Florida Power
CORPORATION

June 26, 1987
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U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Subject: Crystal River Unit 3
Docket No. 50-302
Operating License No. DPR-72
NRC Inspection Report 87-12

Dear Sir:

Florida Power Corporation provides the attached as our response to the subject Inspection Report.

Should there be any questions, please contact this office.

Sincerely,

E C Simpson

E. C. Simpson
Director, Nuclear
Operations Site Support

WLR:mag

Attachment

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

Mr. T. F. Stetka
Senior Resident Inspector

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FLORIDA POWER CORPORATION
RESPONSE
INSPECTION REPORT 87-12

VIOLATION 87-12-01

Technical Specification 6.8.1 requires the establishment and implementation of written procedures for those activities recommended in Appendix A of Regulatory Guide 1.33, November 1972, and for surveillance activities of safety related equipment.

Regulatory Guide 1.33, Appendix A, Section I.1, recommends procedures and/or written instructions for conducting maintenance activities.

Compliance Procedures CP-113, Handling and Controlling Work Requests and Work Packages, which was written to implement the requirements of Section I.1 of Regulatory Guide 1.33, requires in step 5.4.1.C that whenever the scope of work exceeds the instructions provided in part II of the work request, that the entire work package be returned to the Nuclear Planning Coordinator for further evaluation.

Surveillance Procedure SP-354A, Monthly Functional Test of the Emergency Diesel Generator 3A and Engineered Safeguards (ES) Bus A Undervoltage Relays, step 9.8.9 of section 9.8, ES Standby Mode for Auto Start, requires the Control Switch for Diesel Room fan AHF-22B to be placed in the normal-after-stop position.

Surveillance Procedure SP-216, Sample Line Leak Rate Test, specifies the sequence for test performance, the valve lineups, and the test equipment connection points to enable performance of the Leak Rate Test.

Surveillance Procedure SP-335C, Radiation Monitoring Instrumentation Functional Test, (Tech Spec RMA's) step 7.7, requires that the procedure section in progress be completed before a new section in the procedure is started.

Surveillance Procedure SP-317, Reactor Coolant System (RCS) Water Inventory Balance, requires the calculation of the identified and unidentified RCS leakages from data collected over a time interval. This time interval is then used to obtain the RCS leakage rate.

Contrary to the above:

a. On April 13, 1987, maintenance performed on control complex air compressor AHP-1C exceeded the work instructions provided in part II of the work request without the prior evaluation of the Nuclear Planning coordinator.

b. On April 10, 1987, the control switch for AHF-22B was observed to be in the pull-to-lock position thus preventing automatic fan operation.

c. On April 10, 1987, procedure SP-216 was not adhered to in that steps were performed out of sequence, valve lineups were modified without making appropriate procedure changes, and test equipment was connected differently than that provided for in the procedure. Additionally, procedure

SP-216 was not properly established in that the procedure failed to restore systems to the normal configuration prior to allowing procession to following procedure sections and failed to identify the proper sequence of operation for various system valves. As the result of these actions, plant radiation alarms were actuated, system pressures were exceeded, and personnel were contaminated.

d. On April 22, 1987, section 9.4 of procedure SP-335C was started prior to completing section 9.2, which was in progress. As a result of this action, the setpoint for radiation monitor RMA-11 was exceeded causing it to alarm and isolate the applicable ventilation ductwork.

e. On May 1, 1987, procedure SP-317 was performed incorrectly in that the actual data collection time of 10 hours was not used in calculating RCS leakage rates. This resulted in a nonconservative error being made in the calculation of the RCS unidentified leakage.

RESPONSE

1. Florida Power Corporation's Position

Florida Power Corporation (FPC) accepts the stated violation.

2. Apparent Cause of Violation

a. The cause for exceeding the work instructions is personnel error. The belt on the air compressor that was to be adjusted was found to be worn and stretched. The maintenance worker misinterpreted the intent of the work instructions in that he felt it was within the scope of the work request to replace the belt in order to prevent the belt from continued slippage.

b. The cause of this violation is personnel error. The operator in the Control Room (working from a controlled copy of the procedure) restored AHF-22A to the required status, but failed to restore AHF-22B. The "working copy" of SP-354A was presented to the operator to initial the steps that he performed and Step 9.8.9. was initialed as completed.

c. Test personnel performed steps out of sequence in the procedure in an attempt to protect plant equipment involved in the test.

The procedure was inadequate in that sufficient equipment restoration steps were not included. This led to an overpressurization of the hydro test pump and leakage of contaminated fluid onto the floor. The individuals stepped into the contaminated fluid, thereby transferring the contamination to their shoes.

d. The cause of the discrepancy in the performance of SP-335C has been attributed to personnel error. The operator performing the procedure did not assure that any other section of the procedure was in progress as stipulated by the limits and precautions of SP-335C.

e. The cause of the discrepancy in the performance of the SP-317 has been attributed to personnel error. The operator performing the procedure miscalculated the end-point time for the normal eight hour run time. This caused him to run the procedure for ten hours, however, being thoroughly familiar with the procedure and not realizing his error, used the eight hour run time for his calculations. This error was not detected by the individual performing the review of the completed procedure.

Corrective Action

a. The work request was returned to the Nuclear Planning Coordinator and rewritten to allow the replacing of the belt.

b. AHF-22B was correctly positioned upon notification of the violation.

c. The test was terminated. The system was realigned to the proper configuration by the normal system operating procedure. The floor, equipment, and personnel were decontaminated.

d. The procedure was terminated and the system was restored to its pre-surveillance condition.

e. The procedure was corrected to conform with the actual run time of ten hours. The corrected procedure has been transmitted to quality files.

3. Date of Full Compliance

a. Full compliance was achieved on April 23, 1987, the date the work request was rewritten.

b. Full compliance was achieved on April 10, 1987, when AFH-2B was positioned correctly.

c. Full compliance was achieved on April 10, 1987, with termination of the test and realignment of the system.

d. Full compliance was achieved on April 22, 1987, with the termination of the surveillance procedure.

e. Full compliance was achieved on May 11, 1987, when the quality files were updated to reflect the correct leakage.

5. Action Taken To Prevent Recurrence

a. The individual involved reviewed the incident with his supervisor. He was also given a training class on CP-113, with emphasis on his responsibility to follow the work instructions given on the work request or have them revised if other work is required.

b. The individual involved was counseled by his supervisor and the Director of Nuclear Plant Operations. This counseling addressed the cause of the incident, corrective action, and prevention of repeat occurrences.

c. The individual involved in performing the procedure was counseled regarding the need to strictly adhere to written procedures. SP-216 was completely rewritten and validated. It was satisfactorily performed on June 9, 1987.

d. The individual has received counseling by his supervisor and the Director of Nuclear Plant Operations, consisting of a review of the incident, including investigation, corrective action, and suggestions for the prevention of repeat occurrence. The need for strict procedural adherence was also stressed. SP-335C will be reviewed to determine if a more appropriate placement of Limits and Precautions within the body of the procedure will prevent future occurrences.

e. The individuals involved have received counseling by their supervisor and the Director of Nuclear Plant Operations. This counseling included reasons for the error and corrective actions to prevent recurrence. SP-317 has been reviewed and revised for human factor enhancements.