



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

Report No. 50-302/79-51

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

Facility Name: Crystal River

Docket No. 50-302

License No. DPR-72

Inspection at Crystal River site, near Crystal River, Florida

Inspector: D. S. Price 12/15/79
 Date Signed
 Approved by: H. C. Dance 12/15/79
 H. C. Dance, Section Chief, PONS Branch Date Signed

SUMMARY

Inspection on November 19-21, 1979

Areas Inspected

This routine, unannounced inspection involved 18 inspector-hours onsite in the areas of plant operations and review of licensee event reports.

Results

Of the two areas inspected, no items of noncompliance or deviations were identified.

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DETAILS

1. Persons Contacted

Licensee Employees

- D. C. Poole, Plant Manager
- *P. F. McKee, Operations Superintendent
- *G. R. Westafer, Maintenance Superintendent
- *J. Cooper, Jr. QA/QC Manager
- *R. W. Kennedy, Compliance Supervisor
- *K. K. Lancaster, Compliance Auditor
- *T. C. Lutkehaus, Support Engineer

Other licensee employees contaced included 3 technicians, and 6 operators.

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized on November 21, 1979, with those persons indicated in Paragraph 1 above.

3. Licensee Action on Previous Inspection Findings

Not inspected.

4. Unresolved Items

Unresolved items were not identified during this inspection.

5. Plant Operations

The inspector kept informed on a daily basis of the overall plant status. Daily tours of selected portions of the reactor building and turbine building were conducted. Frequent visits were made to the control room to review current reactor operating status. No items of noncompliance or deviations were identified.

6. Licensee Event Report (LERs)

The below listed LERs were reviewed to determine if the information provided met NRC reporting requirements. The determination included adequacy of event description and corrective action taken or planned, existence of potential generic problems and the relative safety significance of each event.

The reports reviewed showed a weakness in their discussion of measures to prevent future recurrences. Licensee management acknowledged this problem and stated that greater attention would be devoted to this area in the future.

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LER 79-85, dated October 11, 1979, concerns control rod 7-7 which dropped from 41 percent withdrawn to 18 percent withdrawn. The LER stated that the cause of this event was not known. No measures to prevent the recurrence of this event were deemed necessary. It appears to the inspector that this is marginal. No technical assistance from the rod drive manufacturer or nuclear steam system supplier was sought in analyzing this problem. This LER is closed.

LER 79-86, dated October 15, 1979, concerns a reactor building high pressure bistable which tripped. The cause of the trip was attributed to a buildup of dust on the shaft of the pressure switch. Corrective action included checking pressure switches in redundant channels for a generic problem. Measures to prevent dust buildup from causing this switch to trip were not addressed.

The inspector's investigation of this event revealed that the pressure switch had failed due to a buildup of corrosion on the switch shaft. This corrosion had occurred because standing water inside the cabinet housing the pressure switch and a failed space heater in this cabinet had resulted in a corrosive environment for the switch. A visual inspection of the cabinet showed the space heater returned to service but the standing water still present. Corrosion and mildew were apparent on the inner sides of the cabinet. The inspector informed the licensee that a revision to the LER should be written which addresses measures to prevent recurrence of the water buildup in the cabinet. The licensee stated that he would re-review this event and submit a revised LER if necessary. This LER is open pending submission of a revised LER.

LER 79-89, dated October 19, 1979, and LER 79-95, dated October 25, 1979, concerns instrumentation problems associated with the decay heat outlet coolers. LER 79-89 reports a failure of the RTD on the 'A' decay heat cooler outlet. This was the second failure of this RTD in a seven month period. No actions to prevent further recurrence were deemed necessary after this second failure. The remote shutdown meter movement for the 'B' cooler had failed and been replaced on October 3, 1979. This meter was repaired, again, on October 17, 1979. The meter movement problem was addressed by LER 79-95. No measures to prevent recurrence were discussed.

The inspector expressed concern that no measures to prevent recurrence were being taken. The inspector was informed that because of the problems with this instrumentation a Request for Engineering Information (REI) had been issued on October 25, 1979, to review ways of making these instruments more reliable. LERs 79-89 and 79-95 are closed.

LER 79-90, dated October 22, 1979, reported that the reactor building temperature had exceeded the limit of 130 degrees due to a failed transmitter. The LER stated that an REI had been written to evaluate the event and provide appropriate corrective action. Subsequent to issuance of the LER, the REI, which had been written but not released, was cancelled. The licensee stated that site personnel had discovered that the temperature

transmitter had been located in an incorrect air stream which may have contributed to its failure. The fact that the E I had not been issued and that new information on this subject was available, had not been reported to the NRC. This LER is closed.

LER 79-91, dated October 22, 1979 discussed erratic trips of reactor protection system channel 'A' caused by the rapid temperature change in the reactor building referenced in LER 79-90. No actions to prevent trips of channel 'A' when area temperatures change rapidly (whether due to equipment failure or operator actions) were discussed. Discussion with the licensee indicates that no further actions concerning this problem plan to be taken. This LER is closed.

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