Florida Power
CORPORATION

POST OFFICE BOX 219 - CRYSTAL RIVER, FLORIDA 32629 - TELEPHONE: (904) 795-3802

April 30, 1987
3F0487-21

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

Subject: Crystal River Unit 3
Docket No. 50-302
Operating License No. DPR-72
NRC Inspection Report No. 86-38
Revised Response

Dear Sir:

Florida Power Corporation provides the attached as our revised response to the subject Inspection Report. This response is being supplemented as a result of an investigation documented in LER 86-020 and described in our original response to this report.

Should there be any questions, please contact this office.

Sincerely,

E C Simpson

E. C. Simpson
Acting Director
Nuclear Site Support

WLR:MSM:mag

Atts.

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

Mr. T. F. Stetka
Senior Resident Inspector

IE01
1/1

FLORIDA POWER CORPORATION
REVISED RESPONSE
INSPECTION REPORT 86-38

VIOLATION 86-38-04

A. Technical Specification (TS) 6.8.1.c requires that procedures be established for surveillance and test activities of safety-related equipment.

Technical Specification 3.1.1.1.1 requires the reactor shutdown margin to be greater than 1.0% delta-k/k.

Surveillance procedure SP-421, Reactivity Balance Calculations, provides the procedure for determining the shutdown margin for the reactor. Step 6.3.1 of this procedure directs the method of calculation to determine the available shutdown margin and in Step 6.3.3 directs the calculation of the required shutdown margin.

Contrary to the above, on November 12, 1986, procedure SP-421 was found to be inadequate in that the procedure calculations could have allowed the reactor shutdown margin to exceed the limits set forth in TS 3.1.1.1.1. As a result of this inadequacy, a shutdown margin was incorrectly calculated on November 11, 1986, (though the requirements of TS 3.1.1.1.1 were not exceeded).

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

RESPONSE

1. Florida Power Corporation's Position

Florida Power Corporation (FPC) agrees the procedure was not adequate in that it was difficult for some operations personnel to use.

2. Apparent Cause of Violation

SP-421 was not written clearly enough to be performed consistently.

3. Corrective Actions

A revision was made to SP-421 to add additional detail that should help prevent similar mistakes in the future.

4. Date of Full Compliance

Full compliance was achieved on February 4, 1987, with issuance of SP-421.

5. Action Taken to Prevent Recurrence

The above should be sufficient to prevent recurrence.

VIOLATION 86-38-10

B. 10 CFR 50 Appendix B, Criterion XVI requires corrective action measures that assure that nonconformances are promptly identified and corrected and that such measures will prevent repetition of these nonconformances.

Section 1.7.1.16 of Florida Power Corporation's (FPC) Quality Program requires nonconformances to be promptly identified and corrected and that corrective action taken to be sufficient to prevent recurrence of the nonconformance.

In License Event Report (LER) 85-32, submitted on January 6, 1986, the licensee identified that an auxiliary transformer installed in the 230 KV switchyard did not have the diverse DC control power, which supplied Units 1 and 2 Batteries, for the primary and backup protective relaying as described in the Final Safety Analysis Report (FSAR). The corrective action for this event included a review of other interfaces as described in the FSAR and verification that no additional deficiencies existed. The corrective action review did not identify any additional deficiencies.

Contrary to the above, the licensee's corrective actions were inadequate in that:

- On December 10, 1986, it was identified that during the period of December 1976 through December 10, 1986, modifications were performed on the Unit 1 and Unit 2 batteries to install additional loads. As a result, these batteries were not tested to the correct load profile until this condition was identified.

- On December 15, 1986, it was identified that during the period of 1981 through 1982 three breakers were installed in the 230 KV switchyard and these breakers did not have independent sets of tripping coils supplied from separate DC supplies as described in the FSAR.

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

RESPONSE

1. Florida Power Corporation's Position

Florida Power Corporation concurs with the violation as stated.

2. Apparent Cause of Violation

The apparent cause of the violation is personnel error in that the scope of the reviews previously performed as part of the corrective action for LER 85-32 was not extensive enough to discover the interface problems associated with the subject violation.

3. Corrective Action

An extensive review is presently being planned to resolve the generic concern of CR-3 interfaces with other FPC generating units and departments. This review is intended to identify areas of interface, review the design/licensing basis of the interfaces, and confirm the actual plant interface configuration. Any discrepancies found during the review will be documented appropriately and corrective actions taken to assure compliance with all requirements.

4. Date of Full Compliance

Based on the complexity and necessary detail required for the review, it is expected the review will be completed by September 30, 1987. Any corrective actions needed as a result of the review will be handled as appropriate to the specific non-conformance.

5. Action Taken to Prevent Recurrence

This inadequacy of the corrective action taken in response to this issue has been discussed with the Engineering and Licensing personnel involved with the original LER 85-32 corrective actions. The need to perform thorough and extensive reviews was emphasized to reasonably assure occurrences of this nature are not repeated.

VIOLATION 86-38-11

C. 10 CFR 50.73(a)(2)(i)(B) requires the submittal of an LER within 30 days of the event for any operation or condition prohibited by the plant's Technical Specifications.

Contrary to the above, on November 13, 1986, the licensee identified that the containment leakage rate could not be verified within the limits specified by the TS. Further, on November 14, 1986, the licensee identified that two TS surveillance requirements were not being fully accomplished. As of January 6, 1987, no LERs had been issued for these events.

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

RESPONSE

1. Florida Power Corporation's Position

Florida Power Corporation agrees with the stated violation in that no LER had been submitted for the identified events.

2. Apparent Cause of Violation

The event concerning the containment leakage rate was not initially evaluated as being reportable based on the assumption total indicated leakage at this penetration was due to the reactor building purge inboard containment isolation valve (AHV-1C) was off its seat, and the assumption

the associated outboard containment isolation valve (AHV-1D) was properly seated. A soap test of the seating surfaces for AHV-1D had indicated no apparent leakage from this valve. Thus, the penetration was within the limits of the action statement of Technical Specification 3.6.3.1.

After further evaluation of this event, prompted by concern expressed by the Resident Inspectors, it was determined the inability to pressurize this penetration to required pressure was reportable under 10 CFR 50.73.A.1.I.B since compliance with Technical Specification 3.6.1.2 could not be demonstrated.

The cause of the failure to report the surveillance deficiencies is attributed to misinterpretation of the Technical Specification surveillance requirements. The person initially reviewing the subject events believed the Technical Specification surveillance requirements were already adequately satisfied by existing procedures and, therefore, no report was necessary.

3. Corrective Action

An LER reporting the containment leakage event (LER 86-027) was issued on January 29, 1987. An LER reporting the deficient surveillance procedures (LER 86-026) was issued on February 4, 1987.

Personnel were provided with a consistent interpretation of the Technical Specification surveillance requirements for valve position surveillance. Plant procedures were revised to include monthly valve position verification for those valves identified in the appropriate surveillance requirements.

4. Date of Full Compliance

Full compliance was achieved on February 4, 1987 when LER 86-26 was submitted to the NRC.

5. Action Taken To Prevent Recurrence

The responsibility for determination of reportability for Nonconforming Operations Reports (NCOR's) has been reassigned to the Nuclear Operations Technical Advisors.

VIOLATION 86-38-02

D. Technical Specification 6.11 requires adherence to procedures for all operations involving personnel radiation exposure. Radiation protection procedure RSP-101, Basic Radiological Safety Information and Instructions for "Radiation Workers," defines posting of radiation areas as a radiological control in step 2.3.26 and requires adherence to these radiological controls in step 3.1.3.4.

Contrary to the above, on November 18, 1986, three individuals were observed in the reactor building, a posted beta protection required area, without beta protection glasses.

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

RESPONSE

1. Florida Power Corporation's Position

   FPC agrees with the stated violation in that three individuals were observed in the reactor building without beta protection glasses.

2. Apparent Cause of Violation

   The cause of this violation is attributed to personnel error. The three individuals had just taken off respirators. One individual had left her glasses where she had put on her respirator. Exhaustion prevented her from returning to that area and donning the glasses. One individual dropped his glasses and believed they may have been contaminated. The third individual, also fatigued, forgot to put on his glasses.

3. Corrective Actions

   Two of the individuals left the area. The other individual donned his safety glasses.

4. Date of Full Compliance

   Full compliance was achieved shortly after the violation occurred on November 18, 1986.

5. Action Taken to Prevent Recurrence

   A Radiological Safety Incident Report was initiated. The individuals involved and the days shift compliment discussed the incident prior to leaving the plant the day of the incident. A management review board meeting was held to determine the root cause of the event.

VIOLATION 86-38-09

E. Technical Specification 4.0.2.b requires each surveillance test to be performed within the specified time interval with a total maximum combined interval time for any three consecutive tests to not exceed 3.25 times the specified interval.

   Contrary to the above, during the period of September 29 through November 14, 1986, eight surveillance tests exceeded their total maximum combined interval times.

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

RESPONSE

1. Florida Power Corporation's Position

   Florida Power Corporation agrees eight surveillance tests exceeded their total maximum combined interval times. LER 86-020 also documents this event.

2. Apparent Cause of Violation

The present computerized surveillance tracking system has had some computer program anamolies. Therefore, the surveillance performance dates are also monitored and tracked manually. The surveillances missed by the 3.25 interval were refueling interval procedures. They were apparently determined not to be due based on their 1.25 interval. Personnel failed to evaluate the 3.25 interval.

LER 86-20 also identified a procedural deficiency exists in Surveillance Procedure SP-443, "Master Surveillance Plan." This deficiency also attributed to exceeding the 3.25 specified interval.

3. Corrective Actions

Upon discovery, appropriate action was taken to have the procedures scheduled and performed as expediently as possible. In addition, a review of all procedures with a six month or greater interval was inititated to determine if other procedures had been missed.

4. Date of Full Compliance

FPC was in full compliance on January 30, 1987 when the last of the identified surveillances was completed satisfactorily.

5. Action Taken to Prevent Recurrence

A complete list of the procedures with a six month or greater interval including calculated due dates and windows has been developed and is being utilized to determine when procedure performance is required. A more reliable computer program is being developed and should be implemented by August 1987.

In addition, SP-443 is being revised to ensure the applicable scheduling is not dependent upon the prior performance date. This revision should be complete by August 1, 1987.

VIOLATION 86-38-05

F. 10 CFR Part 50, Appendix J, paragraph III.D.2(b)(ii), requires air locks, that are opened during periods when containment integrity is not required, be tested at accident pressure (Pa) prior to entering a period that requires containment integrity.

Contrary to the above, during the period of November 14-22, 1986, air locks were opened while containment integrity was not required and were not tested at Pa prior to entering operational modes that required containment integrity.

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

RESPONSE

1. Florida Power Corporation's Position

   FPC concurs with the stated violation in that during the period of November 14-22, 1986, air locks were opened while containment integrity was not required, and they were not tested at Pa prior to entering operational modes that required containment integrity.

2. Apparent Cause of Violation

   The cause of this violation was procedural inadequacy. The procedure failed to implement the requirements of Appendix J.

3. Corrective Actions

   SP-181, Containment Air Lock Test, was revised (Rev. 15) to address the mode restraints for the Appendix J requirements. FPC requested and received NRC exemption from 10 CFR 50, Appendix J III.C.2(B)(III) requirements. SP-181 was again revised to reflect the Appendix J exemption.

4. Date of Full Compliance

   Full compliance was achieved on December 16, 1987 when SP-181 was revised.

5. Action Taken to Prevent Recurrence

   The above corrective action should be sufficient to prevent recurrence.