



**Florida  
Power**

CORPORATION  
Crystal River Unit 3  
Docket No. 50-302

February 28, 1992

3F0292-15

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

Subject: Licensee Event Report (LER) 91-015-01

Dear Sir:

Enclosed is Licensee Event Report (LER) 92-015-01 which is submitted in accordance with 10 CFR 50.73. This supplement addresses corrective actions taken relative to this issue.

Sincerely,

G. L. Boldt  
Vice President  
Nuclear Production

EEF:mag

Enclosure

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

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JE28, 1

## LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, 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										PAGE (3) 1 OF 0 3										
TITLE (4) Failure to Complete Required Technical Specification Surveillance Prior to Mode Change Due to Personnel Error																														
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)															
									N/A						0 5 0 0 0															
1	1	2	5	9	1	9	1	0	1	5	0	1	0	2	2	8	9	2	N/A						0 5 0 0 0					
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																												
3		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)																
POWER LEVEL (10)		20.405(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)																
0 10 10		20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 306A)																
		20.405(a)(1)(iii)				X 50.73(a)(2)(i)				50.73(a)(2)(vii)(A)																				
		20.405(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(vii)(B)																				
		20.405(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)																				
LICENSEE CONTACT FOR THIS LER (12)																														
NAME W. A. Stephenson, Nuclear Safety Supervisor										TELEPHONE NUMBER AREA CODE 9 0 4 7 9 5 - 6 4 8 6																				
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																														
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC																				
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH		DAY		YEAR												
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO																		

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

On November 24, 1991, Crystal River Unit 3 (CR-3) began mode ascension from Mode 3 to Mode 1. The shift supervisor believed the monthly reactor protection system surveillances for the anticipatory reactor trips on loss of main feedwater or main turbine were up to date and mode ascension was allowed. However, these surveillances had not been performed on the required schedule. Thus, at 1700, the plant entered Mode 1 in violation of Technical Specification requirements 4.3.1.1.1 and 4.0.4. This condition was discovered during review of the surveillance procedure on November 26, 1991.

This event was caused by personnel error. The responsible shop supervisor incorrectly thought the surveillance was current and so informed the shift supervisor. To prevent recurrence, the Unit Startup and Shutdown Surveillance Plans have been revised to require the status of surveillances to be presented to the nuclear shift supervisor and to require a sign-off by the responsible shop supervisor. Additionally, shop supervisors have been briefed on these changes and their associated responsibilities.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, 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 1 0 0 0 3 0 2 9 1	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		— 0 1 5	— 0 1	0 2	OF 0 3		

TEXT (If more space is required, use additional NRC Form 306A's) (17)

**EVENT DESCRIPTION**

On November 26, 1991, Florida Power Corporation (FPC) discovered a surveillance required for ascension to Mode 1, Power Operation, had not been performed prior to entry into Mode 1 during the November 24, 1991 plant startup. This is a violation of Technical Specification (TS) 4.0.4, and is being reported per 10CFR50.73(a)(2)(i)(B).

Prior to the discovery, Crystal River Unit 3 (CR-3) was shut down for a planned maintenance outage. On November 17, 1991, CR-3 began mode escalation from Mode 5 (Cold Shutdown) to Mode 4 (Hot Shutdown). On November 18, 1991, CR-3 entered Mode 3 (Hot Standby). On November 21, 1991, in preparation to enter Mode 2 (Plant Startup), the shift supervisor on duty verified that surveillances required for mode escalation were satisfied. At this time, he received information from the Instrumentation and Controls shop supervisor that the monthly surveillances for the Reactor Protection System [JC] were complete or up to date. Actually, the Anticipatory Reactor Trip due to Main Turbine or Both Main Feedwater Pumps had not been tested within the required monthly schedule.

The shift supervisor authorized escalation to Mode 2 and the unit achieved Mode 2 shortly thereafter. Due to problems with one intermediate range neutron detector [JC,DET], the plant did not enter Mode 1. Therefore, during the startup on November 21, 1991, the TS was not violated because the anticipatory reactor trips are not required unless Mode 1 is achieved, per TS 3.3.1.1. However, on November 24, 1991, with the intermediate range neutron detector repaired, CR-3 began mode ascension. The shift supervisor, relying on previously supplied information, believed the monthly Reactor Protection System surveillances were up to date and mode ascension was allowed. Thus, at 1700, the plant entered Mode 1 in violation of TS requirements 4.3.1.1.1 and 4.0.4.

On November 25, 1991, CR-3 tripped from approximately 20 percent power due to a secondary plant transient that caused both main feedwater pumps [SJ,P] to trip. The anticipatory reactor trip due to loss of both main feedwater pumps tripped the reactor as expected.

On November 26, 1991, with CR-3 in Mode 3, the Instrument and Controls shop supervisor discovered the anticipatory reactor trip testing was not up to date and immediately notified the shift supervisor at 1100. The shift supervisor noted that escalation to Mode 1 could not occur until testing was completed. Later that evening, the anticipatory reactor trips were tested satisfactorily. Instrumentation "as found" values were within specification.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

EVENT EVALUATION:

The safety consequences of missing the monthly anticipatory reactor trip testing prior to mode ascension were minimal because the channels were within specification when tested. In addition, a Babcock and Wilcox Owners Group (BWOG) Topical Report has been submitted to the Nuclear Regulatory Commission (NRC) which would allow such testing to be done every 6 months instead of monthly. NRC approval is pending resolution of an unrelated issue. Furthermore, when actually called upon to perform, the anticipatory reactor trip due to loss of main feedwater completed its intended safety function satisfactorily.

The consequence of failure of the anticipatory reactor trip functions would be minor. The primary trips, such as high temperature and pressure, remain available to trip the reactor prior to exceeding any safety limits.

CAUSE:

This event was caused by personnel error. As specified by procedure, the shift supervisor asked the responsible shop supervisor if the monthly surveillance was up to date. The shop supervisor incorrectly thought the surveillance was current.

CORRECTIVE ACTIONS:

To prevent recurrence, FPC has improved controls for ensuring shutdown related surveillances are completed on time. FPC has revised the Shutdown Surveillance Plan and the Startup Surveillance Plan to require the status of surveillances to be presented to the nuclear shift supervisor and to require a sign-off by the responsible shop supervisor to verify that surveillance requirements have been completed satisfactorily or are up to date. Additionally, shop supervisors have been briefed concerning these procedure changes and their responsibility to verify assigned surveillances are completed as required or are up to date.

PREVIOUS SIMILAR EVENTS:

A similar event occurred during startup in 1990 which was reported by LER 90-12. On July 9, 1990, FPC discovered the quarterly calibration of the hydrogen channel for the waste gas decay tank explosive gas monitoring instrumentation [IL] had not been performed as required prior to returning the system to operation. The immediate cause of this event was personnel error. The shop had not been adequately notified of the need to perform the quarterly calibration and the shops incorrectly informed the shift supervisor that the calibrations were complete.

The corrective actions for this previous event would not have prevented this recent event because the actions were directed at equipment removed from service due to a failure.