

U.S. NUCLEAR REGULATORY COMMISSION
REGION 2

Docket No: 50-302
License No: DPR-72

Report No: 50-302/97-04

Licensee: Florida Power Corporation

Facility: Crystal River 3 Nuclear Station

Location: 15760 West Power Line Street
Crystal River, FL 34428-6708

Dates: January 27 through March 21, 1997

Inspectors: S. Cahill, Senior Resident Inspector, paragraph 01.1
T. Cooper, Resident Inspector, paragraph 01.1
P. Fillion, Reactor Inspector, paragraph E8.2
R. Schin, Reactor Inspector, paragraph E8.1

Approved by: H. Christensen, Chief, Engineering Branch
Division of Reactor Safety

Enclosure

EXECUTIVE SUMMARY

Crystal River 3 Nuclear Station NRC Inspection Report 50-302/97-04

This special inspection included aspects of licensee operations and engineering functional areas. The purpose of the inspection was to follow up on the licensee not reporting the emergency feedwater net positive suction head issue and to follow up on other licensee problems in reporting conditions to the NRC as required.

Operations

A weakness was identified regarding an Emergency Action Level classification that was not made in a timely manner following a transformer explosion at an adjacent fossil power plant. An apparent Violation (EEI 50-302/97-04-01) was identified for failure to make an emergency phone report within the time requirements of 10 CFR 73.71. Another apparent Violation (EEI 50-302/97-04-02) was identified for failure to hand carry a suspected reportable issue to the Shift Manager for a reportability review as required by the licensee's procedures (Section 01.1).

Engineering

An apparent Violation (EEI 50-302/97-04-03) was identified for failure to report to the NRC the outside design basis condition, involving insufficient emergency feedwater pump net positive suction head, that was identified in April 1996. This was a failure to report a condition that resulted in escalated enforcement, and the failure to report the condition contributed to a lack of timely NRC awareness and review of the condition. As a result, the NRC missed an opportunity to ensure that appropriate corrective actions were taken to address an outside design basis condition. This failure to report was also a repeat of previous Violations 50-302/94-27-02, 50-302/94-27-03, and 50-302/96-06-06, which involved failures to report outside design basis conditions to the NRC as required by 10 CFR 50.72 and 50.73. (Section E8.1).

A second example of apparent Violation EEI 50-302/97-04-03 was identified for failure to report to the NRC in a timely manner the outside design basis condition, involving a non-safety-related transfer switch installed in safety-related emergency safeguards status indicating light circuitry, that was identified in December 1995. This example also involved a concern with inaccurate information in LER 96-19 regarding the date on which the engineer discovered the nonconforming condition and with the related failure of the LER to address, or include corrective action for, untimely engineering review of the nonconforming condition. (Section E8.2)

The inspectors assessed the licensee's performance in the five areas of continuing NRC concern in the following paragraphs: the assessment is limited to the specific issue addressed in the respective paragraph.

NRC AREA OF CONCERN	ASSESSMENT PARAGRAPH							
	01.1	E8.1	E8.2					
Management Oversight	I	I	I					
Engineering Effectiveness	A	I	I					
Knowledge of Design Basis		I	A					
Compliance With Regulations	I	I	I					
Operator Performance	I	I	A					

S = Superior G = Good A = Adequate/Acceptable I = Inadequate
Blank = Not Evaluated/Insufficient Information

01.1: Timeliness of Recent Licensee Reporting to the NRC
E8.1: Reporting of Emergency Feedwater Net Positive Suction Head Condition
E8.2: Reporting of Non-Safety-Related Transfer Switch Used in Safety-Related Engineered Safeguards Status Indicating Light Circuitry

Report Details

I. Operations

01 Conduct of Operations

01.1 Timeliness of Recent Licensee Reporting to the NRC

a. Inspection Scope (71707)

The inspectors followed up on three observed examples of reporting deficiencies. The licensee had several potentially reportable events that were not thoroughly evaluated within the required time to ensure NRC notification time requirements could be fulfilled.

b. Observations and Findings

On January 30, 1997, at approximately 1:17 a.m., a main step-up transformer at the adjacent coal electric generation plant, Crystal River Unit 4 (CR4), exploded and caught fire. The force of the explosion lifted the transformer off of its base and toppled it onto its side. Although the impact on the nuclear plant, Crystal River Unit 3 (CR3), was only limited to a switchgear perturbation due to CR4 separating from the grid, the licensee's Radiological Emergency Response Plan, Revision 16, requires declaration of a Notice of Unusual Event (NOUE) classification for a "severe explosion near or within the 0.83 Site Boundary but not affecting plant operations". CR4 is approximately 0.7 miles away from the nuclear plant. The control room operators originally believed the event was a fire that did not involve a severe explosion, although the Shift Manager (SM) log referred to the event as an explosion and plant management discussed the event as an explosion at the Plan of the Day meeting at 8:00 a.m. After being questioned by the licensee's Emergency Preparedness Manager about the lack of a declaration and upon receiving further information that indicated the transformer failure was an explosion, the Shift Supervisor on Duty (SSOD) administratively entered and immediately exited a NOUE, at approximately 1:45 p.m., over 12 hours after the event. The SSOD made the subsequent 10 CFR 50.72 report to the NRC Operations Center within one hour of the event classification as required. The licensee initiated corrective action program precursor cards (PC) 97-0680 and 97-0724 to investigate and correct the cause of the delay. The inspectors concluded the event classification and subsequent notification were not timely in that sufficient information was available and well known shortly after the event for the SSOD to make the classification and notifications. Section IV of Appendix E of 10 CFR 50 requires licensees to have the capability to notify offsite authorities within 15 minutes of the declaration of an emergency. 10 CFR 50.72 requires that the licensee notify the NRC not later than one hour after the time the licensee declares one of the emergency classes. The 15 minute and the one-hour periods are measured from the time of declaration of an emergency class. Although the regulations do not specify any time requirement for the classification process itself, they do imply that classification should be made without delay. The SSOD did make a preliminary and timely evaluation of the event against the

classification requirements shortly after the explosion and did refer to them again later in the event. However, the licensee's investigation determined that the SSOD did not adequately pursue final resolution of the classification determination by investigating and gathering the available information. The inspectors concluded the delay was indicative of a weakness in the licensee's process for promptly assessing and reporting events.

The second example of reporting deficiencies also occurred on January 30, 1997. At 6:45 p.m. a potential breach in the Protected Area as a result of maintenance work on a main condenser circulating waterbox was discovered by a security officer. A Protected Area breach is a one-hour reportable event per 10 CFR 73.71 but it was not reported until 1:18 a.m. on January 31, 1997. Although the security force needed some time after initial discovery to assess the opening to determine if it was above the allowable security plan breach size of 96 square inches, these efforts were not expedited sufficiently to make a timely verification. Proper priority was not placed on the investigation by shift management considering it was a suspected reportable problem so the necessary coordination of several plant groups was limited. Efforts were suspended during Operations shift turnover, and delays were encountered due to confined space entry permit requirements. Consequently, the inspector determined from interviews with licensee personnel that the licensee did not determine that the breach was reportable until approximately 10:30 p.m. Then the problem was not officially screened for reportability by the SM until 12:20 a.m. on January 31 while paperwork documenting the breach was prepared by the security staff. Some members of the licensee's staff were not aware that the one-hour reportability requirement starts at the time of recognition or 10:30 p.m., and not the time of reporting the event officially to the SM at 12:20 a.m. on January 31. The inspectors concluded this did not meet the requirements of 10 CFR 73.71 to report the event to the NRC within one hour from the time of discovery of the event. A report was required to have been made by 11:30 p.m. Consequently, this delay was identified as apparent Violation EEI 50-302/97-04-01, Failure to Make an Emergency Phone Report Within the Time Requirements of 10 CFR 73.71.

The third example of reporting deficiencies occurred on February 6, 1997, when corrective action document PC 97-055 was received by the SM for review. This PC documented a situation identified during NRC Generic Letter 96-06 reviews where reactor building system components were potentially outside their design basis because they were not designed to withstand post-accident conditions. Precursor Card 97-055 was generated on January 31 but was not received by the SM for reportability screening until February 6. Although part of the delay was due to verifying the scope and extent of the issue prior to submitting it for review, which is acceptable, a portion of the delay was due to the PC originator mailing it to the SM. This was contrary to Compliance Procedure (CP) 111, Processing of Precursor Cards for Corrective Action Program, Revision 55, which requires all PCs that are suspected reportable to be hand carried to the SM for immediate evaluation. Precursor Card 97-055 was annotated as potentially

reportable due to the suspected design basis problem and was therefore required to be hand carried to the SM for immediate review for reportability requirements. Although the SM determined that only a written 30 day Licensee Event Report (LER) per 10 CFR 50.73 was required, the problems were significant enough that a 4-hour phone report per 10 CFR 50.72 could potentially have been required. It would not have been made in time due to the several day delay from mailing the PC. The inspector determined the SM's reportability evaluation was not timely relative to the recognition of the design basis problem and would not have met the 4-hour reporting requirement if it had been applicable. The inspectors identified this as apparent Violation (EEI 50-302/97-04-02), Failure to Hand Carry a Suspected Reportable Issue to the Shift Manager for Reportability Review.

The licensee initiated PC 97-0841 to evaluate if the above three problems had similar root causes. This effort was not yet finalized at the end of the report period and was being incorporated into the corrective actions for Item OP-4, Upgrade the Operability/Reportability (CP-150/151) Program, on the licensee's and NRC's restart restraint list. The inspector observed that the licensee's Quality Assurance group responded to these problems and performed two surveillance inspections on the licensee's reporting process that found similar deficiencies.

c. Conclusions

The inspectors concluded these examples were indicative of deficiencies in the licensee's reportability screening process. All screening was done via PCs reviewed by the SM which can result in delays while paperwork to complete a PC is generated. The existing process was not always followed. The inspectors also concluded that some licensee personnel did not understand that the reporting time requirements were from time of discovery versus submittal of a PC for review, which created further delays. Additionally, proper priority was not placed on determining the correct status of the event expeditiously in order to make a timely reportability determination.

The inspector assessed the licensee's performance, with respect to this issue, in the five areas of continuing NRC concern:

- Management Oversight - Inadequate
- Engineering Effectiveness - Adequate
- Knowledge of the Design Basis - Not Applicable
- Compliance with Regulations - Inadequate
- Operator Performance - Inadequate

II. Engineering

E8 Miscellaneous Engineering Issues

E8.1 (Open) EEI 50-302/96-19-03, EFW NPSH USQ due to Inadequate 10 CFR 50.59 Safety Evaluation for a Modification

(Closed) VIO 50-302/94-27-02 (dated January 26, 1995), Failure to Make Two 10 CFR 50.73 Reports to the NRC Within the Required Time (plus one subsequent additional example in IR 95-02)

(Closed) VIO 50-302/94-27-03 (dated January 26, 1995), Failure to Make a 10 CFR 50.72 Report to the NRC Within the Required Time (plus one subsequent additional example in IR 95-08)

(Closed) VIO 50-302/96-06-06 (dated July 27, 1996), Failure to Notify the NRC of a Condition Outside the Appendix R Licensing Design Basis in a Timely Manner

a. Inspection Scope (92903)

The inspector noted that EEI 96-19-03 involved a condition apparently outside the design basis of the plant that the licensee had identified in April 1996 and that, as of January 27, 1997, the licensee had not reported to the NRC. As described in Inspection Report (IR) 96-19, the condition had existed from 1987 through April 1996. Licensee PC 96-2196 dated April 20, 1996, had identified the condition and engineering analysis had confirmed it that same month. The condition involved insufficient net positive suction head (NPSH) for the turbine-driven emergency feedwater (EFW) pump in a certain accident scenario [loss of coolant accident (LOCA) and loss of offsite power (LOOP) with loss of the B battery, which would fail the B Emergency Diesel Generator (EDG) and also fail open the discharge flow control valves for the turbine-driven EFW pump]. In that scenario, the turbine-driven EFW pump would automatically start and go to runout, with insufficient NPSH. Also, as described in the Final Safety Evaluation Report (FSAR), in that scenario the A EDG would rely on the operation of the B train turbine-driven EFW pump to share the EFW flow requirements with the A train motor-driven EFW pump in order to maintain the A EDG within its electrical loading limits.

In this inspection, the inspector followed up on the above reportability issue and also followed up on the licensee's corrective actions for three previous violations that involved inadequate reporting of outside design basis conditions.

b. Observations and Findings

In response to the inspector's questions regarding reportability of the EFW NPSH issue, the licensee initiated PC 97-0052 on January 28, 1997. In reviewing the PC, the licensee concluded the same day that the condition was outside the design basis of the plant, that the condition

was reportable in accordance with 10 CFR 50.73, and that the condition had not been reported. The licensee subsequently reported the EFW NPSH condition in LER 97-001, Ineffective Change Management Results in Unrecognized NPSH Issue Affecting Emergency Feedwater Availability, dated February 27, 1997.

The inspector noted that the EFW NPSH condition represented a significant safety concern that had warranted NRC escalated enforcement action (it was addressed at an enforcement conference on January 24, 1997). The inspector also noted that the plant had been shut down in April and May 1996 when this condition was identified, had operated between May 1996 and September 1996, and had been shut down since then. The licensee's failure to report the condition had contributed to a lack of timely NRC awareness and review of the condition. As a result, the NRC had missed an opportunity to ensure that appropriate corrective actions were taken to address an outside design basis condition. The related condition resulted from the licensee's modification to ASV-204 to correct the EFW NPSH condition, and was also a subject of escalated enforcement discussed at the January 24, 1997, enforcement conference.

The inspector reviewed the EFW NPSH issue with engineering and licensing personnel who had been involved with it, and concluded that the licensee had many opportunities to recognize that the condition was outside the design basis of the plant and to report it. PC 96-2196 was reviewed in April 1996 for reportability by the Nuclear SM and by the plant managers who were present at the daily PC review meeting. The PC did not result in a Problem Report and did not receive a formal documented operability or reportability review. Engineering management and the Plant Review Committee (PRC) reviewed the condition in April 1996 when they approved the ASV-204 modification to correct the condition. Licensing reviewed the condition and mentioned the EFW NPSH concern in LER 96-20 on EDG loading but did not identify the EFW NPSH concern as a condition outside the design basis. The licensee's ASV-204 root cause team reviewed the condition but did not identify that it was reportable. The licensee's senior management, in preparation for the January 24, 1997, enforcement conference, reviewed the condition (it was the subject of an apparent violation) but did not identify that it was reportable and was not reported.

The inspector reviewed the licensee's corrective actions in response to three previous violations for failing to report conditions outside the design basis as required by 10 CFR 50.72 and 10 CFR 50.73, to assess whether those actions should have prevented the failure to report the EFW NPSH condition. The inspector verified that the licensee had accomplished the corrective actions for Violations 94-27-02, 94-27-03, and 96-06-06, as stated in their responses to the Notices of Violation, including:

- Reporting each condition to the NRC.
- Revising CP-111, Initiation and Processing of Precursor Cards and Problem Reports, to include steps that direct the originator to

immediately notify the Nuclear SM if the issue is believed to involve safety, reportability, or operability.

- Daily review of all new Precursor Cards where the Director, Nuclear Plant Operations (DNPO) and other line managers can assist in the determination of reportability.
- Issuing a letter from the DNPO to all nuclear operations personnel about the reportability of exceeding the breach allowance of the control complex habitability envelope (CCHE).
- Submitting a Technical Specification (TS) change request to the NRC to address the CCHE, including applicable completion times and surveillance requirements.
- Issuing a new procedure, CP-150, Identifying and Processing Operability Concerns, in October, 1995.

The licensee's corrective actions for the three violations were completed in 1995. In addition, the inspector noted that the licensee had issued another new procedure, CP-151, External Reporting Requirements, in November 1996. Also, the licensee had recently revised the Corrective Action Program, including a more extensive review process for Precursor Cards. Violations 50-302/94-27-02, 50-302/94-27-03, and 50-302/96-06-06 are closed.

c. Conclusions

The inspector concluded that the failure to report to the NRC the emergency feedwater net positive suction head outside design basis condition that was identified in April 1996 was an apparent Violation of 10 CFR 50.73. The licensee's failure to report the condition contributed to a lack of timely NRC awareness and review of the condition. As a result, the NRC missed an opportunity to ensure that appropriate corrective actions were taken to address an outside design basis condition. This failure to report was a repeat of previous Violations 50-302/94-27-02, 50-302/94-27-03, and 50-302/96-06-06, which involved failures to report outside design basis conditions to the NRC as required by 10 CFR 50.72 and 50.73. This apparent Violation is identified as EEI 50-302/97-04-01, Repeat Failure to Report Outside Design Basis Conditions to the NRC.

The inspector assessed the licensee's performance, with respect to this issue, in the five areas of continuing NRC concern:

- Management Oversight - Inadequate
- Engineering Effectiveness - Inadequate
- Knowledge of the Design Basis - Inadequate
- Compliance with Regulations - Inadequate
- Operator Performance - Inadequate

E8.2 (Closed) Unresolved Item 96-06-03, Non-Safety-Related Transfer Switch Used in ES Status Indicating Light Circuitry

(Open) LER 96-19, Classification of Transfer Switch Causes Potential for Loss of Power to ES Status Lights

In PC 95-2770, dated December 4, 1995, the licensee had identified that manual transfer switch ESCP-1 did not meet the requirements with regard to qualification of the equipment. This transfer switch, which is located on a wall in the main control room, consists of four molded-case circuit breakers, bus bar, and an enclosure. ESCP-1 is in the power supply circuit for the equipment status monitoring panel on the main control board. The transfer switch is original plant equipment, and it provides a means to energize the equipment status monitoring panel from either vital bus 3A (train A) or 3B (train B). The switch is arranged such that, in the normal alignment, the train A power source energizes status lamps for train A equipment, and similar for train B. The equipment status monitoring panel falls under the requirements of Regulatory Guide (RG) 1.97, Instrumentation for Light Water Cooled Nuclear Reactors to Assess the Plant and Environs Conditions During and Following an Accident. RG 1.97 requires that the monitoring panel meet several design criteria including seismic events and that it be treated as safety-related. There is no requirement to have the transfer switch; however, since it is installed in the circuit, it must also meet all the requirements that apply to the monitoring panel and its power supply. The problem identified by the license was that ESCP-1 was not purchased safety-related and was not necessarily seismically qualified.

As stated above, the non-conforming condition was discovered in December 1995 and documented in PC 95-2770 on December 4, 1995. According to procedure, PC 95-2770 was reviewed by the Nuclear SM. His instructions, dated December 6, 1995, were to evaluate and respond, which were in accord with the recommendations of the originating engineer. This meant the engineers should determine whether the equipment can be accepted as is by performing an upgrade evaluation.

Evidence indicates that this evaluation was not performed in a timely manner commensurate with the importance to safety. On June 13, 1996, the licensee determined that the issue warranted a Problem Report, and PR 96-195 was initiated. Also, an operability evaluation was performed (OCR-96-ESCP-1) which concluded that the equipment was non-conforming but OPERABLE. On June 14, 1996, the licensee reported this non-conforming condition to the NRC by telephone pursuant to 10 CFR 50.72(b)(1)(ii)(B), which requires a one-hour report. In addition, compensatory measures were initiated, i.e. red tag of alternate position circuit breakers. LER 96-19 was submitted on July 15, 1996, pursuant to 10 CFR 50.73.

The inspector determined that a six-month delay in performing the operability evaluation was not commensurate with the safety significance of the issue. Precursor Card 95-277 initiated the proper evaluation. However, no time limit for completion was specified, and the controlling

procedure, CP-111, Initiation and Processing of Precursor Cards and Problem Reports, Rev 54, did not specify any time limit for this type evaluation.

The inspector noted that Revision 55 of Compliance Procedure CP-111, dated November 22, 1996, requires, in section 4.3.3.5.1, that Nuclear Operations Engineering is to validate suspected Design Basis Issues or unanalyzed conditions within 10 working days.

The LER states that the corrective action will be to either remove or replace transfer switch ESCP-1. Since that time, the licensee has prepared modification 97-01-03-01 to install a fully qualified switch in place of the existing one. The inspector did not review this modification package, because it was not officially issued. The inspector noted that replacement of ESCP-1 was tracked by the licensee as their Restart Item D-21, to be completed prior to plant restart.

The six-month delay in reporting the non-conforming transfer switch to the NRC constitutes a violation of 10 CFR 50.72 and 50.73, which require that reports be made within one hour of the occurrence of the event and within thirty days of the discovery of the event, respectively. The root cause for the late report was the same as the cause for the untimely corrective action mentioned above; i.e., since the evaluation was delayed, recognition of the need for reporting was delayed. The matter is identified as a second example of apparent Violation EEI 50-302/97-04-01, Repeat Failure to Report Outside Design Basis Conditions to the NRC.

Inspection activity related to this issue included the following:

- The inspector examined the equipment status monitoring panel on the main control board, and noted that it included indications for the operator to confirm the position of certain containment isolation valves. The inspector then reviewed the licensee's submittal made pursuant RG 1.97 on March 21, 1988, and the Design Basis Document for Post-Accident Monitoring Instrumentation. Both these documents indicated that automatic containment isolation valve position was a Type B, Category 1, variable as defined by RG 1.97. Therefore, the transfer switch in question was required to be fully qualified. The fact that it was not fully qualified created the potential (i.e. assuming failure of the switch) that control room indications needed to mitigate the consequences of an accident would not be available.
- The inspector verified that switch ESCP-1 was red tagged to ensure that it remained in the normal alignment as stated under corrective action in the LER. The tag number was Eco No. 96-07-05-6, dated July 10, 1996.

- The inspector verified that other components in the power supply circuit to the monitoring panel, namely 115 - 25 V transformers QK and QL, were purchased safety-related through review of documentation. It appears these were originally safety-related.
- The inspector reviewed the operability evaluation, and found that it met the guidance of Generic Letter 91-18, Resolution of Degraded and Nonconforming Conditions and on Operability.
- The inspector noted that LER 96-19 states that the engineer's discovery of the nonconformance occurred on June 13, 1996. This date apparently represents the date that the need for a report to the NRC was recognized as opposed to the initial discovery date. PC 95-2770, dated December 4, 1995, clearly documented the engineer's discovery of the nonconformance at that time. In this regard, the LER is inaccurate. As written, the LER implies that the corrective action program was effective. In fact, the corrective actions were not timely, as described in this section. Also, LER 96-19 did not address, or include corrective action for, the untimely engineering review of the nonconforming condition.

In summary: a second example of apparent Violation EEI 590-302/97-04-03, Repeat Failure to Report Conditions to the NRC, was identified for failure to report to the NRC in a timely manner the outside design basis condition, with a non-safety-related transfer switch installed in safety-related emergency safeguards status indicating light circuitry, that was identified in December 1995. This example also involved an incorrect date for the discovery of the nonconformance. The LER also did not recognize or include corrective action for the untimely engineering review of the nonconforming condition. Unresolved Item 96-06-03 is closed. LER 96-19, Classification of Transfer Switch Causes Potential for Loss of Power to ES Status Lights, remains open for NRC verification that the licensee's modification to correct the problem is completed.

With regard to Unresolved Item 96-06-03, the inspector assessed the licensee's performance, for the time period of June 1996 to present, in the five NRC continuing areas of concern as follows:

- Management Oversight - Inadequate
- Engineering Effectiveness - Inadequate
- Knowledge of the Design Basis - Adequate
- Compliance with Regulations - Inadequate
- Operator Performance - Adequate

III. Management Meetings

X1 Exit Meeting Summary

The inspection scope and findings were summarized in exit meetings held on January 31, February 27, and March 21, 1997. Proprietary information is not contained in this report. Dissenting comments were not received from the licensee.

PARTIAL LIST OF PERSONS CONTACTED

Licensees

R. Anderson, Senior Vice President, Nuclear Operations
 J. Baumstark, Director, Quality Programs
 J. Campbell, Assistant Plant Director, Maintenance
 W. Conklin, Jr., Director, Nuclear Operations Materials and Controls
 J. Cowan, Vice President, Nuclear Production
 R. Davis, Assistant Plant Director, Operations
 B. Gutherman, Manager, Nuclear Licensing
 G. Halnon, Assistant Director, Nuclear Operations Site Support
 B. Hickie, Director, Nuclear Plant Operations
 J. Holden, Director, Nuclear Engineering and Projects
 D. Kunsemiller, Director, Nuclear Operations Site Support

NRC

R. Schin, Reactor Inspector, Region II (January 27 through 31; February 10 through 14; March 3 through 7; and March 19 through 21, 1997)
 P. Fillion, Reactor Inspector, Region II (March 17 through 21, 1997)

INSPECTION PROCEDURES USED

IP 71707: Plant Operations
 IP 92903: Followup - Engineering

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

<u>Type</u>	<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
EEI	50-302/97-04-01	Open	Failure to Make an Emergency Phone Report Within the Time Requirements of 10 CFR 73.71. (paragraph 01.1)

EEI	50-302/97-04-02	Open	Failure to Hand Carry a Suspected Reportable Issue to the Shift Manager for Reportability Review. (paragraph 01.1)
EEI	50-302/97-04-03	Open	Repeat Failure to Report Outside Design Basis Conditions. (paragraphs E8.1, E8.2)

Closed

<u>Type</u>	<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
VIO	50-302/94-27-02	Closed	Failure to Make Two 10 CFR 50.73 Reports to the NRC Within the Required Time. (paragraph E8.1)
VIO	50-302/94-27-03	Closed	Failure to Make a 10 CFR 50.72 Report to the NRC Within the Required Time. (paragraph E8.1)
VIO	50-302/96-06-06	Closed	Failure to Notify the NRC of a Condition Outside the Appendix R Licensing Design Basis in a Timely Manner. (paragraph E8.1)
URI	50-302/96-06-03	Closed	Non-Safety-Related Transfer Switch Used in ES Status Indicating Light Circuitry. (paragraph E8.2)

Discussed

<u>Type</u>	<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
EEI	50-302/96-19-03	Open	EFW NPSH USQ due to Inadequate 10 CFR 50.59 Safety Evaluation for a Modification. (paragraph E8.1)
LER	96-019-00	Open	Classification of Transfer Switch Causes Potential for Loss of Power to ES Status Lights. (paragraph E8.2)

LIST OF ACRONYMS USED

CCHE	- Control Complex Habitability Envelope
CFR	- Code of Federal Regulations
CP	- Compliance Procedure
CR3	- Crystal River Unit 3
CR4	- Crystal River Unit 4
DNPO	- Director, Nuclear Plant Operations
EDG	- Emergency Diesel Generator
EEI	- Escalation Enforcement Item
EFW	- Emergency Feedwater

ES	- Engineered Safeguards
FSAR	- Final Safety Evaluation Report
IP	- (NRC) Inspection Procedure
IR	- Inspection Report
LER	- Licensee Event Report
LOCA	- Loss of Coolant Accident
LOOP	- Loss of Offsite Power
NOUE	- Notification of Unusual Event
NPSH	- Net Positive Suction Head
OP	- Operating Procedure
PC	- Precursor Card
PRC	- Plant Review Committee
RG	- (NRC) Regulatory Guide
SM	- Shift Manager
SSOD	- Shift Supervisor on Duty
TS	- Technical Specification
URI	- Unresolved Item
USQ	- Unreviewed Safety Question
VIO	- Violation