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COMPLIANCE PROCEDURE

CP-111

FLORIDA POWER CORPORATION

CRYSTAL RIVER UNIT 3

DOCUMENTING, REPORTING AND REVIEWING PROBLEM REPORTS

THIS PROCEDURE ADDRESSES NON-SAFETY RELATED COMPONENTS

APPROVED BY: Interpretation Contact

EZ Robinson

DATE: 4/16/93

INTERPRETATION CONTACT: Manager, Nuclear Quality Assessments

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1.0 PURPOSE

1.1 This procedure provides instructions for the preparation, review, classification and distribution of Nuclear Operations Department Problem Reports.

1.1.1 These instructions include determining root causes, developing and processing corrective actions, and performing reviews of proposed and completed corrective actions.

1.1.2 These instructions are required for compliance with 10CFR50 Appendix B Criteria XVI and the Final Safety Analysis Report Section 1.7.1.16 and Table 1-3.

1.2 This procedure provides instructions for performing reportability reviews and preparation of Licensee Event Reports within the Nuclear Operations Department.

2.0 REFERENCES

2.1 IMPLEMENTING REFERENCES

2.1.1 AI-404B, Review of Industry Operating Experience

2.1.2 AI-1100, Retention of Plant Operating Records

2.1.3 CP-113A, Work Request Initiation and Work Package Control

2.1.4 EM-202, Duties of the Emergency Coordinator

2.1.5 EM-206, Emergency Plan Roster and Notification

2.1.6 CR-3 Environmental Protection Plan

2.1.7 CR-3 Radiological Emergency Response Plan

2.1.8 NOD-03, Reporting Requirements Program

2.1.9 CR-3 Technical Specifications 6.7, Safety Limit Violations; 6.9.2, Special Reports

2.1.10 10CFR20, Standards for Protection Against Radiation

2.1.11 10CFR50.36, Technical Specifications; 50.72, Immediate Notification Requirements for Operating Nuclear Power Reactors; 50.73, Licensee Event Report System

2.1.12 10CFR70.52.a, Reports of Accidental Criticality or Loss or Theft or Attempted Theft of Special Nuclear Material

2.1.13 NPDES Permit FL0000159

2.1.14 NUREG 1022, Licensee Event Report System and Supplements

2.1.15 INPO 89-013, NUCLEAR NETWORK Users Manual

2.1.16 NOD-07, Reporting of Significant Environmental Events

2.1.17 Nuclear Procurement and Storage Manual (NP&SM)

2.1.18 FPC Accident Prevention Manual

2.2.19 10CFR73.71, Reporting of Safeguards Events

2.2.20 NC-01, Nuclear Compliance Instructions

2.2.21 29CFR1904.8, Reporting of Fatality or Multiple Hospitalization Accidents

2.2.22 Offsite Dose Calculation Manual

2.2.23 CP-144, Root Cause Analysis

2.2.24 AI-404A, Review of Technical Information

2.2.25 NEP-141, Problem Identification and Corrective Actions

2.2.26 NOD-14, Determining Operability

2.2.27 NEP-147, Failure Analysis

2.2.28 AI-704, Reactor Trip Review and Analysis

2.2.29 NOD-10, Processing Nuclear Operations Term Commitment System

2.2.30 NOD-38, Planning Budgeting and Scheduling Modification and Special Project Controls

2.2 DEVELOPMENTAL REFERENCES

2.2.1 10CFR50 Appendix B Criterion XV and XVI

2.2.2 NOD-42, PROBLEM IDENTIFICATION AND CORRECTIVE ACTION

2.2.3 Final Safety Analysis Report (FSAR) 1.7.1.15 and 1.7.1.16, and Table 1-3, Florida Power Corporation Quality Program Commitments

3.0 PERSONNEL INDOCTRINATION

3.1 DEFINITIONS

3.1.1 Corrective Action

Those actions taken to resolve the problem and restore conditions to an acceptable status. Depending on the nature of the problem, corrective actions may include immediate actions, interim actions, remedial actions, and actions to prevent recurrence.

3.1.2 Corrective Action Plan (CAP)

The CAP identifies the cause(s), contributing factors, associated corrective actions, department(s) assigned to perform corrective action(s) and schedule for completion of the corrective actions.

3.1.3 Design Basis

Design basis is information which identifies the specific functions to be performed by a structure, system, or component of the facility, and the specific values or ranges of values chosen for controlling parameters as reference bounds for a specific design. These values may be:

- Requirements derived from generally accepted "state-of-the-art" practices for achieving functional goals,
- Requirements derived from analysis (based on calculations and/or experiment) of the effects of a postulated accident for which a structure, system, or component must meet its functional goals.

3.1.4 Design Basis Issue

A design basis issue is a condition with potential safety significance where a proven discrepancy exists between the plant design basis and plant conditions.

3.1.5 Nonsignificant (See Enclosure 5 for examples.)

A problem is considered **nonsignificant** unless it meets the definition of significant below.

Nonsignificant problems do not require a structured root cause analysis or corrective actions to prevent recurrence.

3.1.6 Originator

Any individual discovering a problem.

3.1.7 Problem (See Enclosures 3 - 5 for examples.)

A condition or event which impacts CR-3, and which meets any one of the following requirements:

- o It is or might be reportable; OR
- o It requires evaluation or corrective actions beyond what it would receive if documented and processed by one of the following programs or systems:
  - Work Request.
  - Modification Approval Record.
  - Request for Engineering Assistance.
  - Document change process (PRR, DCN, etc); OR
- o It is a violation of, or questionable conformance to, established criteria. Established criteria includes License Conditions, Technical Specifications, Design Basis Requirements, NRC regulations, and the FPC Quality Program.

3.1.8 Reportable

A condition or event which requires a verbal or written report to the State of Florida, the NRC or other authority per the requirements in Enclosure 6 or 7 of this procedure.

3.1.9 Responsible Department

The department or organization that is most likely to perform the corrective actions to resolve the problem. The responsible department coordinates the investigation of the problem and the development of the corrective action plan and schedule. The responsible department must be contacted and accept the assignment. This contact may be made by the department originating the Problem Report, an OTA, or Quality Programs.

3.1.10 Responsible Manager

The individual within the responsible organization who is responsible for resolving the problem. This individual should be one level below the director level of management, or the manager of a functional area (e.g. Procurement Engineering, Radwaste, etc.).

3.1.11 Significant (See Enclosure 4 for examples)

A problem shall be classified **significant** if it:

a. Creates a condition reportable to the NRC (see NOD-03); or

b. Represents a condition contrary or potentially contrary to:

   1. NRC regulation
   2. NRC commitments
   3. FSAR
   4. Plant Technical Specifications; or

c. Results in the unplanned entry into a Technical Specification limiting condition for operation; or

d. Requires the preparation of a justification for continued operation; or

e. Represents an unexpected failure of a safety-related system, structure or component which would prevent the system, structure or component from performing its safety function; or

f. Involves or could cause an unplanned release of radioactive material to the environment; or

g. Results in a long-term reduction of generating capacity; or

h. Is estimated to cost $50,000 or more to repair or rework; or

i. Is recognized as generic or recurring; or

j. Is a high risk condition as determined by a probability and risk analysis review; or

k. Is a condition that warrants a formal root cause analysis or corrective actions to prevent recurrence (see NOD-40); or

l. Is a system or component important to reliable plant operations, e.g., rod control, feedwater, EH, etc. (see NOD-31).

3.1.12 Suspected Design Basis Issue

A situation in which a discrepancy may exist between the plant design basis and plant condition, and which has potential safety significance.

Items which may be considered as suspected design basis issues include, but may not be limited to:

- Events or operating conditions that may not be enveloped by the plant design basis.
- Events that occur, or credible events which could occur, that could have been a greater threat to plant safety with different plant conditions, the advent of another credible occurrence, or a different progression of events.
- Failures of a 10CFR50.59 review to adequately conclude that a previous design change or change to plant configuration did not represent an unreviewed safety question.
- Conditions where administrative, pr ral, or operational errors have been committed that re from a fund mental misunderstanding of plant performan or safety requirements.
- Problems for which the cause is determined to be a design error which could adversely impact the plant or component design basis.

3.1.13 Unplanned Release

A release of radioactive material from the Radiation Controlled Area which has not been evaluated and released in accordance with approved procedures. Refer to the Offsite Dose Calculation Manual, Section 6.4 or contact the Radiochemistry and Environmental Specialist for additional guidance.

3.2 RESPONSIBILITIES

3.2.1 Originator:

- o Immediately notifying the Nuclear Shift Supervisor on Duty (SSOD) or SOTA of conditions and events which pose a threat to plant safety or which may be reportable.
- o Determining the need for a Problem Report with assistance from his/her supervisor.
- o Completing Part 1 of the Problem Report.
- o Submitting the Problem Report to his/her supervisor.

3.2.2 Originator's supervisor:

- o Immediately notifying the Nuclear Shift Supervisor on Duty (SSOD) or SOTA of conditions and events which pose a threat to plant safety or which may be reportable.
- o Determining the need for a Problem Report with assistance from the originator.
- o Determining the significance of the problem.
- o Recommending whether or not the problem should be considered a design basis issue.
- o Preliminary assignment of the Responsible Department/ Organization, if practical. The Director, Quality Programs will concur or assign the Responsible Department/Organization.
- o Identifying and documenting additional Immediate Actions, if warranted.
- o Notifying appropriate management of additional Immediate Actions identified.
- o Reviewing the Part 1 for completeness, accuracy, and validity.
- o Submittal of significant Problem Reports to the Shift Operations Technical Advisor (SOTA).
- o Submittal of nonsignificant Problem Reports to Quality Programs.

3.2.3 Shift Operations Technical Advisor (SOTA):

- o Reviewing Part 1 of significant Problem Reports for completeness.
- o Aiding the SSOD in determining operability, if warranted.
- o Identifying and documenting additional Immediate Actions, if warranted.
- o Notifying appropriate management of additional Immediate Actions identified.
- o Notifying the SSOD of the problem, if necessary.
- o Making notifications for conditions or events which do not involve plant transients.
- o For significant Problem Reports, determining reportability, whether or not it is a Technical Specification Violation and documenting this on Part 2.
- o For reportable Problem Reports, filling out the information on Attachment A, Section 1.

3.2.4 Nuclear Shift Supervisor on Duty (SSOD):

- o Evaluating significant Problem Reports for restrictions imposed by Technical Specifications.
- o Determining operability, if necessary.
- o Making notifications during plant transients.

3.2.5 Nuclear Operations Technical Advisor (NOTA):

- o Investigating reportable events or conditions and identifying and documenting:
  - Apparent Cause(s).
  - Analysis of the Nuclear Safety Consequences.
  - Previous Similar Events/Conditions.
  - Manufacturer/Nameplate Data.
  - Recommended Corrective Actions.
- o Preparing draft Licensee Event Reports and Special Reports.
- o Assisting Quality Programs, as technical reviewer when necessary, with reviews of root cause analyses, corrective action plans, and final closeout of the Problem Report.

3.2.6 Nuclear Configuration Management:

- o Evaluating Problem Reports categorized as a suspected design basis issue. This includes preparing suspected design basis issue evaluations, recommending corrective actions and preparing justifications for continued operation, when applicable.

- o Coordinating corrective action resolution for Problem Reports classified as design basis issues.

- o Performing technical reviews of the corrective action plan and closeout package for design basis issues.

3.2.7 Plant Review Committee (PRC):

For reportable Problem Reports and violations of the Technical Specifications, the PRC reviews and approves the corrective action plan.

3.2.8 Director, Nuclear Plant Operations (DNPO):

- o For reportable Problem Reports, reviewing and approving the SOTA determinations regarding Reportability and Unplanned Release, as well as resolving any disagreement with these determinations.

- o For reportable Problem Reports and violations of the Technical Specifications, reviewing and approving the corrective action plan.

3.2.9 Nuclear Compliance:

- o Ensuring proper notifications/reports are submitted to offsite organizations when required.

- o Assisting with preparation, review and submittal of Licensee Event Reports.

3.2.10 Responsible Manager:

- o Investigating the problem and finalizing:

  - Cause(s).

  - Corrective action plan, including timely completion due dates for incomplete items and corrective action assignments to other organizations.

- o Submitting the Problem Report to Quality Programs for review of corrective action plans.

- o Interfacing with the PRC and DNPO as necessary to resolve any identified deficiencies with corrective action plans submitted for PRC revi...

3.2.11 Assigned Organizations:

Completion of committed items of the action plan by the agreed due date and obtaining approval for extensions/revisions to the corrective action plan items assigned, if necessary.

3.2.12 Quality Programs Department (QPD):

- o Inputting and updating Problem Report data in the NonCompliance Tracking and Trending System (NTTS) for trending.
- o Assuring the appropriate assignment of responsible manager for resolving the problem.
- o Maintaining the Problem Report Number Log and periodically transmitting this log to Records Management.
- o Tracking the Problem Report activities and corrective action plans.
- o Providing periodic reports to management.
- o Reviewing root cause analyses, corrective action plans, and final closeout of the Problem Report, with assistance from technical reviewers as necessary.
- o Transmitting completed Problem Report documentation to Records Management.

4.0 INSTRUCTIONS

4.1 PART 1: INITIATION OF PROBLEM REPORTS

4.1.1 General Instructions

4.1.1.1 Any individual within Nuclear Operations Department may initiate a Problem Report. Persons below the level of supervisor should wait to fill out the Problem Report until **AFTER** discussion with their supervisor or another management representative.

4.1.1.2 IF the originator or his/her supervisor knows or suspects the problem to be reportable (see Enclosures 6 and 7), or the problem involves inoperable structures, systems and components, or the problem obviously requires immediate action,
THEN immediately ensure the SOTA or SSOD has been contacted. This action may be taken prior to contacting the supervisor and prior to completing Part 1 of the Problem Report. This notification does not relieve the originator of the responsibility to initiate the Problem Report.

4.1.1.3 A Problem Report shall be initiated for events and conditions that meet the definition of a problem as defined in this procedure. This includes problems identified from external reports (e.g. Vendor Manuals, SERs, INs) which may have been evaluated through normal review channels (such as AI-404A or B). The individual or group who performed the evaluation and determined that the condition/event is a problem shall generate a Problem Report or assure one has been generated. AI-404A or B processes must still be followed even if a Problem Report is initiated.

4.1.1.4 IF the problem is clearly not reportable,
AND the problem is identified as part of an on-going activity with a predefined scope, such as an engineering walkdown of specific components, a QPD Audit, or a review of an NRC bulletin,
THEN the generation of the Problem Report may be delayed until the completion of the investigation phase on-going activity.

4.1.1.5 A Problem Report does not have to be initiated for events and conditions which are already documented as an NRC Violation, INPO Finding or Recommendation, or similar external report which requires a written response and corrective action commitment to the external organization.

4.1.1.6 Problems associated with defective components not yet installed in the plant which may be reportable under 10CFR21 should be directed to the Manager, Procurement Quality Assurance for processing in accordance with the Nuclear Procurement and Storage Manual.

4.1.1.7 Preservation of Evidence

4.1.1.7.1 When a problem is identified, gather and preserve evidence which may be needed for the root cause determination.

4.1.1.7.2 Important evidence must not be destroyed by actions taken by individuals. Without compromising safety or plant recovery, information must be collected while the event or problem is occurring. Be careful while restoring equipment to avoid destroying valuable evidence.

4.1.1.7.3 See CP-144 concerning details for the preservation of evidence.

4.1.2 Originator

NOTE: Problem Reports must be generated and delivered to the originator's supervisor expeditiously (normally within one regular working day of determining that a problem exists).

NOTE: Problem Report forms may be obtained from Printing Services (GOC) or from the LAN Network, shared drive in WordPerfect.

4.1.2.1 The person discovering a problem or potential problem should discuss the condition or event with his/her supervisor prior to documenting the condition/event on a Problem Report. If the individual's supervisor is not available, the condition should be discussed with another management representative within his/her department.

4.1.2.2 IF based on the above discussion, additional investigation is required to decide if a problem exists,
THEN the investigation must be made in a timely manner.

4.1.2.3 IF the potential problem is not within the area of responsibility of the identifying organization,
THEN the originator or the originator's supervisor should discuss the condition/event with management of the appropriate responsible department to determine if a Problem Report is appropriate. Agreements on the assignment for Problem Report responsibility may be obtained during this discussion.

4.1.2.4 Upon agreement between the problem identifier and his/her supervisor that a Problem Report is required, a Problem Report form is obtained and a Problem Report is initiated. The problem must be documented on the Problem Report as soon as possible after the determination that a problem exists.

4.1.2.5 IF the originator and supervisor can not reach an agreement that a Problem Report is required,
THEN the originator may escalate the issue to management, use the Nuclear Safety Concern system to identify the problem, or generate a Problem Report without obtaining supervisory approval.

4.1.2.6 Record the following information on Part 1 of the Problem Report. If an entry block on the Problem Report form is not applicable, fill in "N/A" or "unknown":

- o Record a brief Title or the subject of the Problem Report.
- o Provide a Detailed Description of the Event/Condition. Answer the questions: What happened or what was discovered? Title or position of who was involved? Provide as much factual data as possible.
- o Record the Equipment Tag Number, if applicable.
- o Record the Vendor Name and the model number, if known, for equipment malfunctions.
- o Record the Requirement(s) Violated. Reference the Technical Specification, applicable Code, or procedure and the Section/Paragraph which was violated or the requirement suspected of being violated.
- o Record any Associated/Related Documents. This could be a WR or the procedure being used or any other document that provides information or instructions relevant to the problem.
- o Record any Immediate Actions Taken. Describe what actions were taken to reduce or mitigate the consequences of the problem (e.g., removed the individual from the RCA; stopped the chemical addition pump).
- o Record the Suspected Causes by checking the appropriate block.
- o Record the Recommendations for Resolving the Problem, if any. Describe your ideas, thoughts or suggestions on how to fix or correct the problem.
- o Record the Method of Discovery. Document how you found the problem (e.g., personnel observation, documentation review).
- o The originator should print his/her name and date in the space provided.

4.1.2.7 IF the originator is not a supervisor,
THEN hand carry the Problem Report to the Supervisor.

4.1.3 Supervisory Review

NOTE: Generally, the Problem Report must be reviewed, classified, and (if feasible) preliminary responsible organization identified by the supervisor within two regular work days from receipt of the Problem Report.

4.1.3.1 The supervisor shall review the condition or event and discuss it with the originator to determine if the condition or event meets the definition of a problem. Enclosures 3, 4, and 5 provide examples of problems.

4.1.3.2 The supervisor shall review Part 1 of the Problem Report for accuracy and completeness. Attach any additional Supporting Information/Documentation.

4.1.3.3 Additional immediate actions may be warranted. If so, notify appropriate management of additional actions identified, and document any additional actions taken on Part 1 of the Problem Report.

4.1.3.4 Recommend if the problem should be considered a Design Basis Issue or a Suspected Design Basis Issue and check the appropriate blocks (yes/no). Configuration Management, Nuclear Engineering may be contacted for assistance in making this determination.

4.1.3.5 Determine the Significance of the problem using the definitions of significant and nonsignificant. Enclosures 4 and 5 provide examples of significant and nonsignificant problems and may be used to distinguish between significant and nonsignificant problems. As part of this evaluation, the supervisor should perform a review to determine if the identified problem is a recurring problem. Various sources of information (e.g., SEEK, WR history, NCOR history, NPRDS, NTTS) may be used to determine previous similar events.

NOTE: The proposed responsible manager should be contacted to obtain concurrence with the assignment. Concurrence should be indicated by initialing by the responsible superintendent or by indicating the date and time of the contact. Do not delay the SOTA reportability review while obtaining concurrence from the responsible manager.

4.1.3.6 Recommend a Responsible Department/Organization. The following is provided as guidance. The Director, Quality Programs will assign, or concur with assignment of, the Responsible Manager and Department/Organization in accordance with Section 4.3.1.1.

4.1.3.6.1 IF the problem involves a design basis issue or a suspected design basis issue,
THEN contact and assign the Manager Nuclear Configuration Management as responsible organization. During nights and weekends, SNES should be contacted instead of Nuclear Configuration Management.

4.1.3.6.2 IF the problem involves an equipment failure or malfunction,
THEN contact and assign the Manager Nuclear Plant Systems Engineering (NPSE) as Responsible Organization.

4.1.3.6.3 IF the problem is Environmental Qualification, Seismic or Modification related,
THEN contact and assign Site Nuclear Engineering Services as responsible organization.

4.1.3.6.4 IF the problem is human performance related,
THEN contact and assign the manager of department in which the error occurred as responsible organization.

4.1.3.6.5 IF the problem is a programmatic deficiency,
THEN contact and assign the department responsible for the program as responsible organization.

4.1.3.6.6 IF the problem is related to a reactor trip or complex transient
THEN contact and assign the Nuclear Safety Group as responsible Organization.

NOTE: Do not delay issuing or processing a Problem Report in order to obtain a Problem Report number.

4.1.3.7 Obtain a number from the PR Number Log maintained by Quality Programs. Problem Report numbers may be obtained by contacting the Quality Programs Department Support Specialist during normal business hours.

4.1.3.8 Provide the following information to the Quality Programs Department Support Specialist for entry in the PR Number Log:

- o Brief description of the problem.
- o Name of the supervisor issuing the Problem Report.
- o PR Issue Date.

4.1.3.9 The supervisor prints his/her name, signs and records PR Issue Dates in Part 1 of the Problem Report.

4.1.3.10 For significant Problem Reports, promptly hand carry or telecopy the Problem Report and supporting documentation to the SOTA for reportability review.

4.1.3.11 IF the Problem Report is telecopied,
THEN forward the original Problem Report to the Director, Quality Programs indicating the person to whom it was telecopied.

4.1.3.12 For nonsignificant Problem reports, forward original Problem Report, with copies of supporting documentation, to the Director, Quality Programs.

4.2 PART 2: PEPORTABILITY DETERMINATIONS

4.2.1 SOTA Evaluation and Reporting

4.2.1.1 Upon receipt of a significant Problem Report or notification of a potentially reportable problem, the SOTA evaluates reportability and immediate actions required to mitigate the problem. Enclosures 6 and 7 may be used to determine reportability.

4.2.1.2 The SOTA must review Part 1 of the Problem Report for completeness and accuracy.

4.2.1.3 The SOTA may determine that additional immediate actions are warranted. If so, the SOTA must notify appropriate management of the additional actions identified and document any additional actions taken.

4.2.1.4 The SSOD performs or directs the performance of verbal notification to offsite agencies for problems associated with plant transients. Guidelines for determining problems associated with plant transients are provided in Enclosures 8A. Verbal notifications to the NRC should be formatted using Enclosure 9.

4.2.1.5 The SOTA review includes determining if a structure, system or component may be inoperable and discussing this with the SSOD. This determination may require implementing the guidance contained in NOD-14, Determining Operability.

4.2.1.6 The SOTA performs or ensures the performance of verbal notifications to offsite agencies for problems not associated with plant transients. Guidelines for determining problems associated with plant transients are provided in Enclosure 8B. Verbal notifications to the NRC should be formatted using Enclosure 9.

4.2.1.7 The SOTA ensures the SSOD has been informed of Problem Reports associated with operations and critical plant equipment. Critical plant equipment includes Technical Specification and Main Control Board equipment.

4.2.1.8 The SOTA completes Part 2 of the Problem Report as follows:

- o Identify if the Problem Report is reportable. On occasion, a Problem Report will require extended review or study to determine reportability.
  - In these instances, the SOTA must exercise judgement in recommending reportability and should note, in the Comments area of Part 2 that the reportability determination is preliminary.
  - IF further review or investigation causes the original reportability recommendation to change, THEN use Section 4.7 of this procedure to revise and process the Problem Report.
- o Identify if the Problem Report involves an Unplanned Release. Refer to the Offsite Dose Calculation Manual, section 6.4 or contact the Radiochemistry and Environmental Specialist.
- o Review and concur with the design basis issue/suspected design basis issue assessment. Use Section 4.7 of this procedure to revise the Problem Report, if necessary.
- o IF the Problem Report is a design basis issue or a suspected design basis issue, THEN assure the Problem Report is telecopied to the Manager, Nuclear Configuration Management.
- o Use the Comments sections to record the reporting requirement and to explain the basis for the reportability determination.
- o Print your name, sign and enter the date/time on the Problem Report.

4.2.1.9 IF the Problem Report is not reportable, THEN forward original Problem Report to the Director, Quality Programs.

4.2.1.10 IF the Problem Report is reportable, THEN go to Section 4.2.2.

4.2.2 Attachment A, Section 1: Plant Conditions

4.2.2.1 SOTA Documentation of Plant Conditions

4.2.2.1.1 For reportable events, the SOTA completes Attachment A, Section 1, Plant Information and Immediate Notifications with help from the SSOD, as follows:

- o Record Plant Conditions existing at the time of acceptance:
  - Mode: Identify the mode as defined in Table 1.1 of Technical Specifications.
  - Reactor Power: Identify the reactor power in percent of rated thermal power.
  - Megawatts Electric.
  - Reactor Coolant System Temperature: Use the most accurate and representative indication of T(ave) available at the time.
  - Reactor Coolant System Pressure: Use the most accurate indication available at the time.
- o Redundant Equipment Available: Identify any equipment available to perform the functions of systems or components rendered inoperable or unavailable as a result of the event or condition.
- o Surveillance Procedure/Maintenance: Identify any Surveillance Procedures or corrective/preventative maintenance in progress which related to the problem.
- o Tech Spec Affected: Confer with the SSOD and identify, by number, any Technical Specifications which are affected as a result of the problem.
- o Action Statement Summary: Provide a summary of the actions taken as a result of Technical Specification Action Statement requirements.
- o Action Entry Date/Time: Identify the date and time of entry into all Technical Specification Action Statements.
- o Document if the Emergency Plan was implemented and the highest emergency classification declared, if applicable.
- o Determine if any notifications are applicable to the problem. Ensure notifications were completed within the time limits specified.

- o Identify personnel notified by name, title, and date/time notified. Record the event number for notification to the NRC Operations Center.

- o Record any Comments: Use this area to record any comments on plant conditions, Technical Specifications and notifications.

- o The SOTA prints his/her name, signs, dates and records the time on the form.

4.2.2.1.2 Attach any additional supporting documentation to the Problem Report package.

4.2.2.1.3 Forward the reportable Problem Reports to the DNPO for review and approval.

4.2.2.2 Director, Nuclear Plant Operations (DNPO) Review

4.2.2.2.1 The DNPO reviews the Problem Report package for completeness.

4.2.2.2.2 Additional corrective actions may be warranted. If so, the DNPO must notify appropriate management of the additional actions identified and document any additional actions taken on the Problem Report.

4.2.2.2.3 The DNPO must review the SOTA determination regarding Unplanned Release and Reportability. Due to time requirements, reports may have already been made.

IF any disagreements are noted,
THEN the Problem Report package must be returned to the Nuclear Safety Group Supervisor (NSGS) or his designee for resolution.

Upon resolution of any disagreements, the Problem Report package must be resubmitted to the DNPO.

4.2.2.2.4 Upon concurrence with all SOTA determinations, the DNPO indicates approval by signing and dating Attachment A, Section 1 and submits the Problem Report to Quality Programs and forwards a copy to the Manager, Nuclear Compliance.

4.2.3 Attachment A, Section 2: Follow-up Notification

4.2.3.1 Upon receipt of the Problem Report package, the Manager, Nuclear Compliance or his designee must complete Attachment A, Section 2 of the Problem Report.

4.2.3.2 IF the Problem Report involved the declaration of an "Alert," "Site Area Emergency," or "General Emergency,"
THEN the Manager, Nuclear Compliance must ensure the following:

- o A written summary of the problem is provided to Florida Division of Emergency Management and the Florida Department of Health and Rehabilitative Services (DHRS) prior to the end of the next business day,
  AND
- o A copy of the above written summary is provided to NRC Region II.

4.2.3.3 IF the Problem Report involved 10CFR20.205 reporting requirements, THEN the Manager, Nuclear Compliance shall ensure that written notification is provided to NRC Region II via telegraph, mailgram, or facsimile.

4.2.3.4 IF the Problem Report involved fire suppression system inoperability in accordance with Technical Specification 3.7.11.1 Action b., THEN the Manager, Nuclear Compliance shall ensure that written confirmation is provided to NRC Region II, no later than the first working day following the event, by telegraph, mailgram, or facsimile.

4.2.3.5 IF the Problem Report does not require written notification, THEN enter "N/A" in the applicable areas.

4.2.3.6 The Manager, Nuclear Compliance must print his name, sign and date Attachment A, Section 2 of the Problem Report indicating that all follow-up notifications are complete or not applicable.

4.2.3.7 At this point, the Manager Nuclear Compliance initiates tracking of Licensee Event Reports, as necessary.

4.2.3.8 The Problem Report package is transmitted (within two working days of receipt) to the Nuclear Safety Group Supervisor for initial evaluation.

4.2.4 Attachment A, Section 3: Initial Evaluation

4.2.4.1 The Nuclear Safety Group Supervisor assigns the initial evaluation activities to a Nuclear Operations Technical Advisor (NOTA). Other personnel qualified by training and/or experience, as directed by the Nuclear Safety Group Supervisor, may perform the initial evaluation.

4.2.4.2 IF the event or conditions described in the Problem Report is a potentially generic problem or might be of interest to the nuclear industry in general,
THEN consideration should be given to preparation and issuance of a NUCLEAR NETWORK entry.

NOTE: The initial evaluation must be completed in a reasonable time to allow time for the responsible department/organization to complete the root cause evaluation and corrective action plan development within 15 days from the PR issue date.

4.2.4.3 The NOTA or assignee completes Attachment A, Section 3: Initial Evaluation of the Problem, as follows:

- o Apparent Cause(s): Attempt to determine all root and contributing causes for the event or condition.
  - CP-144, Root Cause or AI-704, Reactor Trip Review and Analysis may be used to identify root/apparent causes.
- o Analysis of Nuclear Safety Consequences: Assess the consequences and implications of the event or condition with respect to Nuclear Safety.
- o Previous Similar Events/Conditions: Using the apparent cause(s) identified above, review and identify previous events or conditions which involved the same underlying concern or reason why the Problem Report was written (e.g. the same root cause, the same equipment failure or the same sequence of events). Data sources for previous similar events/conditions review may include, but are not limited to:
  - NCOR's and Problem Reports.
  - Nuclear Plant Reliability Data System (NPRDS) data.
  - Work Request history.
  - Machinery history.
- o Manufacturer/Nameplate Data: Identify the equipment manufacturer and nameplate data for any equipment which failed during the event or condition.

  IF the event or condition did not involve failed equipment, THEN the section is not applicable and may be marked "N/A."
- o Recommended Corrective Actions: Based on the apparent cause(s) identified, provide recommended corrective actions for the event or condition. Recommended corrective actions must include some or all of the following:
  - Immediate actions.
  - Interim actions.
  - Remedial actions.
  - Actions to prevent recurrence.

4.2.4.4 Determine if the Responsible Department/Organization is appropriate based on the investigation performed.

IF it appears that a different responsible department/organization is needed to investigate and correct the problem,
THEN revise the assignment in accordance with Section 4.7 of this procedure.

4.2.4.5 Upon completion of the initial evaluation, the NOTA or assignee prints his/her name, signs and dates Attachment A, Section 3 of the Problem Report and forwards the Problem Report package to the Nuclear Safety Group Supervisor for review.

4.2.4.6 The Nuclear Safety Group Supervisor must review the initial evaluation for completeness, accuracy and adequacy.

IF the initial evaluation is not satisfactory,
THEN the Nuclear Safety Group Supervisor must return the Problem Report package for additional evaluation.

IF the initial evaluation is satisfactory,
THEN the Nuclear Safety Group Supervisor must print his/her name, sign and date Attachment A, Section 3 of the Problem Report and forward the Problem Report to the Manager, Nuclear Compliance.

4.2.5 Licensee Event Report Preparation

NOTE: Draft LER's should be forwarded to the Manager, Nuclear Compliance no less than ten (10) days prior to the NRC due date.

Licensee Event Reports (LER) are drafted by the NOTA in accordance with Enclosure 10. Other personnel qualified by training and/or experience, as designated by the Nuclear Safety Group Supervisor, may prepare LERs.

4.3 PART 3: PROBLEM INVESTIGATION, CAUSE AND CAP

4.3.1 Quality Programs Department (QPD)

NOTE: The individual assigned to review the Problem Report must not be the same individual who initially determined the significance classification.

4.3.1.1 The Director, Quality Programs concurs or assigns the responsible Department.

4.3.1.2 QPD reviews Problem Reports and significance classifications.

4.3.1.3 IF discrepancies are identified,
THEN QPD resolves the discrepancy with the appropriate organization and revises the Problem Report per Section 4.7 of this procedure, if necessary.

4.3.1.4 IF not already tracked,
THEN QPD initiates tracking.

4.3.2 Responsible Department

NOTE: Problem investigation, including root cause analysis when required, and development of the corrective action plan (CAP) must be completed within 31 days of the PR issue date.

NOTE: For reportable problems, the root cause analysis and development of the corrective action plan (CAP) must be completed within 15 days of the PR issue date.

NOTE: The responsible department/organization must resolve any disagreements with the reviewers and revise the Problem Report, as necessary.

4.3.2.1 The responsible department manager must review the Problem Report.

4.3.2.2 IF the responsible manager disagrees with the significance classification, reportability or assignment of the responsible organization,
THEN the responsible manager must resolve the disagreement per Section 4.7 of this procedure.

NOTE: Every effort should be made to meet the 15 day response for reportable problems. Extensions for the root cause analysis and CAP development for reportable problems beyond the required 15 days should not go beyond the required LER due date and should allow time for internal reviews.

4.3.2.3 IF the CAP can not be determined or developed within the required 15 or 31 days,
THEN process the extension in accordance with Section 4.7 of this procedure.

4.3.2.4 For reportable problems, the NOTA and the responsible department/organization must work together to assure an accurate description of the root cause and corrective actions are included in the LER and the Problem Report package.

4.3.2.5 Suspected design basis issues must be evaluated per Enclosure 11.

4.3.2.6 Root Cause Investigation

4.3.2.6.1 IF during the investigation of the problem, the scope of the identified problem changes,
THEN the Problem Report should be revised and previous reviews and classifications may warrant re-review per section 4.7.

4.3.2.6.2 For nonsignificant Problem Reports, a root cause investigation is not required but may be done at the discretion of the responsible manager.

4.3.2.6.3 For significant Problem Reports, the responsible manager shall investigate the Problem Report and with the support of any other affected organizations, determine all root and contributing causes.

4.3.2.6.4 CP-144, Root Cause or other departmental implementing procedure, such as AI-704 and NEP-147, must be used to identify root/apparent causes.

4.3.2.6.5 The responsible manager indicates, by checking the appropriate block, whether a Structured Analysis, Deductive Logic, or Apparent/Suspected Cause is used to determine the root cause. Apparent/Suspected Cause must not be checked for significant Problem Reports.

4.3.2.6.6 Document the causes on Part 3 of the Problem Report.

4.3.2.7 Corrective Action Plan Development

4.3.2.7.1 The responsible manger shall ensure that a corrective action plan is developed and documented. The plan must contain corrective actions to address each cause.

4.3.2.7.2 Corrective actions must include some or all of the following:

- Immediate Actions.
- Interim Actions.
- Remedial Actions.
- Actions to Prevent Recurrence.

4.3.2.7.3 Actions to prevent recurrence are required for significant Problem Reports. These actions should include elimination of the root and/or contributing causes of the event or condition or elimination of the connection between the causes and the problem. It is important to consider previous similar events when determining actions to prevent recurrence. Stronger actions to prevent recurrence may be warranted and should be considered for repeated problems.

4.3.2.7.4 Commitments to organizations external to FPC must be approved, as a minimum, by the Vice President, Nuclear Production. Verbal approval is acceptable. In addition, notify the Master Schedule Group of these types of commitments.

4.3.2.7.5 IF remedial actions or actions to prevent recurrence are long term, THEN the responsible superintendent must consider interim actions. Interim actions must be able to be performed in a relatively short time frame. Interim actions must provide reasonable assurance that the event or condition will not recur during the interim period until the long term actions are completed.

4.3.2.7.6 For completed corrective actions, the responsible manager shall obtain necessary documentation of the completed actions. The documentation must be reviewed for adequacy. The responsible manager must resolve any discrepancies noted and assure satisfactory completion of the actions. Documentation of completed corrective actions must be included or properly referenced in the Problem Report package.

4.3.2.7.7 For corrective actions which have not been completed, the responsible manger shall identify on the corrective action plan the planned corrective actions, the assigned department/organizations, and completion due dates. Obtain concurrence from each assigned department for performing the corrective action as scheduled. Concurrence should be indicated by initials of the assignee or by indicating the date and time of contact.

4.3.2.7.8 Indicate the disposition of nonconforming equipment/materials by checking the appropriate block.

- Accept-as-is should be checked if the item is deemed satisfactory without being worked on. Accept-as-is dispositions require engineering justification and approval.

- Repair should be checked if the nonconforming equipment/materials was worked on and the as-corrected condition does not fully meet design requirements. Engineering justification and approval is required for repairs.

- Rework should be checked if the nonconforming equipment/materials was worked on and the as-corrected condition fully meets design requirements.

Attach the engineering justification and approval, if required.

4.3.2.7.9 Upon completion of Part 3, the person who developed the corrective action plan and the responsible manager print their names, sign and date Part 3. Forward the Problem Report package to Quality Programs.

4.4 PART 4: EVALUATION OF PART 3

4.4.1 Quality Programs Department (QPD)

NOTE: Evaluation of the cause, corrective action plan and schedule and its approval or rejection by QPD should be completed within 15 days of receipt.

NOTE: Individual performing reviews must not be the same individual who initially classified the problem or developed the corrective action plan.

4.4.1.1 Quality Programs Department performs a technical review of the Corrective Action Plan and Schedule.

- o IF the Problem Report is associated with industry information processed by AI-404B OR the Problem Report is reportable, THEN assistance from the Nuclear Safety Group must be obtained when performing the technical review.

- o IF the Problem Report is a design basis issue or a suspected design basis issue, THEN assistance from Nuclear Configuration Management must be obtained when performing the technical review.

4.4.1.2 After technical reviews are complete, QPD reviews the Problem Report to identify any discrepancies.

4.4.1.3 QPD will contact the responsible superintendent to resolve discrepancies.

4.4.1.4 After the reviews are satisfactorily completed, QPD:

- o Prints name, signs and dates Part 4.
- o Initiates tracking of the CAP items.

4.4.1.5 IF the Problem Report is reportable or a Technical Specification Violation,
THEN QPD forwards the Problem Report to the PRC.

4.4.2 Technical Reviews

NOTE: Individuals performing technical reviews must not be the same individual who developed the corrective action plan.

4.4.2.1 The technical reviewer must review the Problem Report to verify that the CAP adequately resolves the problem and that the schedule for corrective actions is reasonable. For significant problems, the review verifies that corrective actions reduce the likelihood of recurrence.

4.4.2.2 IF discrepancies are noted,
THEN the technical reviewer must contact the appropriate Department(s) to resolve the discrepancy.

4.4.2.3 When the technical review is complete:

- o Print name, sign and date Part 4.
- o Forward Problem Report to Quality Programs Department.

4.4.3 PRC Review

4.4.3.1 Problem Reports forwarded to the PRC are presented by a representative of the responsible department.

4.4.3.2 The PRC reviews the proposed corrective action plan to assure that it adequately resolves the problem and reduces the likelihood of recurrence. The PRC concurs with the corrective action plan or recommends revisions and records the meeting number. The responsible department/organization must resolve any disagreements with the PRC and revise the Problem Report, as necessary.

4.4.3.3 Following PRC review, the PRC forwards the Problem Report to the DNPO.

4.4.4 DNPO Review

4.4.4.1 The DNPO reviews the proposed corrective action plan to assure that it adequately resolves the problem and reduces the likelihood of recurrence.

4.4.4.2 The DNPO approves or recommend revisions.

4.4.4.3 IF the CAP is not adequate,
THEN the DNPO notifies the responsible organization.

4.4.4.4 IF the CAP approved,
THEN the DNPO signs and forwards the Problem Report to the Quality Programs Department.

4.4.5 Quality Programs Department (QPD)

4.4.5.1 QPD reviews the Problem Report.

4.4.5.2 IF the CAP was revised,
THEN provide the revised CAP to responsible organization and revise tracking of the CAP items, as necessary.

4.5 IMPLEMENTATION OF CORRECTIVE ACTIONS

4.5.1 Assigned Department/Organization

NOTE: Changes to the corrective actions or extensions to the completion schedule are processed in accordance with Section 4.7 of this procedure.

4.5.1.1 Each department/organization assures their assigned corrective actions are performed in accordance with the CAP and schedule.

4.5.1.2 Each department/organization assigned corrective actions provides documentation to Quality Programs by the assigned due date of completion of the assigned actions.

4.5.2 Quality Programs Department (QPD)

4.5.2.1 QPD provides status reports to management of uncompleted corrective actions to assure timely resolution.

4.5.2.2 QPD will collect and compile documentation of the completed corrective actions in the Problem Report package.

4.6 PART 5: FINAL REVIEW AND CLOSEOUT

NOTE: Quality Programs Department review of all completed corrective actions should be performed within 31 days of receipt of notification of completion.

NOTE: Individuals performing final review/verification of the completed corrective actions and technical reviewers must not be the same individual who performed the corrective actions.

NOTE: Final review does not require field verification of the corrective actions but may include field verification at the discretion of the reviewer.

4.6.1 Quality Programs Department (QPD)

4.6.1.1 IF a CAP technical review was performed per Section 4.4.4, THEN assign the same technical reviewer(s) (where applicable) for closure.

4.6.1.2 After technical reviews are completed, QPD reviews the Problem Report to:

- o Assure documentation has been provided for all items have been satisfactorily completed.
- o Review documentation to assure it is adequate for documenting completion of the actions.
- o Assure the Problem Report forms and attachments are properly completed.

4.6.1.3 QPD must resolve any discrepancies.

4.6.1.4 When reviews are satisfactorily completed, QPD:

- o Print name, sign and date Part 5.
- o Closeout Problem Report tracking.
- o Send a copy to the originator.
- o Transmit original to Records Management.

4.6.2 Technical Reviews

4.6.2.1 Review Completed Action Documentation.

- o Review documentation to assure it is adequate for documenting completion of the actions.
- o Assure that the actions, taken as a whole adequately address the causes of the problem.

4.6.2.2 IF discrepancies are identified,
THEN resolve with appropriate Department(s).

4.6.2.3 IF the package is satisfactory,
THEN:

- o Print name, sign and date Part 5.
- o Forward Problem Report to Quality Programs Department.

4.7 PROBLEM REPORT CHANGES AND EXTENSIONS

4.7.1 Changes to the Problem Description/Scope, Significance Classification, Reportability, or the Responsible Organization

NOTE: Time limits associated with responses may be restarted based on these types of re-evaluation. For reportable Problem Reports, extensions of the time limits may not be appropriate. Time limits for responses must ensure the necessary actions are completed in time to support the LER due date.

4.7.1.1 The individual identifying the need for the change must contact the individual or the supervisor of the individual who made the initial determination and discuss the recommended change.

4.7.1.2 If agreeable, the change is made by using a single line to mark out the original information or adding additional information, and initialling and dating the change. This should be done on the original Problem Report. Contact Quality Programs Department to determine where the original may be located.

4.7.1.3 The Problem Report package must then be reprocessed and evaluated for any additional changes. Reprocess the Problem Report based on the point at which the initial evaluation was first performed. For example, if the classification has been revised to significant (Part 1), then the reportability (Part 2) and CAP (Part 3) may also require revision. Revisions to the responsible organization (Part 1) may impact the evaluations performed (Part 2) by the NOTA.

4.7.1.4 Provide original revised Problem Report to the Quality Programs Department.

4.7.2 Extensions to Time Limits for Completion of the Problem Report Evaluations

4.7.2.1 IF the investigation of the problem is still on-going when a response to Problem Report is due,
THEN a written request must be submitted, prior to the initial response due date to the Director, Quality Programs.

4.7.2.2 This request must include:

- o A proposed due date.
- o The current status of the activity including any remedial and interim corrective actions already taken.
- o An explanation or justification for the proposed due date.
- o Approval from the assigned manager or superintendent responsible for the activity.

4.7.2.3 IF the time being spent to develop the response is deemed excessive, THEN the Director, Quality Programs may escalate the issue to management to expedite its resolution.

4.7.3 Revisions to Corrective Actions Plans and Corrective Action Schedules

4.7.3.1 Significant Problem Reports

4.7.3.1.1 All requests to revise the agreed upon corrective action item or an agreed upon corrective action item schedule must be coordinated by the requestor with other organizations which may be impacted by the revision. In addition, the request must be coordinated with individuals or groups who concurred with the original corrective action plan and schedule. This may include discussion and concurrence from the PRC/DNPO, Quality Programs, Technical Reviewers, Nuclear Licensing and the responsible manager as necessary.

NOTE: IF the Problem Report was generated as a result of a QPD Audit,
THEN the Senior Vice President, Nuclear Operations must be informed, by QPD, of any second or subsequent revisions to the corrective action item and the corrective action item schedule.

4.7.3.1.2 An initial request to revise an agreed upon corrective action item or an agreed upon corrective action item schedule must be approved in writing by the director (or manager) of the assigned organization and submitted to Quality Programs.

4.7.3.1.3 Any second or subsequent requests to revise an agreed upon corrective action item or an agreed upon corrective action item schedule must be approved in writing by the director (or manager) of the assigned organization and submitted to Quality Programs.

4.7.3.2 Nonsignificant Problem Reports

4.7.3.2.1 Changes to corrective actions and extensions of schedules must be agreed to by the management of the assigned organization and submitted to Quality Programs.

4.7.3.3 Escalation

IF the time being spent to resolve the issue is deemed excessive or the revised corrective action is inadequate to resolve the problem, THEN Quality Programs will escalate to an appropriate level of management to expedite its resolution.

5.0 FOLLOW-UP ACTIONS

None

PROBLEM REPORT

Number: PR ___ - _____

Page: 1

PART 1: INITIATION, REVIEW, AND ISSUANCE OF THE PROBLEM REPORT BY THE ORIGINATING ORGANIZATION

(1) Title / Subject:

(2) Description of the Condition/Event:

(3) Equipment Tag Number(s):

(4) Vendor Name (if known):

(5) Requirement(s) Violated:

(6) Associated/Related Documents:

(7) Immediate Actions Taken (if any):

(8) Suspected Causes (check all that appear to apply):
[ ] Personnel Error [ ] Inadequate Procedure/Document [ ] Equipment Failure/Malfunction [ ] Design Error
[ ] Unknown [ ] Other (describe):

(9) Recommendations for Resolving the Problem (if any):

(10) Method of Discovery:

(11) Originator (print name): Date:

(12) Originating Dept Supervisor/Manager Review and PR CLASSIFICATION:
PR is: [ ] a KNOWN or [ ] SUSPECTED Design Basis Issue (if either is checked, Classify PR as Significant)
[ ] Not a Design Basis Issue

PR is Classified as: [ ] SIGNIFICANT [ ] NONSIGNIFICANT
Comments:

(13) Responsible Dept:

[ ] Accepted By:
[ ] Recommended

(14) Supv/Mgr (print & sign): PR Issue Date:

PART 2: REVIEW BY THE SOTA/SSOD

(1) This Problem Report is:

REPORTABLE:	[ ] NO	[ ] YES	(a PR Attachment A is required if YES)
A TECHNICAL SPECIFICATION VIOLATION:	[ ] NO	[ ] YES	
AN UNPLANNED RELEASE:	[ ] NO	[ ] YES	

Comments:

(2) Reviewed By (print & sign): Date/Time:

PROBLEM REPORT

Number: PR ___ - _____

Page: ___

PART 3: PROBLEM INVESTIGATION, CAUSE ANALYSIS, AND CAP DEVELOPMENT BY THE RESPONSIBLE DEPARTMENT

(1) **Method of Performing Cause Analysis:**
[ ] Structured Analysis [ ] Deductive Logic [ ] Apparent/Suspected Cause (Limited to Nonsignificant PRs ONLY)

(2) **CORRECTIVE ACTION PLAN (CAP):**
Primary Cause (describe and justify):

Associated Corrective Action:

Assigned Dept/Org: Completion Date:

Secondary Cause (describe and justify):

Associated Corrective Action:

Assigned Dept/Org: Completion Date:

[ ] Additional Causes/Contributing Factors and Associated Corrective Actions are Continued on Page:

(3) **Dispositioning of Nonconforming Equipment/Material:**
[ ] N/A (no nonconforming equipment or material involved) [ ] Accept-As-Is* [ ] Repair* [ ] Rework
[ ] Other (describe): _____
* Engineering Justification and Approval Required for these Dispositions (document on form or attach)

(4) **Developed by** (print & sign): **Date:**

(5) **Responsible Dept Approval by** (print & sign): **Date:**

PART 4: EVALUATION OF CAUSE, CAP, AND COMPLETION SCHEDULE BY THE TECHNICAL REVIEWER & CLOSEOUT ORGANIZATION

Comments:

(1) **Technical Reviewer** (print & sign): **Date:**

(2) **Quality Programs Review By** (print & sign): **Date:**

(3) **PRC:** **MTG No:** **DNPO:** **Date:**

PART 5: FINAL REVIEW OF COMPLETED CORRECTIVE ACTIONS BY THE TECHNICAL REVIEWER & THE CLOSEOUT ORGANIZATION

Comments:

(1) **Technical Reviewer** (print & sign): **Date:**

(2) **Quality Programs Final Package Review by** (print & sign): **Date:**

XX

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PROBLEM REPORT

Number: PR ___ - _____

PR ATTACHMENT A - (Page 1 of 2)

PR Page: ___

SECTION 1: PLANT CONDITIONS AND IMMEDIATE NOTIFICATIONS BY THE SOTA/SSOD

(1) Identification of Plant Conditions:

Mode: _____ RX PWR: _____ MWe: _____ RCS Temperature: _____ Pressure: _____

Other (describe):

(2) Redundant Equip Available:

(3) SP/Maint:

(4) Tech Spec Affected:

(5) Action Statement Summary:

(6) Action Entry Date: Time:

(7) Evaluate Immediate Notification (use EM-202 if Emergency Declared)

Emergency Plan Implemented: NO _____ YES _____ Classification _____

(8) CP-111 Reference	Phone Call Required YES	NO	Time Limit	Organization
a. 10CFR50.72	_____	_____	1 HOUR OR 4 HOUR	NRC OPERATIONS CENTER
b. 10CFR20.205	_____	_____	IMMEDIATE	NRC REGION II
c. 10CFR20.402	_____	_____	IMMEDIATE	NRC OPERATIONS CENTER
d. 10CFR20.403	_____	_____	IMMEDIATE OR 24 HOUR	NRC OPS CENTER/DHRS
e. 10CFR50.36	_____	_____	1 HOUR	NRC OPS CENTER
f. NPDES PERMIT	_____	_____	IMMEDIATE	FPC SUPERVISOR, WATER PROGRAMS
g. TS 6.7.1	_____	_____	24 HOUR	NRC OPS CENTER/FPC SR.VP/NGRC
h. EPP	_____	_____	24 HOUR	NRC REGION II/FPC ENVIRONMENTAL SERVICES
i. ANI/FPC RISK	_____	_____	IMMEDIATE	NRC OPERATIONS CENTER/ANI/FPC RISK
j. 10CFR70.52a	_____	_____	1 HOUR	NRC OPERATION CENTER
k. 29CFR1904.8	_____	_____	IMMEDIATE	FPC NUCLEAR SAFETY SPECIALIST
CP-141 Reference				
a. 10 CFR 73.71	_____	_____	1 HOUR	NRC OPERATIONS CENTER

(9) NOTIFICATIONS:	NAME	TITLE	DATE/TIME	EVENT #
a. SSOD				
b. STATE				
c. NRC(EMS)				
d. NRC (REG II)				
e. FPC				
f. DHRS				
g. OTHER				

Comments:

(10) SOTA (print & sign): Date & Time:

(11) DWPO: Date:

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PROBLEM REPORT

Number: PR ___ - _____

PR ATTACHMENT A - (Page 2 of 2)

PR Page: ___

SECTION 2: FOLLOW-UP NOTIFICATIONS BY NUCLEAR COMPLIANCE

(1) ORGANIZATION(S) REPORT SENT TO:

	DATE	TIME	INITIALS
DHRS WRITTEN CONFIRMATION			
NRC WRITTEN CONFIRMATION			

Comments:

(2) Manager Nuclear Compliance: Date:

SECTION 3: INITIAL EVALUATION BY THE NOTA

(1) Apparent Cause(s):

(2) Analysis of the Nuclear Safety Consequences:

(3) Previous Similar Events/Conditions:

(4) Manufacturer/Nameplate Data:

(5) Recommended Corrective Actions:

(6) NOTA (print & sign): Date:

(7) NRGS: Date:

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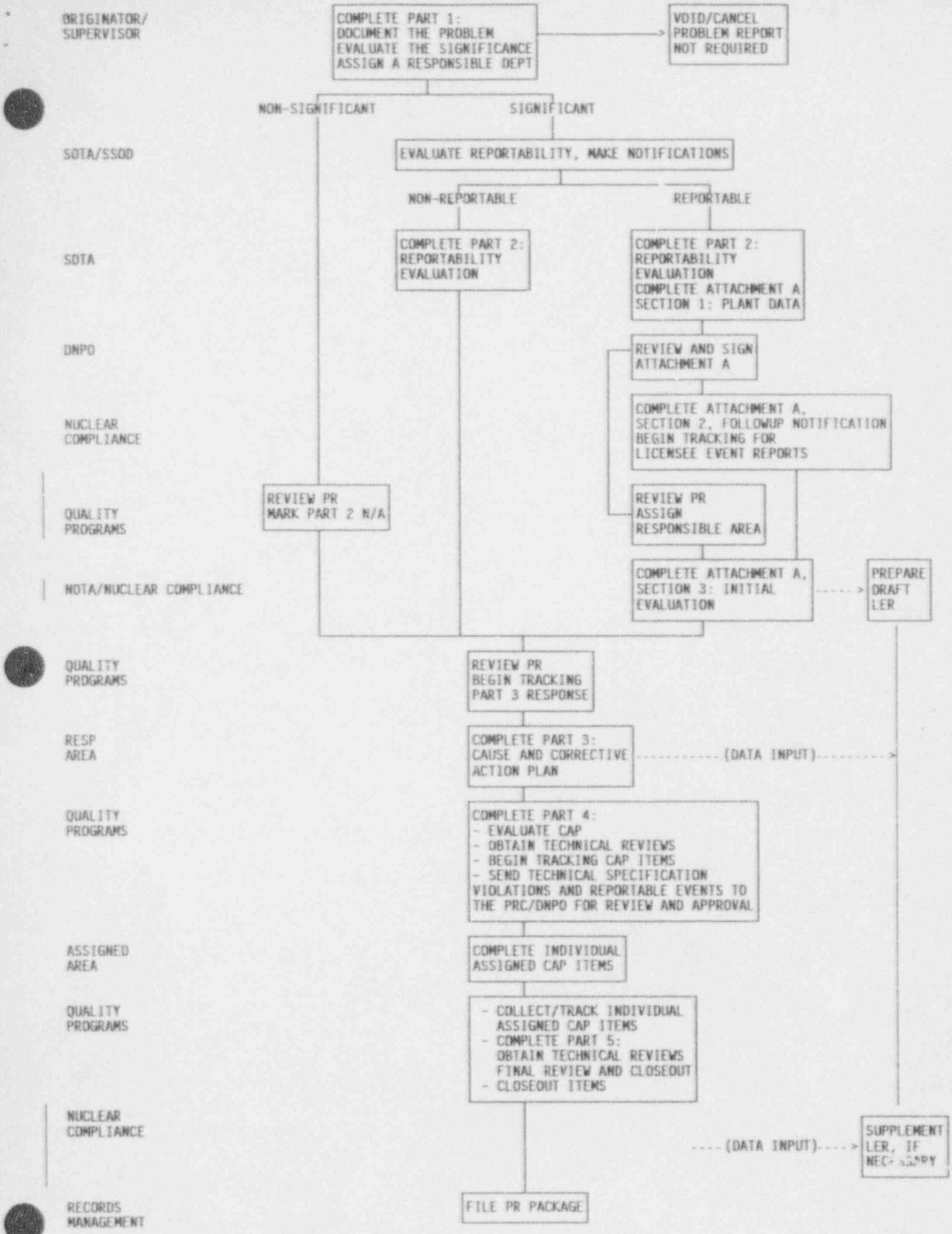
PROBLEM REPORT FLOW DIAGRAM

ENCLOSURE 2



* FOR IMMEDIATE CONCERNS, NOTIFY THE SSOD IMMEDIATELY; DO NOT DELAY NOTIFICATION TO COMPLETE PART 1.

EXAMPLES OF PROBLEMS

The following are examples of conditions or events that should be documented on a Problem Report. All of the examples of significant and non-significant events and conditions are also examples of problems which should be documented on a problem report.

- While hanging a clearance on the instrument air dryer, the operator performed the valve lineup in the incorrect order resulting in a significant drop in instrument air pressure. A problem report is appropriate because of the drop in instrument air system pressure and because this was very similar to a previous event. This is also a problem because this is a procedure violation.

- The actual trip value or response time of an RPS or ES actuation channel exceeds the Technical Specification limit. A problem report is appropriate because it is a violation of a Technical Specification LCO.

- While recaging fuel assembly pins, several pins were not properly caged causing the assembly to hangup when it was being moved. A problem report is appropriated because actions to prevent recurrence are needed.

- Quadrant power tilts exceeding the steady state and transient limits in Technical Specifications were experienced limiting power escalation. A problem report is appropriate because the cause was not readily apparent and thus requires investigation beyond what it would receive if processed by WR, REA, MAR or PRR systems.

- Various Nuclear Instrumentation failures occur. The first failure of an NI does not need a problem report if additional corrective actions to prevent recurrence are not needed. The subsequent failures do warrant a problem report since this involves repetitive occurrences which indicate the existence of a larger problem than simple end of life failure.

EXAMPLES OF SIGNIFICANT PROBLEMS

The following are examples of significant problems:

- Hold point violations associated with POQAM procedures or MAR packages are significant because this is a violation of instructions or procedures required by Technical Specification. Additionally, there have been numerous hold point violations and this may be considered a repeat occurrence.

- OTSG high nozzle flow rate exceeded OP-209 Limit and Precaution. This is significant because it is a violation of a procedure.

- Decay Heat system flow instrument as found data not collected due to performing modifications before test was performed. Additional research is needed to determine if additional instrumentation is affected. This is also a procedure violation.

- Operating procedure RCP NPSH curves are incorrect. Operation close to the curves could lead to pump damage.

- EGDG-1A fuel injection pump bodies were cracked apparently due to valve cage capscrews being too short. The screw loading caused the cast body of the pump to crack. This is significant because it could cause the EGDG to be inoperable and because additional action is needed to check the redundant EGDG.

- Instrument drift in three EFIC channels in a non-conservative direction which would have allowed the setpoint to be exceeded. This is significant because it affected multiple channels to the extent that the safety functions may not be performed. This condition may also be reportable.

- Reactor Building cooling fan failure. The fan failed twice during a year due to bearing failure. This failure is significant because it is a repeat occurrence.

- Unplanned partial ES actuations caused by procedure deficiencies or design errors. This is significant because actions to preclude recurrence are needed.

- Turbine trip at 30% RTP when one of three digital to analog converter cards was removed. This is significant because it could have occurred at higher power levels and lead to a Reactor trip.

- Suspected Design Basis Issues should be considered significant until the actual conformance to the design basis can be determined. These issues should be significant because the issue may be reportable.

EXAMPLES OF NONSIGNIFICANT PROBLEMS

The following are examples of non-significant problems:

- As found setpoint for RPS high pressure bistable trip exceeds procedural limit non-conservatively. However, the setpoint in the procedure was an administrative limit and the setpoint did not exceed the Technical Specification limit.

- Instrument drift in the conservative direction or instrument drift in the non-conservative direction with all redundant instrument strings within an acceptable range.

- Feedwater motor operated valve torque switch settings were found higher than allowed by the MP. Engineering was contacted and determined that the valve was not degraded by the high torque switch setting. Additionally, the valve does not perform a safety function.

- Cotter pin missing from snubber retaining pin. The retaining pin was still in place. No additional snubbers were found with the cotter pin missing.

- Working copy of Task Performance Manual was not up to date.

- Start air line to EGDG cylinder broken. No additional air lines were affected. The problem would not have prevented the EGDG from starting and operating.

- Instrument tubing for Reactor Coolant Inventory Trending system found with a groove .015 to .020 inches. The maximum allowable depth is .014 inches. This was evaluated and determined not to be likely to lead to failure.

- Roughing filters were found with an excessive amount of dirt and improperly installed. This was considered non-significant because the flow was still within acceptable range.

IMMEDIATE NOTIFICATION REQUIREMENTS

A. 10 CFR 50.72 - Immediate Notification Requirements for Operating Nuclear Power Reactors

(a) General Requirements

(1) Florida Power Corporation (CR3) shall notify the NRC Operations Center via the Emergency Notification System of:

(i) The declaration of any of the Emergency Classes specified in EM-202, Duties of the Emergency Coordinator,
OR
(ii) Of those non-emergency events specified in paragraph (b) of this section.

(2) If the Emergency Notification System is inoperative, CR3 shall make the required notifications via the commercial telephone service (301 951-0550), or any other method which will ensure that a report is made as soon as practical to the NRC Operations Center.

(3) CR3 shall notify the NRC immediately after notification of the appropriate State or local agencies (EM-202) and not later than one hour after the time CR-3 declares one of the Emergency Classifications.

(4) When making a report under paragraph (a) (3) above, CR3 must identify:

(i) The Emergency Class declared;
OR
(ii) Either paragraph (b)(1), "One Hour Report," or paragraph b)(2), "Four Hour Report," as the 10CFR50.72 section requiring notification of the Non-Emergency Event.

(b) Non-Emergency Events

(1) One Hour Reports

If not reported as a declaration of an Emergency Class under paragraph (a) above, CR3 shall notify the NRC Operations Center as soon as practical and in all cases within one hour of any of the following:

IMMEDIATE NOTIFICATION REQUIREMENTS (Cont'd)

(i) (A) The initiation of any nuclear plant shutdown required by CR3s Technical Specifications.

(B) Any deviation from CR3's Technical Specifications authorized pursuant to 10 CFR 50.54(x).*

(ii) Any event or condition during operation that results in the condition of CR-3, including its principle safety barriers, being seriously degraded; or results in CR3 being:

(A) In an unanalyzed condition that significantly compromises plant safety;

(B) In a condition that is outside the design basis of the plant;
OR
(C) In a condition not covered by CR3 operating and emergency procedures.

(iii) Any natural phenomenon or other external condition that poses an actual threat to the safety of CR3 or significantly hampers site personnel in the performance of duties necessary for the safe operation of the plant.

(iv) Any event that results or should have resulted in Emergency Core Cooling System (ECCS) discharge into the reactor coolant system as a result of a valid signal.

(v) Any event that results in a major loss of emergency assessment capability, offsite response capability, or communications capability (e.g., significant portion of control room indication, Emergency Notification System, or offsite notification system).

(vi) Any event that poses an actual threat to the safety of CR3 or significantly hampers site personnel in the performance of duties necessary for the safe operation of CR-3 including fires, toxic gas releases, or radioactive releases.

*10CFR 50.54 (x) states that CR-3 may take reasonable action that departs from a license condition or a technical specification in an emergency when this action is immediately needed to protect the public health and safety and no action consistent with license conditions and technical specification that can provide adequate or equivalent protection is immediately apparent.

IMMEDIATE NOTIFICATION REQUIREMENTS (Cont'd)

(2) Four Hour Reports

If not reported under paragraphs (a) or (b)(1) above, CR3 shall notify the NRC Operations Center as soon as practical and in all cases, within four hours of the occurrence of the following:

(i) Any event, found while the reactor is shut down, that, had it been found while the reactor was in operation, would have resulted in CR-3, including its principal safety barriers, being seriously degraded or being in an unanalyzed condition that significantly compromises plant safety.

(ii) Any event or condition that results in a manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS), except when:
(A) The actuation results from and is part of the preplanned sequence during testing or reactor operation;
(B) The actuation is invalid and:
(1) Occurs while the system is properly removed from service;
(2) Occurs after the safety function has already been completed; or
(3) Involves only the following specific ESFs or their equivalent systems:
(*i*) Reactor water cleanup system;
(*ii*) Control room emergency ventilation system;
(*iii*) Reactor building ventilation system;
(*iv*) Fuel building ventilation system; or
(*v*) Auxiliary building ventilation system.

(iii) Any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to:

(A) Shut down the reactor and maintain it in a safe shutdown condition,

(B) Remove residual heat,

(C) Control the release of radioactive material,
OR
(D) Mitigate the consequences of an accident.

(iv) (A) Any airborne radioactive release that exceeds 2 times the applicable concentrations of the limits specified in Appendix B, Table II of 10CFR20 in unrestricted areas, when averaged over a time period of one hour.

(B) Any liquid effluent release that exceeds 2 times the limiting combined Maximum Permissible Concentration (MPC) (see Note 1 of Appendix B to 10CFR20) at the point of entry into the receiving water (i.e., unrestricted area) for all radionuclides except tritium and dissolved noble gases, when averaged over a time period of one hour. (Immediate notifications made under this paragraph also satisfy the requirements of paragraphs (a)(2) and (b)(2) of 10CFR20.403.)

IMMEDIATE NOTIFICATION REQUIREMENTS (Cont'd)

(v) Any event requiring the transport of a radioactively contaminated person to an offsite medical facility for treatment.

(vi) Any event or situation, related to the health and safety of the public or onsite personnel, or protection of the environment, for which a news release is planned or notification to other government agencies has been or will be made. Such an event may include an onsite fatality or an inadvertent release of radioactively contaminated materials.

(vii) Any instance of:

(A) A defect in any spent fuel storage cask structure, system, or component which is important to safety**;
OR
(B) A significant reduction in the effectiveness of any spent fuel storage cask confinement system during use of the storage cask under a general license issued under 10CFR72.210**.

(c) Follow-up Notification

With respect to the telephone notifications made under paragraphs (a) and (b) above, in addition to making the required initial notification, CR3 shall during the course of the event:

(1) Immediately report:

(i) Any further degradation in the level of safety of the plant or other worsening plant conditions, including those that require the declaration of any of the Emergency Classes, if such a declaration has not been previously made,
OR
(ii) Any change from one Emergency Class to another,
OR
(iii) A termination of an Emergency Class.

** A follow-up written report is required by 10CFR72.216(b) including a description of the means employed to repair any defects or damage and prevent recurrence, using instructions in 10CFR72.4 within 30 days of the report submitted in paragraph (a). A copy of the written report must be sent to the administrator of the appropriate Nuclear Regulatory regional office.

IMMEDIATE NOTIFICATION REQUIREMENTS (Cont'd)

(2) Immediately report:

(i) The results of ensuing evaluations or assessments of plant conditions,

(ii) The effectiveness of response or protective measures taken, AND

(iii) Information related to plant behavior that is not understood.

(3) Maintain an open, continuous communication channel with the NRC Operations Center upon request of the NRC.

B. 10 CFR 20.205 Procedure For Picking Up, Receiving, and Opening Packages

(a) Radioactive Contamination

Immediate Notification: CR-3 shall immediately notify by telephone and telegraph, mailgram or facsimile, the NRC Region II Office of: Removable radioactive contamination in excess of 0.01 microcuries (22,000 disintegrations per minute) per 100 square centimeters of package surface found on the external surfaces of any package of radioactive material received at CR-3.

(b) Radiation Levels

Immediate Notification: CR-3 shall immediately notify by telephone and telegraph, mailgram or facsimile, the NRC Region II Office of:

(1) Radiation levels on the external surface of any package of radioactive material received at CR-3 in excess of 200 millirem per hour, OR

(2) Radiation levels at three feet from the external surface of the package in excess of 10 millirem per hour.

C. 10 CFR 20.402 Reports of Theft or Loss of Licensed Material

Immediate Notification: CR-3 shall report to the NRC Operations Center via the Emergency Notification System (alternate means - commercial telephone 301-951-0550) immediately after CR-3 determines that a loss or theft of licensed material has occurred in such quantities and under such circumstances that it appears to CR-3 that a substantial hazard may result to persons in unrestricted areas.

IMMEDIATE NOTIFICATION REQUIREMENTS (Cont'd)

D. 10 CFR 20.403 Notifications of Incidents

(a) Immediate Notification: CR-3 must immediately report to DHRS (see EM-206 for phone numbers) and shall immediately report to the NRC Operations Center via the Emergency Notification System (alternate means - commercial telephone 301-951-0550) any events involving by-product, source, or special nuclear material possessed by CR-3 that may have caused or threatens to cause:

(1) Exposure of the whole body of any individual to 25 rems or more of radiation; exposure of the skin of the whole body of any individual of 150 rems or more of radiation; or exposure of the feet, ankles, hands, or forearms of any individual to 375 rems or more of radiation;
OR
(2) The release of radioactive material in concentrations which, if averaged over a period of 24 hours, would exceed 5,000 times the limits specified in 10 CFR 20, Appendix B, Table II;
OR
(3) A loss of one working week or more of the operation of any facilities affected;
OR
(4) Damage to property in excess of $200,000.

(b) Twenty-Four Hour Notification: CR-3 must immediately report to DHRS (see EM-206 for phone numbers) and shall within 24 hours of discovery of the event, report to the NRC Operations Center via the Emergency Notification System (alternate means - commercial telephone 301-951-0550) any event involving licensed material possessed by CR-3 that may have caused or threatens to cause:

(1) Exposure of the whole body of any individual to 5 rems or more of radiation; exposure of the skin of the whole body of any individual to 30 rems or more of radiation; or exposure of the feet, ankles, hands, or forearms to 75 rems or more of radiation;
OR
(2) The release of radioactive material in concentrations which, if averaged over a period of 24 hours, would exceed 500 times the limits specified for such materials in 10 CFR 20, Appendix B, Table II;
OR
(3) A loss of one day or more of the operation of any facilities affected;
OR
(4) Damage to property in excess of $2,000.

IMMEDIATE NOTIFICATION REQUIREMENTS (Cont'd)

E. 10 CFR 50.36 Technical Specifications

All reports performed under this requirement shall be made to the NRC Operations Center via the Emergency Notification System (alternate means - commercial telephone 301-951-0550).

(a) Safety Limit (STS 2-0): If any safety limit is exceeded, CR-3 shall notify the NRC Operations Center as required by sections A.(b)(1)(i)(A) (10 CFR 50.72, One Hour Reports) or G (STS 6.7.1, Safety Limit Violation) of this enclosure.

(b) Limiting Safety System Settings (STS 2-1): If during operation, the automatic system does not function as required, CR-3 shall notify the NRC Operations Center as required by sections A.(b)(1)(i)(A) (10 CFR 50.72 One Hour Reports) or A.(b)(2)(iii) (10 CFR 50.72 Four Hour Reports) of this enclosure.

F. NPDES PERMIT

Violations of the NPDES Permit require immediate notification (within 24 hours) when the parameter (e.g. pH, delta-temperature) is exceeded to the point of endangering health or the environment.

IF a permit limit has been exceeded to the point where it is suspected that health or the environment may be endangered,
THEN the FPC Supervisor, Water Programs (or alternate) must be notified immediately. He will make a formal determination of the need for immediate notification and will make all notifications required by the NPDES Permit.

In addition, the event should be evaluated to determine whether a Significant Environmental Event has occurred in accordance with Item H. below.

IF it has been determined that the NPDES violation did not have the potential to endanger health or the environment,
THEN refer to the NPDES Environmental Compliance Notification List for further guidance.

G. Technical Specification 6.7 Safety Limit Violation

If a Safety Limit (STS 2-0) is violated, CR-3 shall notify the NRC Operations Center via the Emergency Notification System (alternate means - commercial telephone 301-951-0550) as required by Section A.(b)(1)(i)(A) (10 CFR 50.72, One Hour Reports) of this enclosure AND CR-3 shall notify the Vice President, Nuclear Operations and the NGRC within 24 hours.

IMMEDIATE NOTIFICATION REQUIREMENTS (Cont'd)

H. Environmental Protection Plan (Non-Radiological) Technical Specifications

If a significant environmental event caused by CR-3 operation occurs, NRC Region II shall be notified within 24 hours. Examples of a significant environmental event include excessive bird impaction events, onsite plant or animal disease outbreaks, mortality or unusual occurrence of any species protected by the Endangered Species Act of 1973, unusual fish kills, or an increase in nuisance organisms or conditions. Refer to NOD-07, Reporting of Significant Environmental Events for further guidance.

I. American Nuclear Insurers/FPC Risk Management

1. Notify American Nuclear Insurers (ANI) and FPC Risk Management per EM-202, Duties of Emergency Coordinator, when an Alert, Site Area Emergency, or General Emergency is declared. ANI considers these conditions, "Nuclear Accident."

2. Immediately notify ANI and FPC Risk Management using phone numbers in EM-206, Emergency Plan Roster and Notification, of a serious "Non-Nuclear Accident" involving lightning, explosion, operation of fixed protection equipment, windstorm, vehicular damage to plant, dropping of equipment, emergency or unplanned impairment to fire protection equipment, etc., and serious accidents that involve electrical and mechanical equipment and pressure system components.

J. 10 CFR 70.52 Reports of Accidental Criticality or Loss or Theft or Attempted Theft of Special Nuclear Material

Immediate Notification: CR-3 shall report, within one hour after discovery, to the NRC Operations Center via the Emergency Notification System (alternate means - commercial telephone 301-951-0550) any case of accidental criticality or any loss, other than normal operating loss, of special nuclear material.

NOTE: The reports referenced in K. below will be made by the FPC Nuclear Safety Specialist. In order to ensure that the 48 hour reporting requirement is met, the FPC Nuclear Safety Specialist must be notified immediately to allow time for information collection and analysis.

K. 29 CFR 1904.8 Reporting of Fatality or Multiple Hospitalization Accidents

Within 48 hours after the occurrence of an employment accident which is fatal to one or more employees or which results in hospitalization of five or more employees, the employer of any employees so injured or killed shall report the accident either orally or in writing to the nearest office of the Area Director of the Occupational Safety and Health Administration, U.S. Department of Labor.

CHECKLIST FOR REPORTABILITY

1. Title 10, Code of Federal Regulations

a.	10 CFR 20.205	Procedure For Picking Up, Receiving, and Opening Packages.
b.	10 CFR 20.402	Reports of Theft or Loss of Licensed Material.
c.	10 CFR 20.403	Notifications of Incidents.
d.	10 CFR 20.405	Reports of Overexposures and Excessive Levels and Concentrations.
e.	10 CFR 50.36	Technical Specifications.
f.	10 CFR 50.72	Immediate Notification Requirements For Operating Nuclear Power Reactors.
g.	10 CFR 50.73	Licensee Event Report System.
h.	10 CFR 70.52(a)	Notification of Accidental Criticality or Loss or Theft or Attempted Theft of Special Nuclear Material.
i.	10 CFR 73.71	Reporting Safeguards Events (See CP-141).

2. Standard Technical Specifications

a.	STS 3.7.13.3	Waste Gas System/Ventilation Exhaust Treatment System.
b.	STS 6.7	Safety Limit Violation.
c.	STS 6.9.2	Special Reports.

3. Environmental Protection Plan (Non-Radiological) Technical Specifications

a.	EPP 4.1	

4. Title 29, Code of Federal Regulations

a.	29 CFR 1904.8	Reporting of Fatality or Multiple Hospitalization Accidents.

5. Offsite Dose Calculation Manual

a.	Section 2.14	Special Reports.

SSOD NOTIFICATIONS

The SSOD will make or direct reports related to plant transients and upsets. The SSOD will make all reports associated with:

1. **Entry into the Emergency Plan.** This will assure the following reports are made:

    - o Any natural phenomenon or other external condition that poses an actual threat to the safety of the nuclear power plant or significantly hampers site personnel in the performance of duties necessary for the safe operation of the plant.

    - o Any event that results in a mayor loss of emergency assessment capability, offsite response capability, or communications capability (e.g. significant portion of control room indications, emergency notification system, or offsite notification system).

    - o Any event that poses an actual threat to the safety of the nuclear power plant or significantly hampers site personnel in the performance of duties necessary for the safe operation of the nuclear power plant including fires, toxic gas releases, or radioactive releases.

    - o Any event requiring the transport of a radioactively contaminated person to an offsite medical facility for treatment.

    - o Certain events associated with exceeding radioactive release limits.

    - o Violations of Tech Spec safety limit or limiting safety system settings.

2. **Initiation of plant shutdowns required by Technical Specifications.**

    Note, this type of event will probably also result in entry in the Emergency Plan.

3. **Deviations from Technical Specifications per 50.54 (x).**

4. **Events that result or should have resulted in an ECCS discharge from a valid signal.** Note, this type of event will probably also result in entry in the Emergency Plan.

5. **ANI/FPC Risk Management.** These reports are associated with:

    i. Entry into the Emergency Plan; or

    ii. Serious non-nuclear accidents (windstorm, impairment of fire protection systems, etc.).

SOTA NOTIFICATIONS

The OTA will make any remaining reports (if not reported under a category above). If a report may fall under categories above or below, the SSOD should make the report. The intent is to assure the OTA is involved in transient assessment and not making reports during plant transients. The following is a summary of reports the OTA be responsible for:

1. Any event or condition during operations that results in the condition of the nuclear power plant, including its principal safety barriers, being seriously degraded; or results in the nuclear power plant being:

    A. In an unanalyzed condition that significantly compromises plant safety;

    B. In a condition that is outside the design basis of the p nt; or

    C. In a condition not covered by the plant's operating and emergency procedures.

2. Any event found while the reactor is shut down that, had it been found while the reactor was in operations would have resulted in the nuclear power plant, including its principal safety barriers, being seriously degraded or being in an unanalyzed condition that significantly compromises plant safety.

3. Any event or condition that results in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS). The OTA may not need to make this 4-hour report if ECCS actually discharged into the RCS and a one-hour report has already been made. The OTA must review the one-hour report to assure any information that would be reported under a 4-hour report was actually reported.

4. Any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to:

    A) Shut down the reactor and maintain it in a safe shutdown condition,

    B) Remove residual heat,

    C) Control the release of radioactive material, or

    D) Mitigate the consequences of an accident.

5. Any event or situation, related to the health and safety of the public or onsite personnel, or protection of the environment, for which a news release is planned or notification of other government agencies has been or will be made. Such an event may include an onsite fatality or inadvertent release of radioactively contaminated materials.

SOTA NOTIFICATIONS

6. Events associated with excessive radioactive releases. If not reported under the Emergency Plan, this category should address the following:

   - o Any airborne radioactive release that exceeds 2 times the applicable concentrations of the limits specified in Appendix B, Table II of Part 20 of this chapter in unrestricted areas, when averaged over a time period of one hour.

   - o Any liquid effluent release that exceeds 2 times the limiting combined Maximum Permissible Concentration (MPC) at the point of entry into the receiving water, (i.e., unrestricted area) for all radionuclides except tritium and dissolved noble gases, when averaged over a time period of one hour.

   - o Radioactive contamination or radiation levels on packages per 10CFR20.205. These conditions must be reported immediately to Region II.

   - o Reports of over exposure, radiation levels or excessive damage per 10CFR20.403, immediate and twenty-four hour reports to DHRS and NRC Operations Center.

7. Defects in or reductions in the effectiveness of Spent Fuel Storage Cask systems and structures.

8. Reports of Theft, Attempted Theft, Loss, or Accidental Criticality. This addresses the reporting criteria of 10CFR20.402 and 10CFR70.52. Note, accidental criticalities may be reported under the Emergency Plan, if so, the OTA must review the report made to determine if additional reporting is required. These reports must be made within one hour to the NRC Operations Center.

9. NPDES Permit and Environmental Protection Plan (non-radiological) Tech Specs. NPDES Permit violations need to be reported to the FPC Supervisor, Water Programs within 24 hours. Environmental Protection Plan violations are reported to NRC Region II within 24 hours.

10. Fatalities or Multiple Hospitalization Accidents. These reports must be made to OSHA within 48 hours.

NRC EVENT NOTIFICATION WORKSHEET

NRC COMMUNICATOR _____ NRC EVENT # _____

NOTIFICATION TIME	FACILITY	UNIT	CALLER'S NAME	CALL BACK ENS # 700-821-0027 Or # 1-904-795-6958
_____	CRYSTAL RIVER	3	_____	
EVENT TIME	**EVENT DATE**		**POWER/MODE BEFORE**	**POWER/MODE AFTER**
_____	_____		_____	_____

EVENT CLASSIFICATIONS - 50.72 (a)(1)	1-HOUR NON-EMERGENCY 50.72 (b)(1) (Cont'd)	4 HOUR NON-EMERGENCY 50.72 (b)(2) (Cont'd)
☐ GENERAL EMERGENCY	☐ (iii) Tornado	☐ (iii)(B) RHR Capability
☐ SITE AREA EMERGENCY	☐ (iii) Other Natural Phenomena	☐ (iii)(C) Control of Rad Release
☐ ALERT	☐ (iv) ECCS Discharge to RCS	☐ (iii)(D) Accident Mitigation
☐ UNUSUAL EVENT	☐ (v) Lost ENS	☐ (iv)(A) Air Release >2X Appendix B
1-HOUR NON-EMERGENCY 50.72(b)(1)	☐ (v) Lost Emergency Assessment	☐ (iv)(B) Liq Release >2X Appendix B
	☐ (v) Lost Offsite Communications	☐ (v) Offsite Medical
☐ (i)(A) TS Required Shut Down	☐ (v) Emergency Sirens Inoperable	☐ (vi) Offsite Notification
☐ (i)(B) TS Deviation	☐ (vi) Fire	**OTHER EVENTS**
☐ (ii) Degraded Condition	☐ (vi) Toxic Gas	
☐ (ii)(A) Unanalyzed Condition	☐ (vi) Rad Release	☐ PHYSICAL SECURITY (73.71)
☐ (ii)(B) Outside Design Basis	☐ (vi) Other Hampering Safe Operation	☐ TRANSPORTATION
☐ (ii)(C) Not Covered By OPs/EPs	**4 HOUR NON-EMERGENCY 50.72 (b)(2)**	☐ MATERIAL/EXPOSURE (20.403)
☐ (iii) Earthquake		☐ FITNESS FOR DUTY
☐ (iii) Flood	☐ (i) Degrade While Shut Down	☐ OTHER
☐ (iii) Hurricane	☐ (ii) RPS Actuation (scram)	
☐ (iii) Ice/Hail	☐ (ii) ESF Actuation	
☐ (iii) Lightning	☐ (iii)(A) Safe Shut/Down Capability	

DESCRIPTION

Include: Systems affected, actuations & their initiating signals, causes, effect of event on plant, actions taken or planned, etc.

NOTIFICATIONS	YES	NO	WILL BE					
NRC RESIDENT				ANYTHING UNUSUAL OR NOT UNDERSTOOD?		YES (explain above)		NO
STATE OF FLORIDA				DID ALL SYSTEMS FUNCTION AS REQUIRED?		YES		NO (explain above)
CITRUS & LEVY COUNTIES								
☐ HRS				MODE OF OPERATION UNTIL CORRECTED:		ESTIMATE FOR RESTART DATE:		ADDITIONAL INFO ON BACK?
MEDIA/PRESS RELEASE								

Radiological Release Information	Check or Fill in Applicable Items (**specific details/explanations should be covered in event description**)		
☐ Offsite Release *(state release path in description)*	☐ Offsite Protective Actions Recommended	☐ Areas Evacuated	☐ Personnel Exposed or Contaminated

Release Description	Check or Fill in Applicable Items (**specific details/explanations should be covered in event description**)							
Liquid Release	☐ Monitored	☐ Unmonitored	☐ Planned	☐ Unplanned	☐ Ongoing	☐ Terminated	☐ ODCM Exceeded	☐ RM Alarms
Gaseous Release	☐ Monitored	☐ Unmonitored	☐ Planned	☐ Unplanned	☐ Ongoing	☐ Terminated	☐ ODCM Exceeded	☐ RM Alarms

Release Rates/Limits (From Dose Assessment Team)	**Release Rate** (Ci/sec)	**% ODCM Limit**	**Total Activity** (Ci)	**% ODCM Limit**
Noble Gas				
Iodine				
Particulate				
Liquid *(excluding tritium & dissolved noble gases)*				
Liquid (tritium)				
Total Activity				

Rad Monitor Readings	**Plant Stack** (RMA-2)	**Condenser/Air Ejector Ejector** (RMA-12)	**Main Steam Line** (RMG-25,26,27,28)	**Other (List)**
RAD Monitor Readings:				
Alarm Setpoints:				
% ODCM Limit *(if applicable)*				

RCS or SG Tube Leaks	Check or Fill in Applicable Items: (*specific details/explanations should be covered in event description*)		
Location of the leak (e.g., SG#, valve, pipe, etc.)			
Leak Rate:	Units: gpm/gpd	S.T.S. Limits:	☐ Sudden or ☐ Long Term Development
Leak Start Date:	Time:	Coolant Activity Primary	µCi/ml Secondary µCi/ml
List of Safety Related Equipment Not Operational:			

EVENT DESCRIPTION (Continued from front)

EC INITIALS

LICENSEE EVENT REPORT PREPARATION

NOTE: Draft LER's should be forwarded to the Manager, Nuclear Compliance no less than ten (10) days prior to the NRC due date.

To allow sufficient time for internal reviews, the LER preparation must begin as soon as practical after the identification of an LER-reportable Problem Report. LER preparation may occur in parallel with other reviews and evaluations of the Problem Report.

The NOTA and the responsible department/organization must work together to assure an accurate description of the root cause and corrective actions are included in the LER.

The draft LER shall include the following as a minimum:

- Coversheet (NRC Form 366)
  - Event Title.
  - Event information as requested on the form.
  - Abstract (less than 1400 spaces).
- Text
  - Description of the event.
  - Cause of the event.
  - Analysis of the event.

NOTE: Assure that documentation is available for all corrective actions that are reported as complete. Corrective actions are that are not complete should be included in the CAP for the associated Problem Report.

  - Corrective actions.
  - Additional information such as failed component identification and previous similar events.
  - Figures or illustrations as necessary.

LICENSEE EVENT REPORT PREPARATION

Details on preparation of the draft LER are available in NUREG 1022 and its supplements. Particular attention must be paid to NUREG 1022, Supplement 2, Appendix D, "Text Outline Checklist."

When the draft LER is complete, it must be forwarded to the Nuclear Safety Group Supervisor for review.

After the Nuclear Safety Group Supervisor's review is complete, the draft LER is forwarded to the Manager, Nuclear Compliance.

The draft LER is then processed in accordance with NOD-03, Reporting Requirements Program.

SUSPECTED DESIGN BASIS ISSUE EVALUATIONS

Suspected design basis issue evaluations are performed by Nuclear Configuration Management to determine if the issue is a design basis issue. In the process of performing this evaluation, the impact on plant safety and equipment operability is also assessed beyond the initial assessment performed by the SSOD and SOTA.

Individuals assigned to perform a suspected design basis issue evaluation are expected to take whatever actions are necessary to evaluate the problem. Other Nuclear Operations departments will provide support upon request from the assigned individual. If the support is not provided, the Manager, Nuclear Configuration Management must be notified.

NOTE: The suspected design basis evaluation may identify equipment operability concerns and/or conditions outside the plant design basis. Initiation of operability determinations should be taken in a timely manner consistent with the potential impact on plant safety.

IF the assigned individual finds the problem may cause equipment operability concerns,
THEN the assigned individual must contact the SSOD and/or the SOTA without delay to being an operability assessment.

IF the suspected design basis issue is determined to be an operability issue,
THEN the assigned individual must provide the SSOD with any recommended immediate actions and an internal position for justifying continued operation.

The justification for continued operation must include the following:

- The effect of the problem upon plant safety.
- The effect of the problem upon the operability for the system or structure involved.
- The need for the use of the affected system or structure under normal and accident conditions.
- Availability of redundant systems or structures.
- The probability of an event occurring which would challenge the affected system or structure.
- Compensatory measures that can be immediately implemented.

To meet the time requirements for Corrective Action Plan (CAP) development, Part 3 of the Problem Report may be completed at the time a suspected design basis issue is received by the Manager, Nuclear Configuration Management. The CAP must identify any immediate actions and must provide a schedule for completing the suspected design basis issue evaluation.

SUSPECTED DESIGN BASIS ISSUE EVALUATIONS

Suspected design basis issues must be evaluated within 30 days of Problem Report issuance. The 30 days may be exceeded with justification and approval by the Manager, Nuclear Configuration Management. Extensions for suspected design basis issue evaluations may not exceed 90 days unless approved by the Director, Nuclear Operations Engineering and Projects. These time limits are not to be used as anticipated time frames for evaluation completion. Suspected design basis issues, by their nature, are to be aggressively pursued and resolved in a manner consistent with the potential for impact on plant safety.

The evaluation of a suspected design basis issue must include the following, as applicable:

- The specified safety function of each affected item.
- The specific conditions under which each affected item must perform (e.g., seismic, humidity, temperature, pressure, fire, LOOP, accidents, etc.).
- The physical parameters required to accomplish each specified function.
- Applicable codes and standards for each affected item (if generic, repetition is not necessary).
- Required margin of safety for each item.
- Other parameters or conditions which affect the required function.
- Evaluation of the safety significance. This must include a recommendation of Problem Report significance (e.g., Significant or Non-significant).
- A recommendation concerning reportability.

Upon completion of this evaluation, the Problem Report and supporting documentation must be submitted to the SOTA for a reportability determination.

IF the suspected design basis issue is determined to be a design basis issue, THEN revise the design basis issue and suspected design basis issue blocks on the Problem Report form to reflect the final determination per Section 4.7 of this procedure.

Include documentation associated with the suspected design basis evaluation with the Problem Report.