

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **CRYSTAL RIVER UNIT 3** DOCKET NUMBER (2) **0 5 0 0 0 3 0 2 1** OF **0 3** PAGE (3)

TITLE (4) **Personnel Error During Development & Review of Surveillance Procedures Leads to Inadequate Surveillance Frequency for Four Containment Isol. Valve**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0	1	2	8	8	8	0	0	2	N/A		0 5 0 0 0
0	1	2	8	8	8	0	0	2	N/A		0 5 0 0 0

OPERATING MODE (9) **1**

POWER LEVEL (10) **0 9 8**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(a)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.38(a)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.38(a)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **L. W. MOFFATT, NUCLEAR SAFETY SUPERVISOR** TELEPHONE NUMBER **9 0 4 7 9 5 - 6 4 8 6**

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On January 28, 1988, Crystal River Unit 3 was operating at 98 percent reactor power and generating 870 electric megawatts. An Engineering review of the Technical Specifications listing of containment isolation valves versus surveillance procedures identified four valves which were not being surveilled in accordance with the Technical Specifications frequency.

There were several factors which led to this event. Initially, there was a programmatic deficiency which has since been corrected. An incomplete review of a Technical Specification amendment for procedure changes was due to insufficient knowledge of the Technical Specifications by the reviewer. The inadequate verification review of the surveillance was due to personnel error by a utility non-licensed individual.

The monthly containment integrity surveillance procedure has been revised to include the four valves. Program enhancements are being considered for review of Technical Specification amendments and surveillance verifications. The individual involved in the inadequate verification review has been counselled.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		- 0 0 3	- 0 0 0	0 2	OF	0 3	

TEXT (if more space is required, use additional NRC Form 388A's) (17)

EVENT DESCRIPTION:

On January 28, 1988 at approximately 1600, Crystal River Unit 3 (CR-3) was operating at 98 percent reactor power and generating 870 electrical megawatts. A Quality Programs audit had identified some possible discrepancies involving the surveillance of containment isolation valves [NH,ISV]. Based on this audit nonconformance, Site Nuclear Engineering Services (SNES) reviewed Technical Specifications Table (TST) 3.6-1 versus surveillance procedures to verify that surveillance testing was being done in accordance with section 4.6.1.1 of the Technical Specifications (TS). This review identified four manual containment isolation valves which were not being verified closed once per 31 days as required: 1) The isolation from the secondary side of the "A" steam generator [AB,SG] to the miscellaneous waste tank [WD,TK], Main Steam System (MS) valve [SB,V] MSV-128; 2) The isolation from the secondary side of the "B" steam generator to the miscellaneous waste tank, Main Steam System valve MSV-146; and 3) The isolation valves from the reactor building [NH] to the Containment Monitoring System (WS) valves [IK,V] WSV-1 and WSV-2. This lack of adequate surveillance documentation is a condition prohibited by the TS and is therefore reportable in accordance with 10CFR50.73(a)(2)(i)(B).

CAUSE:

There are actually three distinct events which led to the problem of an inadequate surveillance procedure for the TS requirement. Three of the four valves were in the original version of the TS, yet were not included in the monthly surveillance procedure. This was due to there not being a program in place at that time which ensured surveillance procedures were verified to the TS requirements.

The fourth valve was added to the TST 3.6-1 as part of TS amendment 76 in July 1985, although it was intended to be there since the original version but was inadvertently omitted. In accordance with existing programs and procedures, this TS amendment was sent to each department to ensure required procedure changes were made. The TS amendment package only included the actual changed page of TST 3.6-1. However, there are two TS sections which reference this TST, TS sections 4.6.1.1 and 4.6.3.1. The procedure which implemented the requirements of TS section 4.6.3.1 was changed, yet the procedure for implementing TS section 4.6.1.1 requirements was not changed. This was due to the person reviewing the changes being unaware that more than one TS section referenced TST 3.6-1. TST 3.6-1 is placed directly after TS section 4.6.3.1, although it is also referenced by TS section 4.6.1.1 located several pages earlier.

In June 1987, SNES began a new verification and validation program for surveillance procedures. The verification portion is intended to ensure surveillance procedures adequately implement the TS requirements. The "Monthly Containment Integrity Check" received a verification review in August 1987. This verification did not identify the surveillance discrepancy due to personnel error by the utility non-licensed engineer performing the review.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

EVENT ANALYSIS:

The four valves in this event are all manual containment isolation valves which would be required to be closed during accident conditions. Based on this, the valves are maintained in the locked closed position. The valves have been documented as being locked closed quarterly by a separate surveillance procedure. Since the valves have been documented to be in the correct position, and this event merely involves a matter of proper verification frequency, there is no safety significance as a result of this event.

CORRECTIVE ACTIONS:

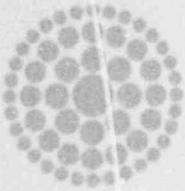
The "Monthly Containment Integrity Check" procedure has been revised to include the four valves in this event so that they are documented as locked closed on a monthly basis. The first problem involving the monthly containment integrity surveillance and the original version of the TS was due to a programmatic deficiency. Since that time, programs have been added to preclude similar occurrences. The TS Coordinator is required to send copies of any TS amendments to all departmental managers and superintendents to ensure procedures within their area are revised to reflect the TS change. A written response back to the TS Coordinator is required to document that the review has been conducted and procedures changed as applicable. In addition, the previously mentioned verification and validation program was established in June 1987.

Regarding the problem involving the review of TS amendment 76 in 1985, some enhancements to the TS amendment review process are being considered. The method for sending out and reviewing the information contained in the amendments has been determined to be adequate. The enhancements being considered involve inclusion of information in addition to the actual TS amendment which may aid in review of the amendment.

The final problem involved personnel error during the verification of the monthly containment integrity surveillance procedure. The employee involved in this event has been counselled. A letter will be sent to all SNES personnel which will include additional guidance on how to conduct the verification reviews and a copy of this LER in order to emphasize the importance of complete reviews.

PREVIOUS SIMILAR EVENTS:

There have been several previous events involving personnel error resulting in an inadequate surveillance frequency, the most recent of which was documented in LER 87-14.



**Florida
Power**
CORPORATION

February 29, 1988
3F0288-21

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

Subject: Crystal River Unit 3
Docket No. 50-302
Operating License No. DPR-72
Licensee Event Report No. 88-003-00

Dear Sir:

Enclosed is Licensee Event Report (LER) 88-003-00 which is
submitted in accordance with 10 CFR 50.71.

Should there be any questions, please contact this office.

Sincerely,

K. R. Wilson
Manager, Nuclear Licensing

WLR:mag

Enclosure

xc: Dr. J. Nelson Grace
Regional Administrator, Region II

Mr. T. F. Stetka
Senior Resident Inspector

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