Florida
Power
CORPORATION
Crystal River Unit 3
Docket No. 50-302

March 10, 1994
3F0394-08

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

Subject: Notice of Violation
NRC Inspection Report No. 50-302/93-16

Reference: A. NRC to FPC letter, 3N1293-40, dated December 30, 1993
B. FPC to NRC letter, 3F0194-08, dated Janaury 14, 1994
C. NRC to FPC letter, 3N0294-04, dated February 10, 1994

Dear Sir:

Florida Power Corporation (FPC) provides the attached as our response to the subject Notice of Violation.

FPC acknowledges that deviations from the expected EOP development process and documentation requirements occurred at CR-3. We acknowledge that the EOP development process is important to the primary concern of ensuring the integrity and adequacy of the EOPs.

We disagree that significant technical problems existed at the time of the inspection. The technical problems were either not safety significant or are legitimate professional disagreements, such as location of "loss-of-all-HPI" guidance. Nevertheless, we expect all issues to be resolved to our mutual satisfaction. To this end, the issue of Small Break Loss of Coolant Accident (SBLOCA) with no HPI was discussed at a recent special meeting of the BWOG Operator Support Committee (OSC) held at CR-3. Currently, all of the B&W Owners deviate from the GTG in this area. It was generally agreed that this scenario should be addressed in the EOPs. There was, however, no agreement concerning where the guidance should reside within specific EOPs.

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FPC is considering including guidance for inadequate subcooling margin with no HPI in a future SBLOCA EOP revision in addition to the guidance currently provided in the SBO procedure.

In conclusion, FPC believes the current EOPs provide effective guidance to the operators at CR-3 and represent a substantial improvement over pre-existing guidance. However, we will thoroughly address the process and technical issues identified in the inspection report and further improve the EOPs. In addition, FPC is also taking appropriate action to enhance management oversight over this and similar activities.

Sincerely,

P. M. Beard, Jr.
Senior Vice President
Nuclear Operations

PMB/RLM:ff

cc: Regional Administrator, Region II
NRR Project Manager
Senior Resident Inspector

FLORIDA POWER CORPORATION
NRC INSPECTION REPORT NO. 50-302/93-16
REPLY TO A NOTICE OF VIOLATION

VIOLATION 50-302/93-16-01

A. 10 CFR 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

1. Contrary to the above, on December 11, 1993, several Emergency Operating and Abnormal Operating Procedures were inadequate as evidenced by the following examples:

   a. Emergency Operating Procedure 03, "Inadequate Subcooling Margin," did not contain appropriate guidance to mitigate small break loss of coolant accident with loss of all high pressure injection.

   b. Emergency Operating Procedure 14, Enclosure 6, could not be performed as written because the procedure did not direct the operator to open Valve CXV-358.

   c. AP-470, "Loss of Instrument Air," contained four incorrect cross references which directed the operator to implement cancelled Abnormal Procedures.

   d. AP-581, "Loss of Non-Nuclear Instrumentation (NNI-X) Power," Enclosure 2, was technically incorrect, in that, instruments identified as unreliable were reliable and other instruments that were unreliable were not identified.

   e. AP-582, "Loss of Non-Nuclear Instrumentation (NNI-Y) Power," Enclosure 2, was technically incorrect, in that, it stated that no instruments would be unreliable on a loss of NNI-Y when, in fact, many instruments would be unreliable.

2. Contrary to the above, on December 11, 1993, the procedures for writing, verifying, and validating Crystal River Emergency Operating Procedures were inadequate as evidenced by the following examples:

   a. AI-402A, "Writer's Guide for Emergency Operating Procedures," contained outdated accident mitigation strategy; stated that verification procedures should be organized by critical safety functions which were no longer applicable; described the old numerical

sequencing of Emergency Operating Procedures which were no longer applicable; and, contained no information regarding the content and format of Rules, Carry-over steps, or Flow Charts.

b. AI-402C, "EOP Verification and Validation Plan," stated that the organization of the Verification Procedures was in accordance with the old critical safety functions vice the new format that presently exists.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

Florida Power Corporation (FPC) accepts the Violation in part. Examples 1.a. and 1.b. are denied. For EOP-03, it remains our best judgement that mitigation of the referenced scenario is adequately addressed in EOP-12, Station Blackout (SBO). However, as discussed in the cover letter, additional guidance may be incorporated in EOP-08, LOCA Cooldown. For EOP-14, written instructions to locate a specific source of water is not considered a requirement. This action falls within the normal skills and knowledge of plant operators and allows flexibility.

REASON FOR THE VIOLATION

1.c. This condition was recognized prior to issuance of the EOPs. A decision was made to issue the EOPs and update the other procedures as soon as possible. Factors considered in this decision were: the level of training that all licensed operators had received; the canceled procedures were obviously replaced by new EOPs; and an Operations Study Book entry had been issued to explain this to the operators.

1.d. The procedure was revised based upon the original issuance of a plant modification. However, subsequent information was not implemented on a timely basis due to personnel error.

The only section of AP-581 (and AP-582) affected by this omission is an Instrument List contained in Enclosure 2. This list contains known unreliable instruments for this specific failure. The operator is still required to confirm valid indications following instrument/power failure. While this may impose additional operator burden, the mitigation strategy is not changed. Operators are trained to recognize a loss of instrumentation and do not rely solely on this list.

1.e. Same as 1.d.

2. The cause for this Violation is lack of management oversight. The approach utilized in developing the EOPs focused on the end product without adequate resources provided to simultaneously complete all the programmatic requirements.

CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED

1. AP-470, AP-581 and AP-582 have been revised and are currently being verified and validated.

2. A plan has been developed to correct the Writer's Guide and the V & V Plan and resources have been allocated to the task.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Programmatic corrective actions will be discussed for all 93-16 violations in the 93-16-05 response.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

See 93-16-05.

VIOLATION 50-302/93-16-02

B. An NRC Order dated February 21, 1984, confirming licensee commitments on emergency response capability, directed Florida Power Corporation to upgrade Emergency Operating Procedures in the manner described in a Florida Power Corporation submittal identified in Section III of the Order. This submittal, dated April 15, 1983, was Florida Power Corporation's response to Generic Letter 82-33 which contained Supplement I to NUREG 0737, Requirements for Emergency Response Capability. In this submittal, Florida Power Corporation committed to implementing the requirements of the generic letter. Item 7.1.b of NUREG 0737, Supplement 1, required that licensees reanalyze transients and accidents and prepare Technical Guidelines. Item 7.1.c required licensees to upgrade Emergency Operating Procedures to be consistent with Technical Guidelines and an appropriate procedure Writer's Guide. Item 7.2.b required a Procedures Generation Package to be submitted which contained Plant Specific Technical Guidelines.

Contrary to the above, on December 11, 1993, a complete Emergency Operating Procedure rewrite documented to Revision 6 of the Babcock and Wilcox Generic Technical Guidelines was completed and implemented without development of current Plant Specific Technical Guidelines.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

FPC accepts the Violation.

REASON FOR THE VIOLATION

Due to his personal knowledge of EOP deviations from the generic technical guidelines (GTG), the EOP coordinator did not consider the completion of a current Plant Specific Technical Guidelines (PSTG) as important as the issuance of the revised EOPs. This went unrecognized due to a lack of management and Quality Assurance oversight.

CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED

A plan to complete the PSTG has been developed and resources allocated to the task.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Programmatic corrective actions will be discussed for all 93-16 violations in the 93-16-05 response.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

See 93-16-05.

VIOLATION 50-302/93-16-03

C. 10 CFR 50, Appendix B, Criterion VI, requires, in part, that measures shall be established to control the issuance of documents, such as instructions, procedures and drawings, including changes there to, which prescribe all activities affecting quality. These measures shall assure that documents, including changes are reviewed for adequacy and approved for release.

NOD-05, "Document Control Program," provides, in part, that documents which specify or provide criteria, parameters and bases upon which completion of a quality related task is based are controlled documents. It required that "The document control program shall contain provisions which insure that ... obsolete or superseded documents are removed from use or destroyed to prevent inadvertent use."

Contrary to the above, on December 11, 1993:

1. The Deviation Document for the previous Emergency Operating Procedures written to Revision Four of the Generic Technical Guidelines was an uncontrolled and unofficial document, in that: it had not been dated, signed, or reviewed; contained no file or reference data; was typed on plain paper with no indication of the originating organization; and had been marked up with multiple pen and ink changes with no indication of the author of the changes.

2. The library copy of the Final Safety Analysis Report contained an obsolete and superseded Appendix 12C, Licensed Operator Requalification Program Description, pages 12C-iii thru 12C-20.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

FPC accepts the Violation.

REASON FOR THE VIOLATION

1. FPC failed to recognize the requirement for maintaining the Deviation Document as a Quality Record.

2. The cause for the FSAR containing outdated material is considered to be personnel oversight.

CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED

1. Upon completion of revising the Deviation Document to the current GTG, it will be maintained as a Quality Record.

2. The outdated material has been replaced.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Programmatic corrective actions will be discussed for all 93-16 violations in the 93-16-05 response.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

See 93-16-05.

VIOLATION 50-302/93-16-04

D. 10 CFR 50.59 requires, in part, that the holder of a license of a utilization facility may make changes in the procedures as described in the safety analysis report without prior Commission approval, unless the proposed change involves a change in the technical specifications incorporated in the license or an unreviewed safety question. The licensee shall maintain records of changes in procedures made pursuant to this section. These records must include a written safety evaluation which provides the bases for the determination that the change does not involve an unreviewed safety question.

Contrary to the above, on July 26, 1993, the licensee did not provide adequate safety evaluations (§ 50.59 review) for 14 of the newly implemented Emergency Operating Procedures. The bases for the determination that the changes to these procedures did not involve an unreviewed safety question was inadequate as evidenced by the following examples:

1. All 14 of the procedures had identical § 50.59 review documentation which did not include any specific details that could withstand an independent review.

2. Emergency Operating Procedures 01, 10, 11, 12, and 14 were developed by the licensee but were not addressed by the Generic Technical Guidelines. The safety evaluations stated that the new procedures were developed in strict accordance with approved vendor guidelines." This statement was not accurate for these procedures.

3. Emergency Operating Procedures 02 through 09, and 13 contained numerous deviations from the vendors generic guidelines which was contrary to the statement provided on the § 50.59 evaluation. The safety evaluations stated that the mitigation strategies had remained unchanged for the design basis events when, in fact, the mitigation strategies had changed. The previous Emergency Operating Procedures utilized Critical Safety Functions which were no longer employed.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

FPC accepts the Violation.

REASON FOR THE VIOLATION

The reason for the Violation was personnel error. The safety evaluations performed to satisfy 10CFR50.59 were developed for the EOPs as a whole. When the packages were assembled, individual differences between the procedures were not identified and incorporated into the more generic 50.59 reviews.

CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED

A plan to re-perform the Safety Evaluations has been developed following completion of the Plant Specific Technical Guideline (PSTG).

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Programmatic corrective actions will be discussed for all 93-16 violations in the 93-16-05 response.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

See 93-16-05.

VIOLATION 50-302/93-16-05

E. Technical Specification 6.8.1 required, in part, that written procedures shall be established, implemented and maintained covering the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, November, 1972.

Regulatory Guide 1.33 listed various safety-related administrative activities including Procedure Review and Approval.

AI-402C, "EOP Verification and Validation Plan," required that the originator of the procedure verification designate independent reviewers to perform enclosure 2 of the procedure (Evaluation Criteria for Procedure Verification).

Contrary to the above, on December 11, 1993, the licensee had not performed verifications and validations on 14 Emergency Operating Procedures in accordance with the procedural requirements of AI-402C as evidenced by the following examples:

1. The verification and validation summaries (Enclosure 1 and Enclosure 3 of AI-402C) for 14 Emergency Operating Procedures did not have any independent reviewer signatures and dates as required by step 4.1.2 of AI-402C.

2. Enclosure 2 of AI-402C, "Evaluation Criteria for Procedure Verification," was not performed for any of the verifications in accordance with AI-402C, as evidenced by the following:

   a. Step 2.2.1 required that differences between the Emergency Operating Procedures and the Generic Technical Guidelines were documented and explained. A large volume of differences existed but were not documented.

   b. VP-580, "Plant Safety Verification," was designed, written, verified, and implemented on September 3, 1993, without conforming to the quantitative acceptance criteria listed in AI-402C.

3. Emergency Operating Procedure 14, Enclosure 6, "OTSG Blowdown Lineup," was not adequately validated. Step 1.1.1 of AI-402C Enclosure 4 required that the procedure contain sufficient information to perform the specified actions. The procedure could not be performed as written because the procedure did not direct the operator to open Valve CXV-358.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

FPC accepts the Violation in part. For item 3, as discussed in Violation 93-16-01 item 1.b., FPC denies that EOP-14 was inadequate and therefore denies it was inadequately validated.

REASON FOR THE VIOLATION

The cause for this Violation is lack of management oversight. The approach utilized in developing the EOPs focused on the end product without proper regard for fully documenting the Verification and Validation process. This lack of management oversight resulted in inadequate resources being provided to the programmatic requirements before issuing the EOPs.

CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED

A plan to re-verify and re-validate all EOPs has been developed and resources allocated to the task.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

FPC has assembled an EOP Task Force comprised of qualified individuals to review existing EOP content. Fundamental process procedures (Writers Guide and V & V procedures) will be reviewed and revised to reflect current practices. All EOPs will be reviewed, revised, re-verified and re-validated as necessary. Management oversight of this and other significant activities will be enhanced to prevent recurrence.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

All corrective actions are expected to be completed prior to restart from Refuel 9, currently scheduled for June 6, 1994.