



**FLORIDA
POWER**
CORPORATION

April 4, 1997
3F0497-31

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

Subject: Licensee Event Report (LER) 94-006-06 Correction

Reference: Licensee Event Report (LER) 94-006-06, 3F0397-30, dated 3/26/97

Dear Sir:

Enclosed please find corrected page one of Licensee Event Report (LER) 94-006-06 which was sent to you on March 26, 1997. A typographical error was discovered in Block 7, "Report Number". The original submittal incorrectly listed the year as 96 rather than 97.

If you have any questions, please contact Mr. J. A. Frijouf, Senior Nuclear Regulatory Assurance Specialist, at (352) 563-4754.

Sincerely,

J. J. Holden
Director, Nuclear Engineering and Projects

JJH/JAF

Att. 9704090048 970404
PDR ADOCK 05000302
S PDR

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

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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 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)

05000

PAGE (3)
1 OF 20

TITLE (4)

Deficiency in Understanding of Technical Requirements Leads to Nonconservative Safety Systems Setpoint and Violations of Improved Technical Specifications

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
01	18	95	94	-- 006	-- 06	03	26	97	FACILITY NAME	DOCKET NUMBER
										05000
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
1			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)	
100			20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vi)		OTHER	
			20.405(a)(1)(iii)		X 50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)	
			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

James A. Frijouf, Sr. Nuclear Regulatory Specialist

TELEPHONE NUMBER (Include Area Code)

(352) 563-4754

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
X					

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On October 6, 1994, Florida Power Corporation's (FPC) Crystal River Unit 3 (CR-3) was in MODE ONE (POWER OPERATION), operating at 100% power. It was determined that the potential existed for CR-3 to have operated outside plant Improved Technical Specifications (ITS) relative to the Reactor Protection System (RPS) setpoints. FPC personnel were reviewing a revised calculation when it was discovered that RPS setpoints may not be conservative relative to ITS. A further review of RPS setpoints determined that the Variable Low Pressure Trip (VLPT) setpoint was set at the ITS limit without provision for instrument error. The Shutdown Bypass trip setpoint was also found to be set at its ITS limit. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). The remainder of the RPS trip setpoints were determined to be in compliance with ITS requirements. Subsequent evaluations determined that one Emergency Feedwater Initiation and Control System (EFIC) setpoint, two Engineered Safeguards Actuation System Bypass bistable setpoints, and instruments used to monitor Reactor Coolant System (RCS) total flow were also potentially non-conservative relative to ITS. The cause of these events was personnel error. Corrective actions include: implementation of a setpoint action plan encompassing recalibration, procedure changes, and assuring adequate setpoints for other actuation systems.