



USNRC REGION II  
ATLANTA, GEORGIA

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**Florida  
Power**  
CORPORATION

March 9, 1983  
3F-0383-11

Mr. J. P. O'Reilly  
Regional Administrator, Region II  
U. S. Nuclear Regulatory Commission  
Office of Inspection & Enforcement  
101 Marietta Street N.W., Suite 2900  
Atlanta, GA 30303

SUBJECT: Crystal River Unit 3  
Docket No. 50-302  
Operating License No. DPR-72  
IE Inspection Report No. 82-28

Dear Mr. O'Reilly:

Enclosed is Florida Power Corporation's response to Inspection Report 82-28, dated February 7, 1983.

In response to your staff's request for a description of actions taken or planned to improve the effectiveness of Florida Power Corporation's management control system, we offer the following information.

1. A new administrative procedure was issued to define and implement appropriate corrective measures following procedural nonconformance.
2. A Nuclear Operations trending program procedure has been established to identify program weaknesses and aid in determining appropriate corrective actions.

Sincerely,

Dr. P. Y. Baynard  
Assistant to Vice President  
Nuclear Operations

Enclosure

PGH/mlg

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

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FLORIDA POWER CORPORATION RESPONSE  
INSPECTION REPORT 82-28  
March 9, 1983

A. VIOLATION

Technical Specification 3.0.4 prohibits entry into an operational mode when the Limiting Conditions for Operation (LCO) for that mode relies on an Action Statement.

Technical Specification 3.5.2.d requires both Emergency Core Cooling System (ECCS) trains to be capable of transferring suction from the borated water storage tank (BWST) to the containment sump during operational Modes 1 through 3. The Action Statement for this LCO allows one train to be out of service for up to 72 hours.

Contrary to the above, at 4:00 P.M. on October 29, 1982, while the plant was starting up from an outage, motor operated valve DHV-42 that provides one of the suction paths to the containment sump, was found to be inoperable in that the valve control switch was red tagged to prevent operation and the circuit breaker was racked out as the result of an equipment clearance order. The plant had entered operational Mode 3 at 3:06 P.M. on October 28, 1982.

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

A. RESPONSE

- (1) FLORIDA POWER CORPORATION'S POSITION: On October 29, 1982, in the event of an accident, one of the suction paths from the containment sump would have been inoperable due to the deactivation of DHV-42. Florida Power Corporation had originally denied this violation on the basis that the location of the breaker for DHV-42 was accessible to allow operator entry for valve operation. Upon further review, we find we must agree with the violation since studies we were required to complete for NUREG-0578 indicated the maximum dose rates following an accident could make the area inaccessible.
- (2) DESIGNATION OF APPARENT CAUSE: This event was caused by personnel error. During startup operations, personnel failed to recognize that DHV-42 was inoperable.
- (3) IMMEDIATE CORRECTIVE ACTIONS: Upon recognition that DHV-42 was inoperable, power was restored to the valve's circuit breaker returning it to full operability. In addition, operations personnel rechecked the clearance log to assure that there were not any other outstanding safety related clearances.
- (4) LONG TERM CORRECTIVE ACTIONS: Plant Heatup Procedure (OP-202) was revised requiring a signoff to assure that outstanding safety related clearances are identified and appropriate actions are taken.
- (5) DATE OF FULL COMPLIANCE: On December 14, 1982, OP-202 revision was completed and thus full compliance was achieved.

## **B. VIOLATION**

Technical Specification Surveillance Requirement 4.7.1.4 requires secondary coolant system gross beta activity to be determined at least once per 72 hours.

Contrary to the above, during the period of July 30, 1982 through August 9, 1982, the gross beta activity of the secondary coolant system was not determined.

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

## **B. RESPONSE**

- (1) FLORIDA POWER CORPORATION'S POSITION: Florida Power Corporation agrees with the violation. For the period between July 30, 1982, and August 9, 1982, we cannot document that secondary coolant sample was taken and analyzed for gross beta activity as required by Specification 4.7.1.4.

Other analysis for the period of time (tritium sampling and analysis, main steam resin column gamma isotopic analysis and iodine dose equivalent analysis) were reviewed. These analyses did not indicate any evidence of a primary to secondary leak which is the primary basis for performing a gross beta activity analysis.

- (2) DESIGNATION OF APPARENT CAUSE: This violation was caused by personnel error. Personnel failed to recognize that the gross beta activity had not been determined for the secondary coolant.
- (3) IMMEDIATE CORRECTIVE ACTIONS: Chemistry schedules were reviewed to assure that no other required analysis had been overlooked.

Personnel were reinstructed on the necessity to perform the secondary gross beta analysis every 72 hours.

- (4) LONG TERM CORRECTIVE ACTIONS: Florida Power Corporation considers the immediate corrective actions to be adequate to prevent a recurrence.
- (5) DATE OF FULL COMPLIANCE: On August 9, 1982, Florida Power Corporation was in full compliance.

## **C. VIOLATION**

Technical Specification 3.7.12 requires all penetration fire barriers protecting safety-related areas to be functional at all times. With one or more of the penetration fire barriers nonfunctional, a continuous fire watch is required to be established on at least one side of the affected penetration within one hour. Fire doors in fire barriers are penetration fire barriers and must be maintained functional or a fire watch established.

Contrary to the above, fire door A-202 for the fire barrier penetration between the hot machine shop and the 119 foot elevation of the auxiliary building was found at 8:38 A.M. on November 5, 1982, to be nonfunctional and a fire watch had not been established. This door was found blocked and wedged in the open position.

This is a Severity Level IV Violation (Supplement I). Similar items were previously identified by NRC Reports 50-302/81-21 and 50-302/81-25.

### C. RESPONSE:

- (1) FLORIDA POWER CORPORATION'S POSITION: Florida Power Corporation agrees with the violation. On November 5, 1982, fire door A-202 was incapable of performing its intended function without personnel action (closing the fire door) and no fire watch was posted.
- (2) DESIGNATION OF APPARENT CAUSE: This violation was caused by personnel error. Personnel apparently forgot to close the fire door after moving equipment through the door.
- (3) IMMEDIATE CORRECTIVE ACTIONS: Immediately following notification, the fire door was closed and returned to operability. In addition, personnel were instructed of importance of fire door operability.
- (4) LONG TERM CORRECTIVE ACTIONS: Due to repeated instances of fire door inoperability caused by personnel oversight, the fire doors were painted red to clearly identify affected doors. Furthermore, a new procedure was written to emphasize and implement corrective measures when personnel fail to follow procedures (such as fire door operability). Fire doors not on the key card system are currently checked by guards approximately every hour.
- (5) DATE OF FULL COMPLIANCE: Full compliance was achieved on November 5, 1982, when the fire door was closed.

### D. VIOLATION

Technical Specification 6.8.1a requires adherence to procedures required by Appendix A of Regulatory Guide 1.33, November 1972. Regulatory Guide 1.33, Section I requires written procedures for the repair or replacement of equipment. Procedure MP-123, Disassembly and Reassembly of Nuclear Service Closed Cycle Cooling Water Pumps SWP-1A, 1B and 1C, requires in step 8.5.16 that the pump coupling faces are checked to insure that they are parallel and in vertical alignment and that the alignment results be recorded on Enclosure 3 of the procedure. Enclosure 3 requires recording of both face-to-face and rim-to-rim alignment measurements. In addition, step 8.5.16 requires a Quality Control inspector to verify this alignment.

Contrary to the above, at approximately 4:00 P.M. on November 9, 1982, while performing maintenance on pump SWP-1B, procedure MP-123, section 8.5.16 was not adhered to in that the coupling rim-to-rim measurement was not made. In addition, this step was verified as properly completed by the Quality Control inspector.

This is a Severity Level IV Violation (Supplement I). Previously cited violations which address the area of failure to follow procedures during safety-related maintenance are identified in reports 50-302/81-13, 81-21, 82-02, 82-11, and 82-18.

### D. RESPONSE:

- (1) FLORIDA POWER CORPORATION'S POSITION: Florida Power Corporation agrees with the violation. On November 9, 1982, the Quality Control inspector incorrectly signed a verification that a rim-to-rim inspection was complete and satisfactory.

- (2) DESIGNATION OF APPARENT CAUSE: This event was caused by personnel error and procedural inadequacy. The inspector recognized that the procedure was inaccurate and failed to implement a temporary change to the procedure to correct the inadequacy.
- (3) IMMEDIATE CORRECTIVE ACTIONS: On November 22, 1982, inspection personnel were reinstructed on the importance of procedural compliance and the approved methods for changing procedures.  
  
On December 3, 1982, an interim change to Maintenance Procedure (MP-123) was approved for implementation. The interim change clarifies and corrects the verification requirements of MP-123. Additionally, the Quality Control inspector involved was dismissed.
- (4) LONG TERM CORRECTIVE ACTIONS: The permanent change to MP-123 is scheduled to be issued by March 31, 1983.
- (5) DATE OF FULL COMPLIANCE: Florida Power Corporation will be in full compliance on March 31, 1983.