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Florida Power
CORPORATION

March 14, 1986
3F0386-06

Dr. J. Nelson Grace
Regional Administrator, Region II
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
101 Marietta Street N.W., Suite 2900
Atlanta, GA 30323

Subject: Crystal River Unit 3
Docket No. 50-302
Operating License No. DPR-72
Inspection Report 85-41, Supplemental Response
Inspection Report 85-44

Dear Sir:

Please find attached supplementary information regarding violation number 85-41-03 requested by your January 24, 1986 letter. An additional example of this type of occurrence was noted in violation number 85-44-03. As noted in the attached, Florida Power Corporation (FPC) considers these to be two examples of failure to follow the explicit details of a Radiation Work Permit.

The discussion with your staff regarding this event reinforces a concern FPC has expressed in the past associated with verbal requests for submittals, supplements, and commitments. In order to assure FPC's ability to track such commitments; and in order to provide opportunity for adequate management attention and review both at FPC and the NRC, we consider written requests for such supplements to be more appropriate. We would note that the Commission adopted just such a policy for Licensee Event Reports when it codified 10 CFR 50.73(c). FPC requests that the Region adopt this as a practice for Crystal River 3 related items. Your attention to this matter would be appreciated.

Sincerely,

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

KRW/feb

Attachment

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FLORIDA POWER CORPORATION
INSPECTION REPORT 85-41
SUPPLEMENTAL RESPONSE

VIOLATION 85-41-03

Technical Specification 6.8.1.a requires adherence to the written procedures listed in Appendix A of Regulatory Guide 1.33, November 1972. Appendix A of Regulatory Guide 1.33, Section 5.G, requires procedures for radiation work permits (RWPs).

Chemistry and Radiation Protection Procedure RSP-101, Basic Radiological Safety Information and Instructions for "Radiation Workers", Step 3.1.3.4 requires that the requirements established on RWPs be observed and adhered to.

Contrary to the above, on October 7, 1985, procedure RSP-101 was not adhered to in that an individual was observed inside a contaminated area without the required protective clothing listed on the RWP.

This is a Severity Level IV Violation (Supplement I).

RESPONSE

1. Florida Power Corporation Position:

   Florida Power Corporation agrees with the stated violation in that an individual was working inside a contaminated area without all the required protective clothing listed on the RWP. This failure did not result in any personnel contamination.

2. Apparent Cause:

   The cause of the violation was inattention on the part of the individual. He failed to follow the clothing requirements as specified on the RWP.

3. Corrective Actions:

   Upon discovery of the protective clothing discrepancy, the individual stopped work and immediately dressed in the protective clothing in accordance with the requirements of the RWP.

4. Action Taken to Prevent Recurrence:

   A Radiological Safety Incident Report was filed to document this occurrence. The individual involved was counseled concerning the importance of adhering to the protective clothing requirements as specified on the RWP. Counseling was conducted and documented.

5. Date of Full Compliance:

   Full compliance was achieved October 7, 1985 after the individual met the specified clothing requirements.

FLORIDA POWER CORPORATION
RESPONSE
INSPECTION REPORT 85-44

DEVIATION 85-44-01

A letter to the Nuclear Regulatory Commission from Florida Power Corporation dated June 6, 1985, responded to the violation identified in NRC Inspection Report 50-302/84-33. This letter stated that a temporary nitrogen source would be connected to an instrument tap of the affected Waste Gas Decay Tank (WGDT) so that the direct addition of nitrogen to the tank could be accomplished. The letter further stated that this action would be completed by June 20, 1985.

Contrary to the above, as of January 5, 1986, the temporary nitrogen source was not connected nor was the equipment available for the direct addition of nitrogen to the WGDTs.

RESPONSE

1. FLORIDA POWER CORPORATION'S POSITION:

   Violation 84-33-01 cited FPC's failure to comply with Technical Specification 3.7.13.5, Action Statement b. That Action Statement requires that when hydrogen and oxygen concentrations are both greater than 4% by volume in a waste gas decay tank (WGDT), that 1) waste gas additions to the tank be suspended, and 2) that the oxygen concentration be reduced to within its limit. It was determined that the method employed by FPC to reduce oxygen concentration by diluting with nitrogen also allowed more waste gas to be added to the affected tank. In the Supplemental Response to Violation 84-33-01, dated June 6, 1985, FPC committed to provide a methodology to add dilution nitrogen to an affected tank that would not result in also adding more waste gas. FPC did not commit to the use of any specific pieces of equipment, any particular location for the equipment, nor to the actual use of the equipment. The pertinent issue was, cessation of the former nitrogen addition procedure not utilization of any particular alternative.

   In accordance with that commitment, FPC revised OP-412 to provide a methodology to dilute the WGDTs with nitrogen without the addition of waste gas. The procedure requires temporary nitrogen addition equipment consisting of two segments of temporary tubing and a pressure regulator be used to connect a nitrogen source to the affected WGDT. The procedure further requires that the tubing be disconnected from the affected WGDT when nitrogen addition has been completed. The NRC closed Violation 84-33-01 in July 1985 based on the revision to OP-412. FPC's internal tracking did likewise.

2. DESIGNATION OF APPARENT CAUSE:

   While it was FPC's intention to leave the regulator and tubing in place in the vicinity where it is used, it was not FPC's intention to leave them connected for use. The regulator and tubing were moved from their use location during plant housekeeping activities.

3. CORRECTIVE ACTION:

The temporary nitrogen addition equipment was replaced in response to the Region's concern. Nevertheless, the aforementioned procedure change remains the basis for compliance with the commitment.

4. ACTION TAKEN TO PREVENT RECURRENCE:

Information concerning the requirement to maintain the temporary nitrogen addition equipment has been transmitted to the appropriate maintenance personnel. The equipment has been tagged to identify its relationship with OP-412 and Violation 84-33-01.

5. DATE OF FULL COMPLIANCE:

No period of noncompliance with our commitment existed.

VIOLATION 85-44-03

Technical Specification 6.8.1.a requires adherence to the written procedures listed in Appendix A of Regulatory Guide 1.33, November 1972. Appendix A of Regulatory Guide 1.33, Section 5.6, requires procedures for radiation work permits (RWPs).

Chemistry and Radiation Protection Procedure RSP-101, Basic Radiological Safety Information and Instructions for "Radiation Workers", step 3.1.3.4 directs that the requirements established on RWPs be observed and adhered to.

Contrary to the above, on December 30, 1985, procedure RSP-101 was not adhered to in that an individual was observed inside a contaminated area without the required protective clothing listed on the RWP.

This is a Severity Level IV violation (Supplement I).

RESPONSE:

1. Florida Power Corporation Position:

Florida Power Corporation agrees with the stated violation that the individual was not wearing the specific items of clothing specified on the RWP while working in the hot machine shop. The individual had donned several pair of plastic shoe covers and one pair of rubber shoe covers as specified on the RWP. The use of several pair of shoe covers in this situation facilitated his movement between several individual contamination control areas in the hot machine shop, each with its own step-off pad, while protecting the worker from personal contamination. This is viewed to be an acceptable practice, but was not specifically identified on the RWP. The worker had also worn a skull cap under the hood specified on the RWP, but removed the hood when it became damp during performance of his job, leaving only the skull cap. This failure to follow RWP dress requirements did not result in any personnel contamination.

2. Apparent Cause:

The cause of this occurrence was the worker's failure to follow the RWP dress requirements by substituting clothing that he felt, based on extensive experience, was equivalent for the hazard involved.

3. Corrective Action:

Upon discovery of the protective clothing discrepancy, the individual stopped work and immediately dressed in the protective clothing in accordance with the requirements of the RWP.

4. Action Taken to Prevent Recurrence:

A Radiological Safety Incident Report was filed to document this occurrence. The individual involved was counseled concerning the importance of adhering to the protective clothing requirements as specified on the RWP. Counseling was conducted and documented.

5. Date of Full Compliance:

Full compliance was achieved on December 30, 1985 after the individual met the specified clothing requirements.

ADDITIONAL INFORMATION

Florida Power Corporation does not feel the two examples cited in violations 85-41-03 and 85-44-03 indicate a programmatic deficiency. These occurrences were appropriately addressed by programs in place which are designed to correct errors and track performance in order to detect programmatic problems.

Radiation Protection Procedure, RSP-105, "Radiological Safety Incident Report (RSIR)", provides a mechanism for documenting, evaluating, reviewing, and trending occurrences affecting radiological safety. Responsible Supervisors and the Radiation Protection Manager are required to evaluate RSIRs and take appropriate corrective actions. Those RSIRs that involve procedure noncompliance are forwarded for review by the Plant Review Committee subcommittee on procedure compliance for review and approval of the corrective action.

Radiation Protection Procedure, HPP-101, "Radiological Safety Incident Report (RSIR) Trending Program", describes a computer-based trending program to help identify trends in RSIRs and programmatic problems in the area of procedure noncompliance involving radiation protection.

Site Nuclear Operations Policy 5 (SNOP5), "Compliance with Florida Power Corporation Procedures", establishes that it is the responsibility of the appropriate Superintendent/Manager to conduct a thorough investigation of the circumstances of any procedural noncompliance. As a result of this investigation, appropriate actions are taken as follows:

- First Violation: Counseling, unless a flagrant violation and/or unsatisfactory attitude on the part of the individual is involved. If so, then a Management Review Board could be convened to determine appropriate action. In either case, a written report is generated.

- Second Violation: A Management Review Board is convened. This board consists of a minimum of three Superintendent/Manager level individuals. The Board will reach a unanimous decision concerning both corrective and disciplinary actions.

- Third Violation: A second Management Review Board is convened and it is mandatory that this board make a determination of the individual's suitability to remain in their work assignment.

In Violation 85-41-03, as well as the most recent occurrence, both RSIR and SNOP5 requirements were invoked with all required management attention. Florida Power Corporation management recognizes that mistakes similar to these will occur, but as evidenced by the systems described above, management does not accept failure to follow existing procedures. There has been and continues to be in place a proceduralized system of checks and balances that assures effective corrective actions for this type of isolated occurrence.

VIOLATION 85-44-06

The Crystal River Unit 3 Final Safety Analysis Report (Section 8.2.3.3) requires that two independent sources of control power be provided for the 230 KV breakers and the protective relaying schemes for the 230 KV substation.

10 CFR Part 50.72 requires the NRC Operations Center be notified via the Emergency Notification System within one hour of any event during operation that results in the nuclear power plant being in a condition that is outside the design basis of the plant.

Contrary to the above, on December 5, 1985, a one hour report was not made to the NRC Operations Center, when it was determined that two independent sources of 125 volt DC control power that provided protective relaying power for the 230 KV breakers were found to be in a condition that is outside the design basis of the plant.

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

RESPONSE

1. FLORIDA POWER CORPORATION'S POSITION:

   Florida Power Corporation (FPC) agrees with the stated violation in that a one hour report was not made to the NRC Operations Center upon discovery of a condition that was outside the design basis of the plant. FPC wishes to note, however, that the NRC was notified within one hour through the NRR Project Manager for Crystal River 3.

2. APPARENT CAUSE OF VIOLATION:

The cause of this violation is personnel error. The personnel involved in the investigation into the design deficiency did not initially recognize the applicability of the reporting requirements of 10 CFR 50.72 and 10 CFR 50.73.

3. CORRECTIVE ACTIONS:

The design deficiencies were corrected. After the deficiencies were corrected, a Non-Conforming Operations Report (NCOR) was written. The NCOR was evaluated, and the applicability of 10 CFR 50.72 and 10 CFR 50.73 was documented.

4. ACTION TAKEN TO PREVENT RECURRENCE:

The individuals involved in the investigation into the deficiency have been made aware of this violation and the requirements of 10 CFR 50.72.

5. DATE OF FULL COMPLIANCE:

FPC was in full compliance on December 10, 1985 when the NCOR was evaluated and the reportability was documented.