REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8710280031 DOC. DATE: 87/10/23 NOTARIZED: NO DOCKET #
FACIL: 50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
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RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-024-01: on 870913, reactor controls manipulated by non-licensed person under supervision of licensed operator. Caused by personnel error. Personnel counseled. W/871023 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD2-2 LA	1	1	PD2-2 PD	1	1
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INTERNAL:	ACRS MICHELSON	1	1	ACRS MOELLER	2	2
	AEOD/DOA	1	1	AEOD/DSP/NAS	1	1
	AEOD/DSP/ROAB	2	2	AEOD/DSP/TPAB	1	1
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	NRR/DEST/ADS	1	0	NRR/DEST/CEB	1	1
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	NRR/DREP/RAB	1	1	NRR/DREP/RPB	2	2
	NRR/DRIS/SIB	1	1	NRR/PMAS/ILRB	1	1
	REG FILE 02	1	1	RES DEPY GI	1	1
	RES TELFORD, J	1	1	RES/DE/EIB	1	1
	RGN2 FILE 01	1	1			
EXTERNAL:	EG&G GROH, M	5	5	H ST LOBBY WARD	1	1
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NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Turkey Point Unit 3	0 5 0 0 0 2 5 0	1 OF 0 4

TITLE (4) Reactor Controls Manipulated by a Non-Licensed Person Under the Direct Supervision of a Licensed Operator

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 9	1 3	8 7	8 7	0 2 4	0 1	1 0	2 3	8 7	N/A	0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 3 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	X OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	Voluntary Report
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Gabe Salamon, Compliance Engineer	AREA CODE 3 0 5 — 2 4 6 - 6 5 6 0

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On September 13, 1987, at 0300, with Unit 3 at 30% power, a non-licensed person under the direct supervision of a Reactor Control Operator (RCO), turned the Reactor Control Make-up Switch to Start on two occasions. This resulted in a 30 gallon, then a 20 gallon dilution of the Reactor Coolant System (RCS). At this time, a flux map was being run. Negative reactivity was being added due to Xenon buildup. In order to minimize flux distortion, control rod motion was being minimized, and to counter the negative reactivity addition, the RCS was being diluted often. The RCO directly supervised both dilutions. Unevaluated information regarding other control manipulations by the non-licensed person in question is being investigated by FPL. The cause of the event was personnel error, in that the RCO failed to comply with the requirements of 10CFR50.54(i) and 10CFR55.3. Contributing to the event were inadequate procedures and training on the requirements of 10CFR50.54(i) and 10CFR55.3. The Plant Supervisor-Nuclear (PSN) counseled the RCO and the non-licensed person. The PSN discussed the event at the shift turnover meeting. Memos explaining the requirements of 10CFR50.54(i) were issued. All licensed operators have been required to read and sign the memo prior to assuming shift responsibility. Additional corrective actions will be taken upon evaluation of the results of ongoing investigations.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

EVENT

On September 13, 1987, at approximately 0300, with Unit 3 at 30% power, a non-licensed person under the direct supervision of a licensed operator, turned the Reactor Control Make-up Switch to Start on two occasions in close succession. The first occasion resulted in a 30 gallon dilution of the Reactor Coolant System (RCS), and the second occasion resulted in a 20 gallon dilution. At the time of the event, a 30% power flux map was being run. As a result of Xenon buildup, negative reactivity was being added. In order to minimize flux distortion, control rod motion was being minimized, and to counter the negative reactivity addition, boron was being removed by diluting the RCS. The dilution was being performed by adding preset quantities of water to the RCS periodically. During this event, the Reactor Control Operator (RCO) preset the water quantity to 30 gallons, then permitted a non-licensed person to turn the Reactor Control Make-up Switch to the Start position. The system response to the 30 gallon dilution was not sufficient, and the above evolution was repeated with the water quantity preset by the RCO to 20 gallons. The RCO directly supervised both dilutions. FPL is investigating unevaluated information regarding other similar control manipulations by the non-licensed person in question. Should this investigation confirm any other manipulations, the NRC will be notified.

CAUSE OF EVENT

A thorough investigation was performed independently by both the plant Quality Assurance department and the Operations department. The investigations were performed by personnel interviews, review of documents, personnel statements, notes, and reports of management personnel who had been on shift. The investigations had the following main goals:

a) review the timeliness of management actions
b) determine if this was an isolated event
c) review for potential reportability
d) determine existing procedural requirements addressing this event
e) determine training performed on this 10CFR50.54(i) and 10CFR55.3 requirement

The investigations concluded that the cause of the non-licensed person manipulating a control which directly affected the reactivity of the reactor was personnel error, in that the RCO failed to comply with the requirements of 10CFR50.54(i) and 10CFR55.3. Contributing to the absence of a full understanding of regulatory requirements were the following:

1) plant procedures and training did not detail the requirements of 10CFR50.54(i) and 10CFR55.3,
2) plant procedures were not revised to address the revision of 10CFR55.3 which became effective in May, 1987
3) no training which addressed the revisions of 10CFR55.3 was performed.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

ANALYSIS OF EVENT

While the manipulation of controls, as defined in 10CFR50.54(i) and 10CFR55.3, were performed by a non-licensed person under the direct supervision of the RCO, this action did not result in any operation of the unit outside of normal parameters. The evolutions performed by the non-licensed person were controlled and directly supervised by the RCO. Even though as a result of this event there were no safety consequences, the event represents a violation of regulatory requirements. This event is not a reportable event under either 10CFR50.72 or 10CFR50.73. However, Florida Power and Light is voluntarily submitting this Licensee Event Report because of the generic concerns and lessons to be learned, in addition to the safety significance of this event.

CORRECTIVE ACTIONS

Turkey Point has in place a Management on Shift program, the aim of which is to observe and improve Turkey Point's operation. The manipulation cited in this event was observed by the management personnel on shift at that time. The Operations Supervisor was notified of this event the following morning (September 14), and the Operations Superintendent and Plant Manager were notified at 1830 on September 14. The following immediate corrective actions were taken:

1) At 0001 on September 15, the Plant Supervisor-Nuclear (PSN) counseled the RCO and the non-licensed person involved in the event regarding the restrictions on manipulating controls.

2) The PSN discussed manipulation of controls by a non-licensed person and the requirements of 10CFR50.54(i) and 10CFR55.3 at the shift turnover meeting.

The Operations Superintendent decided to investigate this event further. Since this event had already been determined not to be reportable under 10CFR50.72 the investigation's purpose was to establish the facts of the event in order to be able to take long term corrective actions to preclude recurrence. The investigation did not start until September 21, as the Operations Supervisor, the subject RCO, and the Operations Superintendent were offsite on September 15, 16, and 17, and the subject RCO did not report to work on September 18 and 19 due to sickness.

On September 22, the Operations Supervisor issued a memo explaining the requirements of 10CFR50.54(i) and 10CFR55.3. All licensed operators have been required to read and sign the memo prior to assuming shift responsibility.

The Quality Assurance Superintendent, upon the request of the Vice President of Turkey Point Nuclear, initiated an independent investigation on September 23.

The Vice President of Turkey Point Nuclear issued a letter to all site personnel on September 24 describing the event and emphasizing compliance with the regulations. A second letter was issued on October 2, emphasizing the safety significance of the event.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

The incident was discussed by management with over 600 FP&L employees at special meetings held on Saturday, September 26.

The RCO was relieved of licensed duties on September 26 until the completion of ongoing investigations. Subsequently, the RCO briefed each shift of the event and its regulatory implications.

The Vice President of Turkey Point Nuclear held meetings with each operating shift to discuss this event.

The following long term corrective actions are being taken:

1) Development of a training module detailing the requirements of 10CFR50.54 and 10CFR55.

2) Development of a procedure to incorporate changes to 10CFR into plant documents and training. A formal review of future 10CFR revisions to determine applicability to Turkey Point will be initiated. The FP&L commitment tracking system, CTRAC, will be utilized to assure that these reviews will be accomplished.

3) Revise procedures as required in order to assure compliance with the requirements of 10CFR50.54, 10CFR55, and the relevant IE Bulletins, Notices, and Regulatory Guides.

4) Steps have been taken to assure that only individuals who are under the direction and in the presence of a licensed operator or senior operator, manipulate the controls of the facility as a part of the individual's training in Turkey Point's training program as approved by the Commission to qualify for an operator license, in accordance with 10CFR55.13.

ADDITIONAL INFORMATION

Similar occurrences: There have been no previous LERs on this type of event.

Other additional information: A Turkey Point site investigation has determined that there may be additional instances in which non-licensed personnel, who were not in training to obtain an operator license, manipulated controls under the supervision of a licensed operator. A report is in the final stage of preparation and will be forwarded to the NRC when completed.

P. O. BOX 14000, JUNO BEACH, FL 33408-0420

FPL

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OCTOBER 2 3 1987

L-87-429

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Gentlemen:

Re: Turkey Point Unit 3
Docket No. 50-250
Reportable Event: 87-24 (Voluntary Report) (Revision 1)
Date of Event: September 13, 1987
Reactor Controls Manipulated by a Non-Licensed Person
Under the Direct Supervision of a Licensed Operator

This is to supplement Florida Power & Light Company (FPL) LER 87-24 (voluntary report) concerning the manipulation of reactor controls by a non-licensed person at the Turkey Point Plant.

As indicated in the subject revised LER, FPL is conducting a further investigation of the event. Some information suggests the possiblity that the unlicensed person mentioned in the subject LER may have performed certain additional manipulations but the investigation is not yet concluded. NRC will be advised of the results.

A Turkey Point site investigation has determined that there may have been a few additional instances in which non-licensed personnel manipulated controls under the supervision of a licensed operator. A report on that matter is in the final stage of preparation and will be forwarded to the NRC when completed.

Very truly yours,

C. O. Woody
for Group Vice President
Nuclear Energy

COW/PLP/gp

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

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