



Florida Power

CORPORATION
Crystal River Unit 3
Docket No. 90-302

January 18, 1995
3F0195-11

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

Subject: Licensee Event Report (LER) 94-008-01

Dear Sir:

Enclosed is Licensee Event Report (LER) 94-008-01 which is submitted in accordance with 10 CFR 50.73.

This supplement provides a date correction as well as a modification of cause of this event.

Sincerely,

G. L. Boldt
Vice President
Nuclear Production

GLB/JAF:ff

Attachment

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

240020

CRYSTAL RIVER ENERGY COMPLEX: 15760 W Power Line St • Crystal River, Florida 34428-6708 • (904) 795-6486

A Florida Progress Company

9501250205 950118
PDR ADOCK 05000302
S PDR

JE22

EXPIRES 6/31/96

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HOURS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (MNB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON DC 20503.

FACILITY NAME (1)

CRYSTAL RIVER UNIT 3 (CR-3)

DOCKET NUMBER (2)

0 5 0 0 0 3 0 2 1 OF 0 4

PAGE (3)

TITLE (4)

Inattention to Detail Leads to Failure to Complete Surveillance Test Within Designated Time Period Resulting in Violation of Technical Specifications

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)													
1	0	1	9	4	9	4	0	0	8	0	1	0	1	1	8	9	5	N/A	0	5	0	0	0

OPERATING
MODE (9)

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (CHECK ONE OR MORE OF THE FOLLOWING) (11)

POWER
LEVEL
(10)

20.402(b)

20.405(c)

50.73(a)(2)(iv)

73.71(b)

20.405(a)(1)(i)

50.36(c)(1)

50.73(a)(2)(v)

73.71(c)

20.405(a)(1)(ii)

50.36(c)(2)

50.73(a)(2)(vii)

OTHER (Specify in Abstract
below and in Text, NRC Form
366A)

20.405(a)(1)(iii)

X

50.73(a)(2)(i)

50.73(a)(2)(viii)(A)

20.405(a)(1)(iv)

50.73(a)(2)(ii)

50.73(a)(2)(viii)(B)

20.405(a)(1)(v)

50.73(a)(2)(iii)

50.73(a)(2)(x)

LICENSEE CONTACT FOR THIS LER (12)

NAME

J. A. Frijouf, Nuclear Regulatory Specialist

TELEPHONE NUMBER

AREA CODE

9 0 4 5 6 3 - 4 7 5 4

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

CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED
SUBMISSION
DATE (15)

MONTH DAY YEAR

YES (If yes, complete EXPECTED SUBMISSION DATE)

X NO

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

On October 11, 1994, Florida Power Corporation's (FPC) Crystal River Unit 3 was in MODE 1 (MODE ONE), operating at 100% reactor power and generating 877 megawatts. FPC personnel incorrectly concluded that a procedural note permitted a 4 hour vice 1 hour time period to verify the required circuit status from the time the diesel generator (EGDG) was declared inoperable during performance of a functional test. Several hours after the applicable conditions of the Technical Specification (TS) Limiting Conditions for Operation (LCO) were entered, operators were notified the functional test procedure was complete. The EGDG was started and the TS LCOs were exited. Since completion of the functional test procedure occurred within 4 hours, operators did not perform the Power Distribution Breaker Alignment And Power Availability Verification Surveillance procedure (SP-321).

On October 12, 1994 the on-coming shift questioned the previous shift logs, and recognized they had not met the TS requirement to perform SP-321. Failure to complete this verification constitutes a TS violation and is reportable under 10CFR50.73. The cause was inattention to detail coupled with poor communication and teamwork between licensed operators. Corrective actions for this event include actions to improve communications and teamwork, and applicable procedure revisions.

EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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

EVENT DESCRIPTION:

On October 11, 1994, Florida Power Corporation's (FPC) Crystal River Unit 3 (CR-3) was in MODE 1 (MODE ONE), operating at 100% reactor power and generating 877 megawatts. At 1700, operations personnel and maintenance personnel were discussing preparations for the performance of the Monthly Functional Test of "A" 4160 volt Engineered Safeguards Bus Undervoltage Relaying (Monthly Functional Test- SP-907A).

At 1717, the "A" Emergency Diesel Generator (EGDG)[EK,DG] fuel rack was tripped as required by SP-907A to prevent auto-start during testing. The Shift Supervisor On Duty (SSOD), in accordance with the procedure, entered the applicable conditions of Technical Specification (TS) Limiting Conditions for Operation (LCO) 3.8.1 and 3.3.8. LCO 3.8.1 requires two EGDGs be operable, and LCO 3.3.8 requires that three channels of loss of voltage Function and three channels of degraded voltage function EGDG Loss of Power Start (LOPS) instrumentation per EGDG be operable. The control board operators reviewed the Special Conditions Surveillance Plan (SP-442) for an inoperable EGDG which identified the need to perform SP-321, Power Distribution Breaker Alignment And Power Availability Verification Surveillance. Further discussions concerning the Monthly Functional Test Procedure- SP-907A continued between control room operations personnel. Rather than applying the TS requirement to verify the correct breaker alignment and indicated power availability for each required circuit within 1 hour from the time the EGDG was declared inoperable, they erroneously concluded that the procedure permitted a 4 hour grace period if performance of the procedure was intended to satisfy a surveillance.

At 2015, the control room operators were notified that the Monthly Functional Test procedure- SP-907A was complete. Within 1 hour, the "A" EGDG was started to verify operability, and at 2100 the SSOD exited the TS LCOs. Since the completion of the Monthly Functional Test procedure- SP-907A occurred within 4 hours, the SSOD did not have the operators perform the Power Distribution Breaker Alignment And Power Availability Verification Surveillance procedure (SP-321).

At 0148 on October 12, 1994, the next shift of control room personnel shutdown the "A" EGDG. Operators tripped the fuel racks and entered the applicable TS LCO as required by the Monthly Functional Test for the Emergency Diesel Generator EGDG-1A surveillance procedure (SP-354A) and performed the Power Distribution Breaker Alignment And Power Availability Verification Surveillance procedure (SP-321).

At 1717 on October 13, 1994, the original shift returned and reviewed the previous shift logs. They were made aware that they had not met the requirement to perform the Power Distribution Breaker Alignment And Power Availability Verification Surveillance procedure (SP-321) and documented their thought process for reporting purposes. Failure to complete this verification within one hour of EGDG inoperability constitutes a violation of TS and is reportable under 10CFR50.73(a)(2)(i)(B).

EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER)
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TEXT (If more space is required, Use additional NRC Form 366A's (17))

EVENT EVALUATION

There were no nuclear safety consequences due to this event. Subsequent verification of the physical plant status (breaker alignment) ensured the plant was not in violation of TS power requirements. This event did not compromise the health and safety of the general public.

CAUSE

The cause was inattention to detail coupled with poor communication and teamwork between licensed control room operators. The "Operations Plan for Enhancement of Team Performance" lists the following "tools" available to control room personnel: knowledge, procedure adherence, questioning attitude, effective communications, and pre-job briefing. In this instance, the tools not properly utilized were knowledge and effective communications. The Assistant Nuclear Shift Supervisor (ANSS) and control board operators held a pre-job briefing prior to performance of the Monthly Functional Test Procedure- SP-907A, however they incorrectly interpreted the procedure requirements. They stated that they did in fact perform the required verification of offsite breaker alignment and power availability, but did not document the data. Therefore, the surveillance must be considered "not performed". Had effective communication existed between the SSOD and the ANSS, the SSOD would have recognized the erroneous conclusion and the requirement to complete the Power Distribution Breaker Alignment And Power Availability Verification Surveillance procedure (SP-321).

A contributing factor to this event was that the note in the Monthly Functional Test Procedure- SP-907A is confusing and not human factored for ease and clarity of interpretation. Only acronyms are used in the text, TS references are listed by number without titles. Had the note been less confusing, the operators would have had the knowledge to make the correct decision.

CORRECTIVE ACTION

Corrective actions for this event include the following:

1. A review was performed to ensure full compliance with the TS, and the requirements of the Power Distribution Breaker Alignment And Power Availability Verification Surveillance procedure (SP-321).
2. The SSOD and ANSS worked on effective communication to build stronger teamwork skills. The SSOD and ANSS made a presentation to the Manager, Nuclear Plant Operations. This presentation addressed the attention to detail, communication and teamwork skills improved since the occurrence of this event.

EXPIRES 5/31/95

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TEXT (If more space is required, Use additional NRC Form 386A's (17))

3. The Monthly Functional Test of 4160 volt Engineered Safeguards Bus Undervoltage Relaying procedures for both "A" and "B" channels has been revised for human factors problems to ensure correct interpretation of the required surveillances to be performed following the declaration of the EGDGs as inoperable.
4. A new "Event Free Operations" program is being implemented, expanding the concept of human performance tools by focusing on both worker and management use of such tools.

PREVIOUS SIMILAR EVENTS

There has been one previous reportable event involving a Power Distribution Breaker Alignment and Power Availability Verification surveillance.