



**Florida
Power**
CORPORATION

Crystal River Unit 3
Docket No. 50-302

October 8, 1993
3F1093-01

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

Subject: Notice of Violation (NRC Inspection Report 50-302/93-21)

Reference: 1) NRC letter to FPC, 3N0993-06, dated September 9, 1993

Dear Sir:

Florida Power Corporation (FPC) provides the attached as our response to the subject Notice of Violation.

Sincerely,

P. M. Beard, Jr.
Senior Vice President
Nuclear Operations

EEF:mag

Enclosure

xc: Regional Administrator, Region II
NRR Project Manager
Senior Resident Inspector

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FLORIDA POWER CORPORATION
NRC INSPECTION REPORT 50-302/93-21
REPLY TO NOTICE OF VIOLATION

VIOLATION 50-302/93-21-01

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, and the licensee's accepted Quality Assurance Program, FSAR, Chapter 1, require that measures be established to assure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. The licensee's letter to the NRC of June 22, 1993, in response to Notice of Violation 50-302/93-09-01, stated that the inadequate locally posted instructions for manual operation of Decay Heat Closed Cycle Cooling Heat Exchanger Outlet Valve (DCV-177) have been replaced with interim instructions for taking manual control of the valve without repositioning.

Contrary to the above, measures did not assure corrective actions would preclude repetition of the Reactor Coolant System overcooling event of March 5, 1993. On August 11, 1993, the licensee's interim corrective actions described in response to Violation 50-302/93-09-01 were inadequate in that the revised interim instructions for taking manual control of DCV-177 could not be performed with the valve in a mid-position (as required to prevent a system overcooling transient). With the valve in a mid-position, a steel plate prevented the performance of step three of the instructions (removal of the valve stem pin).

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

Florida Power Corporation (FPC) accepts the Violation.

REASON FOR THE VIOLATION

The violation was the result of FPC's:

- 1) Untimely recognition and understanding of the necessity for removing the valve stem pin in taking manual control of DCV-177, and
- 2) Failing to take timely appropriate action when the true root cause of the problem was discovered.

During the event of March 5, 1993, the locally posted instructions for this valve contributed to the Reactor Coolant System (RCS) overcooling by causing the valve to go to the full open position. During the attempt to take manual control of the valve, when the valve stem pin could not be removed, it was initially assumed to be another deficiency in the locally posted instructions and was not identified as a separate problem. Thus, when the instructions were initially revised to prevent the valve from repositioning to full open, the ability to remove the pin was not considered. Failure to validate the effectiveness of the revised instructions at the time of posting also contributed to the misconception.

Later, a formal failure analysis recognized the revised instructions were not an improvement. However, it was also recognized that a modification would be required to completely resolve the problem. It was further recognized that this effort was underway with commitment dates established for completion. For these and other reasons, the revised instructions were improperly allowed to remain in place. The proper course of action should have been to remove the locally posted instructions and procedurally advise the operating staff to change cooling trains if a similar problem occurred. Follow up to assure these items were addressed did not take place because it was assumed the circumstances that would result in the necessity to take manual control were remote and no individual felt a sense of urgency to assure these details were resolved. In addition, no one had been designated single point of contact for this problem, which resulted in no one feeling ownership for the full scope of the problem. This contributed to the poor coordination, untimely actions and lack of a sense of urgency. These weaknesses also led to the incomplete response made to the NRC in the LER correspondence.

CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED

1) DCV-177 and similar valves have had the upper diaphragm casings replaced with ones incorporating handwheels and jackscrews acting directly on the diaphragm and have been functionally tested. This modification eliminates the requirement to remove the connecting pin when taking manual control of the valve. The appropriate procedure has been revised to include instructions for taking manual control of these valves with the new mechanism. Locally posted instructions for taking manual control have been similarly revised.

2) The lessons learned from this event have been discussed with the supervisors and managers involved to ensure their understanding and support in preventing similar mistakes in the future.

3) An Operations Study Book entry has been made stressing to the operations staff the requirement to validate significant revisions to operations procedures.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

An individual will be designated to have overall responsibility for each future reportable event. All actions and information relating to these occurrences will be channelled through this single point to assure full coordination and communication is achieved across all departments, including senior FPC management. This independent oversight function will ensure the validation and verification of corrective actions and the accuracy of correspondence to the NRC.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.