

UNITED STATES NUCLEAR REGULATORY COMMISSION **REGION II** 101 MARIETTA ST., N.W., SUITE 3100 ATLANTA, GEORGIA 30303

Report No. 50-302/79-44

Licensee: Florida Power Corporation 3201 34th Street, South St. Petersburg, Florida 33733

Facility Name: Crystal River Unit 3

Docket No. 50-302

License No.: DPR-72

Inspection at Crystal River site near Crystal River Florida

Inspector: ron McHen 'Approved by: on Chief, RONS Branch SUMMARY

Date Signed Date igned

Inspection on October 15-19, 1979

Areas Inspected

This routine unannounced inspection involved 36 inspector-hours on site in the areas of followup on previous enforcement matters and inspector identified items.

Results

Of the two areas inspected, one item of noncompliance was found in one area. (Deficiency: Failure to submit prompt report, paragraph 5.d)

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DETAILS

1. Persons Contacted

Licensee Employees

*G. P. Beatty, Jr., Plant Manager

P. F. McKee, Operations Superintendent

- *J. Cooper, QA/QC Compliance Manager
- W. A. Cross, Operations Engineer
- *R. W. Kennedy, Compliance Supervisor
- *G. M. Williams, QA/QC Supervisor
- L. A. Hill, Compliance Auditor
- K. K. Lancaster, Compliance Auditor
- *F. W. Pluebell, Electrical Supervisor
- *W. E. Kemper, Technical Specification Coordinator

Other licensee employees contacted included technicians, operators, and office personnel.

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized on October 19, 1979, with those persons indicated in Paragraph 1 above. Items discussed included the licensee's acknowledgement and corrective actions with regard to one item of noncompliance. In addition, management committed to perform a calibration check of the 3A Diesel Generator frequency meter (paragraph 6).

- 3. Licensee Action on Previous Inspection Findings
 - c. (Closed) Deficiency (78-26-01): Failure to take corrective action when data was not within acceptance criteria. The inspector reviewed selected procedures and verified that corrective actions were indicated in cases where data recorded did not meet the acceptance criteria. In addition, discussions with plant compliance auditors indicated that similar occurrences had not been identified during routine audits of completed procedure data. Based upon the inspector and compliance audits it appears that this item was an isolated case caused by oversight and that the licensee's corrective actions with regard to this matter are satisfactory.
 - b. (Closed) Infraction (79-03-01): Failure to document supervisory review of surveillance test results. The inspector verified that surveillance Procedure (SP) 713 data sheets had been reviewed by supervisory personnel and had been transmitted to quality files prior to the September 17, 1979 commitment date. In addition, an administrative policy had been implemented to require routine review and filing of SP-713 data sheets. Licensee corrective actions with regard to this item are satisfactory.

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- c. (Closed) Deficiency (79-03-02): Failure to review and approve radiation chemistry data sheets. The licensee did not complete corrective actions committed to in response to this item within the time period specified and was issued a Notice of Deviation (79-26-01). Therefore, this item was closed in that, a complete review of this matter will be conducted during a subsequent review of licensee action with regard to Deviation 79-26-01.
- d. (Closed) Infraction (79-13-01): Failure to approve a temporary procedure change. The inspector verified that operating Procedure (OP) 209 had been revised to provide for exclusion of steps not required for all plant cooldowns. No further action with regard to this item appeared to be required, therefore this item was closed.
- e. (Closed) Infraction (79-13-02): Failure to perform surveillance requirements on the containment sump. The inspector verified that surveillance Procedure (SP) 300 had been revised to require the routine logging of both wide and narrow range sump levels. This action will provide for sump monitoring as required by Technical Specification when the sump is beyond the narrow range indicator. The inspector had no further questions or concerns with regard to this item.

4. Unresolved Items

Unresolved items were not identified during this inspection.

- 5. Inspector Identified Item Review
 - a. Item 77-11-03, Potential Boron Dilution

This item involved a potential unreviewed safety question due to the possible return to criticality caused by NaOH dilution. Licensee action with regard to this matter resulted in Amendment 20 to the Technical Specifications (TS) to insure sufficient shutdown margin and borated water to preclude a potential boron dilution event. Specifically, TS section 3.1.1.1.1 and 3.1.1.1.2 were revised to require additional shutdown margin and T.S. 3.1.2.8 was revised to required additional concentrated boric acid. The inspector had no further questions with regard to this item which was closed.

b. Item 78-24-04, Control Problem with Limitorque Valves

The item was associated with failure of a limitorque valve to operate properly and the resulting concern over the possible generic aspects of the failure. The inspector ascertained that only one additional known limitorque control failure had occurred since the original event, reported in LER 78-34. Further, the licensee intends to continue to evaluate future problems to ascertain the root cause of limitorque control failures. Since the failure frequency associated with this item appears too low to be of generic concern, this item was closed.

c. Item 78-24-05, Battery Electrolyte Stratification

This item involved the recurring problem, identified in LERs 78-38 and 78-41, with the failure of plant batteries to meet specific gravity acceptance criteria. This problem had been related to electrolyte stratification and an engineering evaluation (REI-677) was requested by the licensee. Discussions with the electrical supervisor indicated that the resolution of this problem was still under investigation by engineering and the battery vendor. This item remains open and pending completion of the evaluation of this problem by the licensee and subsequent review by the NRC during a future inspection.

d. Item 79-03-03, Change of Acceptance Criteria

This item was identified as requiring inspector followup to ascertain the acceptability of new acceptance criteria specified on daily surveillance Procedure (SP) 300. The inspector discussed the change of acceptance criteria, on the SP-300 log associated with the level requirements in the spray additive tank, with plant personnel. The licensee had determined that the correlation between indicated level in percent, and actual level in gallons, was incorrect. Further, it was determined by the licensee that the spray additive tank, required in operating Modes 1, 2, 3 and 4, had been maintained at a level in excess of the requirements specified by Technical Specifications 3.6.2.2. This condition was determined on August 10, 1979, with the plant in Mode 5, and was corrected prior to entry into mode 4 as required by Technical Specifications (TS). The inspector had no further questions regarding the change of acceptance criteria and this item was closed.

During the review of the above items, the inspector determined that no report of the above event had been submitted. Discussions with responsible plant personnel indicated that a 30 day report had not been submitted since the plant was in Mode 4. The inspector stated that a 30 day report was not required; however, since it was determined that the unit had been operating with the spray additive tank above the TS limit, a prompt report, required by TS 6.9.8.1.b. should have been submitted. Technical Specification 6.9.8.1.b requires a prompt report with written followup for operation of the unit or affected systems when any parameter subject to a limiting condition for operation is less conservative than the least conservative aspect of the limiting condition established in the Technical Specification. The fact that a prompt report was not submitted on August 10, 1979, when it was determined that the spray additive tank level was less conservative than allowed by the Technical Specification, was identified as an item of noncompliance.

This item of noncompliance was discussed with cognizant personnel and plant management. Since a prompt report was initiated immediately upon notification of this item, and plant management committed to review all future events for similar reportability, no response to this item of noncompliance was required.

e. Item 79-13-03, Revision of Training Program

This item required inspector followup to ascertain the status of operator training program revision as a result of the Three Mile Island event. The inspector discussed this item with training department personnel. It was determined that a 40-hour small break course had been incorporated into both, the hot license and requalification, training programs. In addition, facility design changes had been incorporated into associated lesson materials. The inspector had no further questions with regard to this item which was closed.

f. Item 79-13-04, Emergency Procedure Revision

This item required inspector followup to assure that emergency procedures were revised as required due to the Three Mile Island event. Procedure revision verification was performed during inspection number 50-302/79-22, therefore this item was closed.

g. Item 79-27-07, Functional Testing of Diesel Alarms

This item was open pending satisfactory completion of modified diesel alarm testing in accordance with an approved procedure. The inspector reviewed completed MAR 79-6-04, which functionally tested the diesel alarms installed by MAR 77-7-33 and 33A. No problems were identified and this item was closed.

6. Calibration of Safety-Related Metering and Relaying

During a tour of the control room, the inspector noted that the frequency meter for the 3A emergency diesel generator was not indicating meter mechanical zero with the engine shutdown. This item was discussed with the electrical supervisor who agreed that normally such meters would indicate mechanical zero. Further, no calibration documentation to indicate as-left data was available to verify proper meter calibration. This item was discussed at the exit meeting. Plant management committed to verify the calibration of the 3A diesel generator frequency meter prior to, or during, the next diesel generator operation. This item will remain open pending verification of meter calibration during a future inspection. (79-44-01)

The inspector also determined that no routine program for calibration and/or testing of safety related metering and relaying devices existed. Licensee representatives stated that the absence of a routine program resulted from the lack of on-site personnel qualified in the calibration, testing and repair of meter and relay type devices. The inspector stated that routine calibration of meters associated with surveillance testing of Technical Specification equipment is required; however, the area of metering and relaying requirements would have to be evaluated. This item was identified as open pending a review to determine the requirements associated with a routine safety related meter/relay calibration and testing program (79-44-02).

7. Facility Tours

The inspector toured the auxiliary building and control room several times. During these tours particular attention was paid to radiation control being properly established, monitoring equipment operating as required, and general plant housekeeping. Control room operations were observed and discussed with control room personnel to assure compliance with Technical Specifications. No problems were identified.