum.
>
> Item c. of the proposed NOV states the operators did not respond to the alarm as required by AR-403. AI-500 4.3.2.2.4 states:
>
> > Annunciator Response Procedures (AR's) shall be utilized as follows:
> >
> > 1. Annunciator response procedures shall be used to diagnose alarms not expected (**not directly related to intentional manipulation of plant controls**), and for any alarm the operators are not explicitly familiar with. [emphasis added]

2. The Control Board Operators shall interpret and verify that annunciator alarm signals are consistent with plant conditions.

Clearly, the administrative guidance to the operators did not require any response to the alarm because it resulted directly from the manipulation of plant controls. Furthermore, the operators would have had contradictory indications (plant computer and control board recorder) to determine if the alarm was valid. Because the recorder was the qualified control room instrument, it would be expected the operators used the recorder to validate the alarm.

No timeliness requirement is present in this procedure and, as documented in IR 95-22, no administrative guidance for timeliness of alarm response existed.

The control room alarm was driven from a computer algorithm that approximated OP-103B Curve 8. This algorithm did not provide any deadband causing the alarm to activate whenever make-up tank pressure was at or above the limit given by OP-103B Curve 8. Therefore, activation of the alarm does not indicate the make-up tank allowable pressure is being exceeded.

You have consistently characterized my professional objection as "personal views." This is not my "personal views," but instead is a professional objection arising from both my operational experience at commercial nuclear power plants and facts from my involvement with the OI interviews and on-site inspection. Just because my professional objection is in direct opposition to management's desired outcome does not diminish the fact it is indeed professional and not "personal."

Attachments: Memorandum of July 27, 1995
Comments on proposed NOV

cc: J. Johnson
K. Landis

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

May 3, 1996

MEMORANDUM TO: Stewart D. Ebneter
Regional Administrator

FROM: Curtis W. Rapp, Reactor Engineer
Division of Reactor Safety

SUBJECT: DPV PANEL RESULTS

Your memorandum of April 12, 1996, transmitted the results of the management-initiated DPV Panel for my memorandum to A. Gibson dated February 5, 1996. After reviewing these results, I must take exception to the conclusions reached by the DPV Panel. In general, the responses to my concerns do not address the actual points which I was making. Further, a number of statements in the Discussion section of the DPV Panel report are grossly misleading if not factually incorrect.

I wish to reiterate that I did not submit my "lessons learned" as a Differing Professional View but as recommendations to improve NRC processes in the future. However, rather than accepting these recommendations in the constructive spirit in which they were offered, NRC management chose to construe them as adversarial and concentrated on "disproving" my observations. I see no evidence that the underlying concerns were given due and impartial consideration in a productive manner. Additionally, the manner in which they were handled serves to promote a chilling effect.

The following paragraphs are detailed explanations for my exception to the DPV Panel conclusions.

Lesson 1: Inspect First, Then Investigate

The DPV Panel did not address the point I was making, which was an apparent weakness in the Agency policies and practices pertaining to cases of potential wrongdoing which require both investigation and inspection. I was using my experiences with the Crystal River Makeup Tank as an example to point out the consequences of postponing critical inspection activities on the basis of avoiding "compromising the OI investigation of wrongdoing." The DPV Panel's response to my recommendation was to simply reiterate the very guidance and practices which I was questioning. This did nothing to address my concern, and indicated that my recommendation was dismissed without due consideration.

The Discussion contained an extremely misleading paragraph which indicated that adequate inspection was in fact performed prior to and during the period in which the OI investigation was ongoing by listing six inspection reports as having been issued "prior to the release of the OI Investigation Report." The number of inspection reports issued prior to the release of the OI report is irrelevant and misrepresentative. In fact, only one inspection report, IR 94-22, was issued prior to the on-site OI investigation conducted in

December 1994. This level of inspection was clearly not adequate in that it failed to identify critical information such as the performance of evolution conducted on September 4, 1994 which did not become known to NRC until July 1995. Yet, according to the FPC Internal Investigation report and the OI interviews, the September 4 evolution was properly entered in the Reactor Operators' log book, the computer data had not been erased, and engineering personnel had reviewed the computer data. The absence of any recommendations leads me to conclude that the DPV Panel accepted any level of inspection effort, even if inadequate, to "disprove" my concern.

Next, the DPV Panel proceeded to discredit me professionally. The Discussion contains the following statement:

> He did not review pertinent background material (resident reports or panel documents) or discuss the issue with the residents before accompanying OI to the site.

This statement and others collectively imply that the necessary information was available and that I was responsible for performing such a review. Further, the Discussion implies that I was at fault for not knowing about matters (such as that an enforcement panel had been conducted) that management elected not to inform me of.

I commonly conduct a comprehensive review of background information when preparing for inspection; however, as I told the DPV Panel, management indicated that my involvement in the issues was intended to be insignificant. I was directed that my role would be to simply keep the OI investigator from becoming "overwhelmed" by technical information and commonly used acronyms. In fact, when I specifically asked what I was supposed to do, Mr. Gibson directed me to "Keep your mouth shut and speak only when you're spoken to." This reinforced my understanding that my management desired my presence to be supportive rather than participatory, and clearly <u>not</u> to conduct any inspection. When I did attempt to inspect this event more completely, Mr. Gibson told me he did not want me doing any further inspection because of the on-going OI investigation. As inspections by other personnel continued, management took no actions to inform me of activities or results. The extent to which I was able to stay informed was through my own initiatives and was beyond my expected role as Mr. Gibson clearly communicated to me.

Even though I explained this information to the DPV Panel, and informed them of Mr. Gibson's directive, they evidently decided to slant the findings to evade the issue and protect a senior manager.

<u>Lesson 2: Refrain From Making Inappropriate Comparisons</u>

Again, the DPV Panel evades the issue of concern, which was the loss of technical credibility which results from extreme and inappropriate comparisons. The Chernobyl comparisons have in fact been recognized by NRC management as inappropriate and unfortunate, and were therefore discontinued (e.g., deletion of such a reference from the proposed Enforcement Conference remarks). Yet when I questioned such comparisons, management defended them as appropriate.

The fact that Crystal River's engineering staff was "bothered" at all indicates that the comparison was both technically and professionally inappropriate. Furthermore, Crystal River managers took exception to this comparison; specifically Mr. Bruce Hickle and Mr. Greg Halnon. I have included pertinent portions of these individuals transcripts where the Chernobyl comparison was discussed as Attachment 1

Whether Crystal River personnel "were probably as much bothered by FPC management's continuing comparisons to Chernobyl as they were of NRC's", and whether the "NRC staff interviewed by the NRC Panel understood" the analogy, are irrelevant to whether licensee personnel were bothered by the Chernobyl comparisons made by NRC management.

An NRC action resulting in a loss of credibility can have both tangible and intangible effects. Although "The Panel determined from the two investigators that the reference to Chernobyl did not impact their investigations", the comparisons had a tangible negative effect on my own investigation and inspection. Further, the intangible effects of credibility loss are discounted and go unaddressed.

Finally, the technical comparisons made in the Discussion in an attempt to justify the comparison fall short. The reactor and systems technologies used at Chernobyl were substantially different from that used at Crystal River. The September 4 and 5, 1994, evolutions did not affect core reactivity, safety systems were not bypassed, and *identified* safety limits were not violated. Also, the fact that INPO considers this a serious event should have no bearing on how NRC conducts business, including use of proper comparisons.

Lesson 3: Don't surprise the licensee

The DPV Panel failed to address my points that 1) NRC failed to inform the licensee in a timely manner of the level of NRC concern, initially leading them to believe that the matter was not considered especially egregious, then surprising them later with the opposite response, and 2) both the initial message that the incident was not of serious regulatory concern, and the subsequent opposite message that the event was "like Chernobyl" influenced the actions taken by licensee management toward the operators. Instead of addressing the issues which I raised, the DPV Panel discusses at length about the unrelated issue (not raised by me) of whether it is appropriate to introduce a topic at a meeting about a different topic, and how the licensee should respond in a hypothetical instance of that nature.

The Discussion acknowledges the fact that the licensee was surprised at the November 22, 1994, meeting by the level of NRC concern to which this matter had risen. This acknowledgement directly substantiates the first portion of my concern. Furthermore, keeping FPC informed may have prompted FPC to conduct a timely in-depth review of the September 5, 1994, evolution resulting in identification of the September 4, 1994, evolution earlier. The failure to identify the September 4, 1994, evolution resulted in severe disciplinary actions against the operators involved including termination.

My concern that strong NRC statements at the November 22, meeting influenced the disciplinary actions taken by licensee management toward the operators is substantiated by the sequence of events on record. At the November 22, meeting, licensee management stated that they had not immediately taken the involved SROs off shift. One was still on shift at the time, and as a result of direct statements at the November 22, meeting, was immediately removed from shift duties. There is no evidence this action was planned by licensee management prior to the November 22, meeting.

Lesson 4: Include all knowledgeable persons in the enforcement process

Once again, the DPV Panel presents information in a misleading manner and does not address my actual concern. As I have repeatedly explained, the essence of my concern was that I was excluded from discussions of the case prior to July 1995. This included exclusion from active participation in the development of the draft NOVs and any discussions on proposed enforcement. It was only through my own significant efforts that I managed to keep informed to any extent at all regarding factual developments outside the direct scope of the OI investigation. Had I been allowed to contribute my knowledge of the case and my general expertise, I believe that events would have proceeded more effectively and productively. The DPV Panel attempts to refute my concern by documenting my involvement in the enforcement process subsequent to July 1995. This was never in dispute and is completely irrelevant.

However, indirectly the DPV Panel acknowledges the validity of my concern. As stated in the Discussion, "The panel determined that Mr. Rapp was not included in the task of initially drafting the proposed violations in the July 1995 time period." However, the claim is then made that "This task is the administrative portion of the enforcement process," implying that the activities from which I was excluded were of no importance. This is not true and highly misleading. Obviously, the enforcement process is more than an administrative one, as an important decision making process occurs prior to the preparation of the supporting documentation. I was excluded from this important part of the process. Further, the Discussion states that, "He was involved in the review of the NOVs." I did review and comment on the draft NOVs as documented in my memorandum to Ellis Merschoff dated July 27, 1995; however, my involvement was a result of my own initiative. Management did not seek this review, despite my obvious knowledge of the case. As I have repeatedly expressed, my continued efforts to participate had been directly rejected by management. The fact that Mr. Merschoff issued a memorandum dated August 9, 1995, to advise me that he considered my knowledge of the case important does not change the fact that prior to July 1995, my participation was actively discouraged.

To illustrate how my participation prior to July 1995, was actively discouraged by management, the first time I was asked about my views on Crystal River was during an inspection debriefing with Mr. Gibson on July 11, 1995, about the missed criticality at H. B. Robinson. At this meeting, Mr. Gibson asked me to explain my differing view on the draft NOVs for Crystal River. I had been attempting for some time to get management to listen to my views and give them consideration so I explained to Mr. Gibson that although I did not believe that the operators should have conducted an

unauthorized test, neither did I believe that they had committed the violations as stated in the draft NOVs. I did not believe that citing these violations would not be valid because the operators had used approved procedures, anticipated system response, and took compensatory measures. In response, Mr. Gibson falsely accused me of thinking that the operators had done nothing wrong, and basically told me my thinking was in error. Mr. Gibson went on to misconstrue what I had said and to behave as if expressing my professional opinion was inappropriate. He stated that the agency needed to send a message that conducting tests is unacceptable, and ". . . we need everyone to get behind this." Even though I have never contended that conducting unauthorized tests is acceptable, a comment in my FY 1995 performance appraisal stated that I feel inappropriate actions are justified if they result in a safety benefit. This accusation about me was untrue and had a chilling effect. As I told the members of the DPV Panel, I have never expressed this view, only that the operators had perform the evolution nominally within the bounds of plant operating procedures, which had already received a 50.59 evaluation, and that the balance of safety consequences versus safety benefit should be considered when developing any enforcement actions.

The claim in the Discussion that my review of the OI transcripted interviews ". . . was a related and important task." has been disproven. Recently, Mr. Gibson has made derogatory remarks about the "matrix" I developed from the review of the OI transcripts saying that ". . . we have lost control of the Crystal River allegations" and the matrix ". . . is a mixed bag" and ". . . I have no faith the matrix captured everything." As directed by Mr. Gibson's memorandum to me dated August 31, 1995, the purpose of my review was to develop areas for future inspections; not to develop an index of allegations. This is substantiated by the decision to exclude allegations of NRC wrongdoing from the review.

Lesson 5: Don't single out an individual

The DPV Panel acknowledges the basis for my concern, stating "It is possible that the licensee did review the individual's performance more closely because of the NRC management comments," and "It is likely that NRC's comments were made with the intent that the licensee review the shift supervisor's actions more closely because of this past performance." In fact, during my discussions with the DPV Panel, Mr. Crlenjak said he took "great exception" to my contention that Mr. Fields was singled out by NRC management.

Yet the Discussion then denied the validity of the concern by stating "An individual was not singled out; predecisional enforcement conferences were scheduled with six individuals." This is a grossly misleading statement because the number of people brought in for enforcement conferences is irrelevant to the issue of explicitly encouraging extra licensee management scrutiny of a particular individual.

The Discussion contained the telling caveat that "It is appropriate for NRC managers to carefully raise concerns relative to a licensed operator's current performance based on previous concerns with the individual, providing the facts relative to previous performance are known and pertinent." This

statement serves only to further substantiate my concern. Mr. Fields was singled out by Mr. Gibson in a conversation with FPC management about ". . . certification/validation errors" by Mr. Fields. This established Mr. Fields as a regulatory liability to FPC. However, it is debatable whether the facts of the previous performance were "known and pertinent." I discussed the validity of the finding with the Senior Resident Inspector, Ross Butcher, who told me that the regional inspectors work ". . . in a vacuum" and that the inspector should have first discussed the issue with him before pursuing as a violation.

The statement in the Discussion that "Whether the licensee scrutinized the shift supervisor's actions more closely because of NRC management concerns was not revealed in the transcripts reviewed" is factually incorrect. As stated by Mr. Gary Boldt in his transcribed OI interview, FPC did indeed examine the actions of Mr. Fields more closely because of Mr. Gibson's contact. The relevant pages from Mr. Boldt's interview are included as Attachment 2.

As I told the DPV Panel, if the NRC has a problem with the conduct of a licensed operator, we should take individual enforcement action rather than pressuring the licensee to do our dirty work. Otherwise, we should cite the licensee and leave it to them to handle internal personnel issues as they see fit. If Mr. Fields' actions were sufficiently egregious for Mr. Gibson to take the issue to FPC management, why did we not follow the established enforcement process and allow Mr. Fields to the opportunity to explain his actions directly to NRC management?

Conclusion

Since the management-initiated DPV Panel failed to fully examine my "concerns," I can only conclude either they failed to understand what they were reading or they failed to seriously review the concerns I raised. In any case, the DPV process was a sham serving no purpose except to protect NRC senior managers. Furthermore, instead of my efforts being appreciated, I have been subjected to both professional and personal ridicule, given work assignments that cannot be accomplished in the time allowed, isolated from the inspection process, and subjected to adverse and untrue statements in my performance appraisal for expressing my professional objections on safety issues. I doubt seriously if my professional contribution will ever be positively recognized by Region II management.

Attachments:
1. Portion of OI Interviews with Mr. Bruce Hickle and Mr. Greg Halnon
2. Portion of OI Interview with Mr. Gary Boldt

MR. DOCKERY: -- looks for that.

Mr. Hickle, we have heard, and this is totally unrelated to what we've been discussing, but as a filler here, we have heard from many people or many instances

wherein the evolutions of the 5th and as it turns out the 4th were likened to Chernobyl. Have you heard that that comparison?

THE WITNESS: Yes.

MR. DOCKERY: Do you know where that emanated from?

THE WITNESS: As I understand that -- that was a statement that was made -- made by someone very, very high in the Nuclear Regulatory Commission organization, possibly by one of the commissioners. But I don't know that because I heard this information secondhand.

MR. DOCKERY: To your knowledge was that -- was Chernobyl first uttered by -- by somebody in FPC or by somebody in the NRC?

THE WITNESS: Well, I would say the NRC, but I don't know what utterings -- I mean, all together I don't know what people utter all the time.

MR. DOCKERY: Well, I understand --

THE WITNESS: I wouldn't characterize it in any way, shape or form like Chernobyl.

MR. DOCKERY: Well, I think we all have a little -- we might have a little bit of trouble with that analogy.

THE WITNESS: Okay.

MR. DOCKERY: But it has been termed it was

bandied about with respect to the evolutions on those two dates and it's -- we just wondered if you knew the genesis of it?

THE WITNESS: No. I -- I don't know the genesis of that. I don't agree with that analogy.

MR. VORSE: Did Chernobyl ever -- Did that word Chernobyl ever come down to you?

THE WITNESS: Yeah. I mean, that --

MR. VORSE: Did that come down from NRC to you?

THE WITNESS: Actually, that came from all over. I mean, there was people -- When you hear unauthorized test, the first thing you think of is Chernobyl. So --

MR. DOCKERY: Would that be the first thing that you would think of?

THE WITNESS: I didn't think of that. I think Paul Fleming hit me with that first thing. But we didn't look at that as being as significant as Chernobyl from a technical standpoint. Maybe a standard standpoint where you had a violation of procedures, which there was probably a host of violations in procedures in Russia. I don't know.

I didn't make the connection myself, no.

MR. DOCKERY: You mentioned some history regarding Mr. Fields. Did you have any reason to question his competence or his judgment or ability prior to September 1994?

THE WITNESS: Not -- No. I wouldn't say his competence. We watch him -- We watched him closely in the simulator several times. I mean, his crew. We watched the crew perform. I don't think we felt that anything was unsafe.

I think -- The only nagging feeling we had is that whether he communicated well or not. I think, you know, there's always been kind of a feeling that he's more confrontational, maybe, than some others and may not communicate as well.

MR. DOCKERY: Mr. Boldt, would you characterize the issue of Curve 8 --

THE WITNESS: Let me go back and -- There have

been a few other issues that have turned up with Dave. And I don't recall whether they were before or after. But certainly the 1991 reactor trips were.

But I remember getting a call from Al Gibson from Region II regarding Dave's signing off on work requests, some post-maintenance tests as being completed which were not yet performed. We probed that issue. It wasn't an issue of -- you know, of trying to intentionally falsify a document. There's been some -- There's been a practice in some cases where we're coming up out of refueling outage and there's a regularly scheduled surveillance that's going to perform the post-maintenance test.

There have been cases where the work request has been closed out because it's a scheduled evolution, and then that test is subsequently performed and married with the package.

But that was the issue when we looked at it. Now, that was not a good practice, as a rule, not a good standard There was no reason to have to close out the work orders. So that issue had come up regarding Dave's judgment and it was kind of in the back of our minds.

So over the period of time from December and sometime after December we took Dave off shift. He was never fired at that point. I think we felt that there were a number of issues of judgment, the September -- or the October-November 1991 reactor trips, this particular evolution, the phone call we had from Al Gibson about the work requests, and others that, you know, judgment wasn't good. And so we needed to get him -- We needed to get him out of shift work. So we were moving in that direction.