



Florida Power

CORPORATION

Crystal River Unit 3

Docket No. 50-302

April 26, 1995

3F0495-17

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

Subject: NRC Notice of Violation and Inspection Report 50-302/95-07
3N0395-20

Dear Sir:

By your letter of March 30, 1995, Florida Power Corporation (FPC) received a Notification of Violation concerning an inadvertent loss of a 4160 Volt Engineered Safeguards bus that resulted from non compliance with procedural requirements. The purpose of this letter is to provide our response to the violation.

Sincerely,

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

PMB/RLM

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

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FLORIDA POWER CORPORATION
NRC INSPECTION REPORT 50-302/95-07
REPLY TO A NOTICE OF VIOLATION

VIOLATION 50-302/95-07-01

Technical Specification 5.6.1.1 states that written procedures shall be established, implemented, and maintained covering activities as recommended in Regulatory Guide 1.33, Rev. 2, Appendix A, February 1978. Regulatory Guide 1.33, Appendix A recommends procedures regarding surveillance testing.

SP-907A, Monthly Functional Test of 4160V Engineered Safeguards Bus A Undervoltage Relaying, step 3.7.16, states to completely open trip block switches TBS1 and TBS2.

Contrary to the above, on February 7, 1995, technicians performing SP-907A step 3.7.16, did not open trip block switch TBS1 resulting in the loss of Engineered Safeguards Bus A when the Secondary Level Undervoltage Relay test push button was depressed per step 4.11.2 of SP-907A.

ADMISSION OR DENIAL OF THE ALLEGED VIOLATIONS

Florida Power Corporation (FPC) accepts the violation.

REASON FOR THE VIOLATION

A Human Performance Evaluation System (HPES) evaluation was conducted for this event. The HPES concluded that the primary cause of the event was personnel error based on inattention to detail by maintenance personnel performing the approved procedure by failing to properly position a trip block switch. The maintenance personnel performing the procedure were teamed up so that one was reading the procedure and the second was performing the steps with "repeat backs". A contributing cause was an error in communicating a step as complete that actually was not completed.

A second contributing factor to this event was the means of switch identification. A clear plastic switch cover, used to prevent inadvertent switch actuation contained the switch identification information. Additionally, labels are mounted above each of the associated trip block switches. However, they are partially obscured by the wiring going to the trip block switch.

CORRECTIVE ACTIONS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

Corrective actions for this event include the following:

1. The maintenance crew members conducting the procedure were counselled relative to this event.
2. The entire maintenance department discussed human error and event free operations in a shop meeting and further studied the issue.

3. A label has been placed on the appropriate cabinet door to ensure positive switch identification following removal of the clear plastic cover.
4. The procedure has been revised to strengthen the applicable steps.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The above completed corrective actions are considered sufficient to prevent recurrence.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The corrective actions were completed with the issuance of the revised procedure on April 13, 1995.