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**Florida  
Power**  
CORPORATION

April 30, 1984  
3F0484-22

Mr. J. P. O'Reilly  
Regional Administrator, Region II  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
101 Marietta Street N.W., Suite 2900  
Atlanta, GA 30303

Subject: Crystal River Unit 3  
Docket No. 50-302  
Operating License No. DPR-72  
IE Inspection Report No. 84-02

Dear Mr. O'Reilly:

Florida Power Corporation provides the attached as our revised response to the subject inspection report.

Sincerely,

G. R. Westafer  
Manager, Nuclear Operations  
Licensing and Fuel Management

AEF/feb

Attachment

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FLORIDA POWER CORPORATION  
RESPONSE

INSPECTION REPORT 84-02

VIOLATION 84-02-01

Technical specification 6.11 requires adherence to procedures required by 10 CFR Part 20 for operations involving personnel radiation exposure. Chemistry and Radiation protection procedure RP-101 provides a procedure for controlling radiation protection for plant personnel. Chemistry and Radiation protection procedure CH-338 provides a procedure for sampling waste gas decay tanks and purging of release path radiation monitors.

Contrary to the above:

1. On January 8, 1984, procedure RP-101, section 3.4.1 concerning adherence to Standing Radiation Work Permits (SRWP), was not adhered to in that equipment was not surveyed prior to removal from a contaminated area. This action resulted in the contamination of an individual.
2. On January 13, 1984, procedure RP-101, section 4.2.2 concerning entry into a posted high radiation area, was not adhered to in that an individual was observed inside such an area without a radiation monitoring device to continuously indicate the radiation dose rate in the area. Subsequent surveys by health physics technicians indicated that the maximum general area dose rate was 60 MR/HR.
3. On January 20, 1984, procedure RP-101, section 3.4.1 and 3.4.2 concerning the applicability of a SRWP and Radiation Work Permit (RWP), was not adhered to in that a potentially contaminated system was opened under a SRWP. Procedure RP-101 requires use of a RWP for such an evolution.
4. On January 24, 1984, procedure CH-338, section 3.1 which provides instructions for purging a release path radiation monitor, was not adhered to in that a prerequisite valve line-up was not conducted and the stated purging pressure limits were exceeded resulting in damage to the radiation monitor.
5. On January 27, 1984, procedure RP-101, section 4.8.5 which provides the Radiation Control Area (RCA) exit procedure, was not adhered to in that an individual was observed exiting the RCA without conducting a whole body frisk.
- \*6. On February 29, 1984, procedure CH-338 was not adhered to in that a prerequisite valve line-up was not performed.
- \*7. On March 5, 1984, procedure CH-301 was not adhered to in that a prerequisite valve line-up was not conducted which resulted in a pressurizer gaseous radioactivity release to the Auxiliary Building ventilation system. RM-A2 alarmed and the Auxiliary Building fans tripped.

(This is a Severity Level IV Violation)

\*These two instances of nonadherence to procedure occurred subsequent to the inspection report, and are addressed as Examples 6 and 7 in this violation response.

## RESPONSE

### 1. Florida Power Corporation's Position:

Florida Power Corporation concurs with the above stated violation on non-adherence to procedures.

### 2. Designation of Apparent Cause:

(All Examples)

Individuals' failure to follow procedure resulted in this violation. The individuals involved were cognizant of and capable of performing the procedure's requirements. However, the individual(s) demonstrated inadequate compliance with the procedure.

(Example 7)

In addition to the aforementioned, inadequate shift turn-over contributed to the procedure violation.

### 3. Corrective Action:

(Examples 1, 2, 3, and 5)

A Health Physics Violation Report and a Nonconforming Operations Report were written for each incident. Each individual has been counseled by his Supervisor, who has reinforced the need for adherence to procedures. Each individual involved with the incident has been instructed on the requirements of RP-101.

(Examples 4 & 6)

Individuals have been counseled on the importance of procedural adherence. In addition, revisions were made to clarify the steps of procedure CH-338 for purging waste gas radiation monitors. The valve line-up for CH-338 has been revised to more adequately reflect the requirements of the procedure.

(Example 7)

Individuals have been counseled on the importance of procedural adherence. Improved log-keeping practices should also result in better shift-turnover and personnel awareness.

(Examples 4, 6 and 7)

The Training Department continues to emphasize to all technicians, the importance of procedural compliance.

### 4. Corrective Action to Prevent Recurrence:

The corrective actions listed above are considered adequate to prevent recurrence of these specific items. Florida Power's program to increase awareness of management policy on procedural adherence should also lead to improved performance.

### 5. Date of Full Compliance:

Florida Power Corporation has completed the corrective actions listed above and considers the above items resolved.

## VIOLATION 84-02-02

10 CFR 50, Appendix B, Criterion V, as implemented by the licensee's Quality Assurance program section 1.7.1.5 requires that activities affecting quality be accomplished in accordance with approved written procedures. Section 1.7.1.5 also requires adherence to these procedures.

Site Nuclear Quality Control Department procedure NCL-01, Test Equipment, Standards, and Calibration Control, provides a method for the calibration and control of test equipment. When equipment is removed from storage for use in the field, the procedure requires in part:

- Completion of the Test Equipment Sign-Out Log (section 6.4) when the equipment is put in use; and,
- Installation of a "Calibration Sticker" (section 6.6) when the equipment is calibrated.

Technical Specification 4.7.7.1 requires the control room temperature to be verified once per 12 hours to insure the control room emergency ventilation system is operable.

Contrary to the above, on January 25, 1984, test instrument TI-398 was found to be uncalibrated because the instrument had not been entered in the Test Equipment Sign-Out Log when put into use nor was a calibration sticker affixed to the instrument. Test instrument TI-398 is used to measure the control room air temperature. Subsequent testing by the licensee revealed that the instrument was in calibration.

This is a Severity Level V Violation (Supplement D).

## RESPONSE

### 1. Florida Power Corporation's Position:

Florida Power Corporation agrees with the stated violation, in that instrument TI-398 was not recalibrated by January 13, 1984, as required and completion of the test equipment signout log was not accomplished.

### 2. Designation of Apparent Cause:

This violation was caused by a failure of the individual receiving the instrument to properly signout on the log in the calibration lab.

3. Corrective Action:

The uncalibrated instrument was immediately replaced by a calibrated thermometer from the calibration laboratory. The out-of-date instrument was recalibrated, found to be within proper calibration and placed in the calibration laboratory available for re-use. Each of the persons involved in the controls related to removal of portable calibration instruments from the calibration laboratory have been reinstructed on the existing procedures.

Florida Power Corporation has tightened the control over portable calibration instruments that are removed from the calibration laboratory during backshift hours. A new signout log has been added in the control room to control the calibration laboratory key. This log will be completed prior to the shift supervisor authorizing removal of the key for entry into the calibration laboratory. A second key in the possession of the QC inspection organization will be controlled through a signout log maintained in the calibration laboratory. Through the use of these two new control measures the individuals removing calibrated instruments from the laboratory during the backshift hours will be clearly identified.

In addition, the supervisor responsible for the calibration laboratory will, on a weekly basis, monitor the signout log and compare records of these logs with the actual removal of instruments from the cal laboratory.

4. Corrective Action to Prevent Recurrence:

The corrective actions listed in item 3 above are considered adequate to prevent the recurrence of this violation.

5. Date of Full Compliance:

Full compliance has been achieved.