UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
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November 3, 2000

Mr. John P. Cowan, Vice President
Nuclear Operations
Florida Power Corporation
ATTN: Manager Nuclear Licensing (NA1B)
Crystal River Energy Complex
15760 West Power Line Street
Crystal River, FL 34428-6708

SUBJECT: CRYSTAL RIVER UNIT 3 - NRC INSPECTION REPORT 50-302/00-06

Dear Mr. Cowan:

On October 5, 2000, the NRC completed a team inspection at your Crystal River Unit 3 reactor facility. The enclosed report documents the inspection findings which were discussed on October 5, 2000, with Mr. J. Holden and other members of your staff.

The inspection examined activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and representative records, observed activities, and interviewed personnel.

The inspection team concluded that overall implementation of the corrective action program was effective. Problems were properly identified, evaluated, and resolved.

One green finding was identified associated with the depth and effectiveness of your evaluation and corrective actions for an issue addressed in the corrective action program. The issue involved deficiencies in rigging the reactor vessel plenum and was addressed in a previously issued NRC Non-cited Violation.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publically Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Leonard D. Wert, Chief
Reactor Projects Branch 3
Division of Reactor Projects

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

Enclosure: NRC Inspection Report 50-302/00-06
With Attachment; NRC's Revised Reactor Oversight Process

cc w/encl:
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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No:	50-302
License No:	DPR-72
Report No:	50-302/00-06
Licensee:	Florida Power Corporation (FPC)
Facility:	Crystal River Unit 3
Location:	15760 West Power Line Road Crystal River, FL 34428-6708
Dates:	September 25 - October 5, 2000
Inspectors:	Thierry Ross, Senior Resident Inspector, St. Lucie (Lead) Scott Stewart, Senior Resident Inspector, Crystal River 3 Frank Jape, Senior Project Manager, Region II
Approved by:	Leonard Wert, Chief Reactor Projects Branch 3 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000302-00-06, on 09/25-10/5/2000, Florida Power Corporation, Crystal River Unit 3, annual baseline inspection of the identification and resolution of problems. The licensee's corrective action program was acceptable with one green finding and two negative observations identified.

The inspection was conducted by two senior resident inspectors and a regional senior project manager. One green finding was identified. The significance of the finding is indicated by the color (green, white, yellow, red) as determined by the Significance Determination Process (see Attachment; NRC's Revised Reactor Oversight Process).

Identification and Resolution of Problems

- Overall, the licensee's corrective action program was effective at identifying, evaluating, and correcting problems. The threshold for entering problems into the corrective action program was sufficiently low. Reviews of operating experience information were comprehensive. The priority grading system ensured timely resolution and corrective actions commensurate with safety significance. Corrective action backlog and precursor card evaluation timeliness were well managed. Root cause analyses were thorough. However, issues addressed in NRC inspection findings were not specifically reviewed to ensure adequate corrective actions. Licensee self-assessments and audits were effective in identifying deficiencies in the corrective action program. These deficiencies were entered into the corrective action program and, for the most part, resulted in the implementation of corrective actions. However, numerous Health Physics peer assessment recommendations, although entered in the corrective action program, were closed with inadequate documentation of disposition and corrective actions. A safety conscious work environment was present where employees felt free to raise safety concerns.

Cross Cutting Issue: Identification and Resolution of Problems

- Green. A finding was identified associated with the depth and effectiveness of the licensee's evaluation and corrective actions for precursor card 99-4142. This precursor card addressed deficiencies involved with rigging of the reactor vessel plenum during reactor assembly. NRC Non-cited Violation 50-302/99-07-01, Reactor Plenum Rigged Improperly, also addressed this issue. The licensee did not fully assess the nature and extent of the issue. Consequently, important causal factors were not identified and corrective actions to prevent recurrence were not thorough.

  This issue was determined to have very low safety significance because the licensee adequately addressed the potential adverse impact on equipment prior to reactor startup. The licensee's examination did not identify any damage to the reactor vessel or plenum. This instance of ineffective corrective action was an isolated example and is not considered indicative of the licensee's overall corrective action program. (Section 4OA2.2).

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope:

This inspection reviewed licensee corrective action activities documented since September 1, 1999, which corresponded to the completion of the last NRC corrective action program (CAP) team inspection (see IR 50-302/99-06). The inspectors reviewed issues documented in NRC inspection reports and the plant issues matrix within the past twelve months. Problem identification and resolution effectiveness during this period was also discussed with the resident inspectors who routinely observed these activities as part of the baseline NRC inspection program.

The inspectors also reviewed logs and records associated with various equipment problems; the second quarter System Health Reports for the feedwater, decay heat removal, emergency diesel generator, and radiation monitoring systems; temporary alteration logs and alteration records for two valves that had been leak repaired (DHV-3 and MUV-110); open work orders and precursor cards for deficiencies on the emergency diesel generator and decay heat removal systems; and, completed surveillance procedures SP-340E, “DHP-1B, BSP-1B, and Valve Surveillance;” dated July 5, 2000, April 13, 2000, and September 28, 2000, to verify deficiencies were being entered into the licensee’s CAP.

The inspectors toured areas of the plant containing equipment important to safety; conducted a detailed walkdown of the decay heat removal system; observed control room activities; and discussed plant activities with various system engineers, maintenance technicians, plant operators, and supervisors to determine if the corrective action system was being used to disposition problems and if significant issues were being identified and properly addressed.

The following sample of operator logs, during both reactor operation and shut down, were reviewed by the inspectors:

Log Name	Period	Plant Status
Main Control Room log	10/1 - 10/31/99	shut down
Nuclear Shift Managers log	10/1 - 10/31/99	shut down
Main Control Room log	8/1 - 8/31/00	operating
Nuclear Shift Managers log	8/1 - 8/31/00	operating
Aux. Bldg. Operators log	8/1 - 8/31/00	operating

The logs were reviewed to verify that adverse problems were being entered into the CAP. A sample of 40 problems were selected by the inspectors from the operator logs to verify that they had been entered into the CAP.

Nuclear General Review Committee (NGRC) meeting minutes were reviewed, along with the associated audit report (see section 4OA2.3) and precursor cards. The inspectors also interviewed the NGRC chairman and senior Quality Assurance (QA) auditor.

Approximately 60 Employee Concerns Program (ECP) issues were reviewed by the inspectors to verify any conditions adverse to quality identified by the ECP process were properly addressed as part of the CAP. The ECP Manager was also interviewed to verify that ECP issues involving conditions adverse to quality were properly dispositioned.

The inspectors reviewed industry operating experience (OE) that was available during the past year to determine if this information had been appropriately evaluated for applicability and whether problems identified through these reviews were entered into the CAP. These sources of OE and/or generic communications included industry events/notices, NRC Information Notices (IN) and Generic Letters (GLs), NRC daily event reports, 10 CFR Part 21 Reports, Vendor Safety Concern (SC) Reports, and other NRC publications. There were no NRC Bulletins issued during the inspection scope, and only one applicable GL (see report section 4OA2.2).

Twenty one IN's were issued by the NRC from September 1, 1999 to September 1, 2000. The licensee determined that eleven of these IN's were applicable to Crystal River Unit 3, and entered into the CAP. These IN's were reviewed by the inspectors to verify the licensee's action. Additionally, the inspectors independently examined the other ten IN's that were not entered into the CAP.

During the period of September 1, 1999 to September 1, 2000, the industry issued nineteen operating events/notices for consideration by all licensees. All 19 were considered applicable by the licensee and were entered into the CAP. These notices were examined by the inspectors for applicability and assessment.

b. Issues and Findings:

No findings of significance were identified. The licensee's threshold for entering problems in the CAP was sufficiently low. Reviews of operating experience information were comprehensive. The inspectors did not identify any plant equipment problems or other issues that had not been entered into the CAP.

.2 Prioritization and Evaluation of Issues, and Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed all corrective action system precursor cards (PC) graded B and C, and a large number of precursor cards graded D and X, to verify that the grading was consistent with CAP guidance. The risk and regulatory significance of the condition was also assessed. There were no precursor cards of grade A significance opened or closed since September 1, 1999. All precursor cards that were initiated, but subsequently rejected by management, were also specifically reviewed to assure that significant conditions adverse to quality were being properly dispositioned.

The inspectors reviewed the following level B and C precursor cards in detail to evaluate effectiveness of licensee actions to determine appropriate causal factors, and develop and implement applicable corrective actions to correct the adverse condition and prevent recurrence. An additional sampling of precursor cards graded D or X was briefly reviewed to assess overall licensee effectiveness. The following sample was specifically selected to include risk significant issues and still maintain some distribution across all NRC inspection program cornerstones.

PC #	Level	Title/Description
99-0490	C	Containment tendon reporting criteria exceeded for grease addition
99-3014	B	SWV-353 stroked too slow during SP-344A
99-3247	B	FWP-2A tripped resulting in EFW actuation
99-3268	B	Two control rods exceeded the technical specification value for rod drop times
99-3634	B	Radioactive material found outside the radiological control area, Personnel contamination
99-4277	C	DHV-37, suction relief valve for A DH train lifted during leak check
99-4424	B	Work Initiated on Wrong Air Compressor
99-4499	C	Feedwater pump FWP-2B delta pressure control erratic
00-0111	B	HPI Upgrade (MAR 02-12-01)
00-0129	C	Audit Findings 98-2727 and 99-2364
00-0273	D	MUV-60 indications of valve bonnet gasket leakage - repeat
00-0333	B	Reliability of Fire Protection system has declined
00-0379	C	Discovery that switchgear powered additional components not previously known
00-0457	C	RWP-2A bearing horizontal vibration in the alert range
00-0461	C	Numerous instances of missed chemistry samples
00-0610	C	Incorrect component replaced during planned maintenance
00-0914	D	AHF-1A tripped while in fast speed
00-1043	C	Hot tool room tool found in cold tool room
00-1081	B	Reactor Coolant system leak from DHV-3
00-1158	C	Security discovered fuel tank cover unlocked and open
00-1227	C	Lost calibrated tools and test equipment (203 items)
00-1248	C	Increasing trend in Operations Human Performance Issues
00-1474	X	Prints for EFV-11 and EFV-32 identify limit switch values with no tolerance
00-1564	D	High Radiation Area controls are not sufficient (CRSA 2000-42)
00-1570	D	Significant leakage noted from DHV-37 during SP-412
00-1640	C	Decay heat valves DHV-11, DHV-12 have not been documented as environmentally qualified
001777	C	Inaccurate historical PI data reported to NRC
00-1880	C	Insufficient quality of information in CAP for some completed corrective actions (CRSA 2000-45)
00-1915	D	BWST level alarm nuisance
00-2113	C	MUP-1A apparent outboard motor bearing oil leak
00-2160	C	MUP-1A had large oil leak requiring pump to be secured
00-2449	C	Feedwater flow started to oscillate and both feedwater pumps had to be taken to hand

The inspectors also reviewed the following precursor cards associated with issues addressed in previous NRC non-cited violations, to verify the effectiveness of licensee causal determinations and corrective actions:

PC #	NCV	Title/Description
99-2894	99-06-02	Two relief valves failed their setpoint tests without sample expansion
99-3844	99-07-04	Internal dose evaluations not timely
99-3874	00-02-01	Unplanned exposure greater than 100 mrem
99-4073	99-07-02	Operator closed DHV-46 vice SFV-46
99-4142	99-07-01	Plenum hung up while being lowered into reactor vessel

The following OE items, and associated precursor cards, were reviewed in detail to evaluate the effectiveness of licensee corrective actions:

PC #	IN #	Title/Description
00-1497	2000-08	High-Efficiency Particulate Air Filter-Differential Pressure
00-1905	2000-09	Steam Generator Failure at Indian Point Unit 2
00-2059	95-03 Sup2	Loss of Reactor Coolant Inventory While in a Shutdown Condition

PC #	OE #	Title/Description
00-1060	SEN 212	High Bearing Temperature Causes Inoperability of Both Decay Heat Removal/Low Pressure Injection Pumps
99-2911	O&MR 428	Inadequate Control of Chemicals, Liquids, and Gases

PC #	Generic	Title/Description
99-2331	GL 99-02	Laboratory Test of Nuclear Grade Activated Charcoal
00-0268& 00-1411	Part 21	Potential Defect Involving Static Switch Control Assembly and Regulated Rectifier Control Assembly Used in Uninterruptable Power Supply
99-3945	Part 21	ABB K-Line Breaker Defect
00-2119	Vendor SC 2-00	Core Flood Line Break, Framatome Technologies, Inc.
00-1426		10CFR50.65 Maintenance Rule Application
00-0451	NRC event report	Common Mode Failure of Both LPI Pumps at sister unit (February 8, 2000)

The inspectors also interviewed responsible plant personnel and reviewed additional documentation to verify implementation of selected corrective actions associated with the precursor cards listed above.

On September 26, the inspectors attended plant management's plan of the day meeting. On September 27, they attended the unit evaluator's meeting. These meetings were an intended to be an integral part of the CAP process for assigning PC grades and ownership by the evaluators and for ensuring management oversight of problem prioritization and resolution. On October 4, the inspectors also interviewed the Director of Engineering as a member of the Corrective Action Review Board (CARB) to confirm implementation of CAP review and approval responsibilities of the CARB.

Lastly, the inspectors reviewed the PC evaluation and corrective action backlog, examining both the age and inventory size of open PC's from a grade level and risk significance perspective. The inspectors also independently searched the PC database to verify licensee reports regarding incomplete PC evaluations and corrective actions, especially any that might be overdue.

b. Issues and Findings:

One green finding was identified, as discussed below. Overall, the licensee's CAP was effective at identifying, prioritizing, and resolving conditions adverse to quality. The licensee's priority grading system ensured timely resolution and level of corrective actions commensurate with safety significance. Corrective action backlog and precursor card evaluation timeliness were well managed. Root cause analyses were thorough and detailed.

A green finding was identified associated with the depth and effectiveness of the licensee's evaluation and corrective actions for precursor card 99-4142. This precursor card addressed deficiencies involved with rigging of the reactor vessel plenum during reactor assembly. On November 6, 1999, the NRC issued NCV 50-302/99-07-01, Reactor Plenum Rigged Improperly, which also addressed this issue.

PC 99-4142 was a grade C PC. As such, a formal root cause analysis was not completed. An apparent cause determination was performed. The inspectors reviewed PC 99-4142 in detail and discussed the extent of condition, apparent and contributing causes, and immediate and long-term actions with the responsible PC owner. The inspector's review and discussions identified that the licensee had not addressed all the specific findings documented in Section O1.5 of NRC Inspection Report 99-07. The PC owner acknowledged that he was unaware of the NRC findings, and had not read the NRC report.

The inspectors concluded that the licensee did not fully assess the extent of the problem, particularly the specific findings of IR 99-07. Although the immediate corrective actions taken were sufficient to restore the plant to a safe condition and recover from the event with no significant damage, the long-term actions to prevent recurrence were not comprehensive. Considering the potential adverse impact of this event, and the human performance errors involved, more comprehensive casual factor determinations and corrective actions appear to be warranted. The licensee re-opened PC 99-4142 for further evaluation and additional corrective actions.

The improper rigging issue was determined to have very low safety significance because the licensee adequately addressed the potential adverse impact on equipment prior to reactor startup. The licensee's examinations did not identify any damage to the reactor vessel or plenum. This instance of ineffective corrective action was an isolated example and is not considered indicative of the licensee's overall corrective action program effectiveness. Consequently, this corrective action program finding was characterized by the Significance Determination Process as having very low safety significance. Additionally, the inspectors determined that this issue did not involve a significant condition adverse to quality and was not a violation of NRC regulatory requirements.

A negative observation was identified. The Crystal River Licensing Manager indicated that, since the NRC's enforcement policy change regarding non-cited violations, FPC had not been specifically verifying that the CAP had captured all aspects of NRC documented findings identified as NCVs. Subsequently, the licensee also initiated PC 00-2741 to ensure that the issues associated with NRC Non-cited Violations would be properly addressed by their CAP.

.3 Effectiveness of Self-Assessments and Audits

a. Inspection Scope

The inspectors reviewed the following QA audits and Crystal River self-assessment (CRSA) reports to verify if findings and recommendations were being entered into the licensee's CAP, and that appropriate corrective actions were taken to resolve identified adverse conditions or program deficiencies. Audits and CSRA's were verified to be consistent with NRC findings, as applicable. The inspectors focused primarily upon CSRAs related to various elements of the licensee's CAP implementation. There were no audits of the CAP conducted by QA during the inspection scope.

CRSA	Title/Description
2000-02	Corrective Action Program dated April 20, 2000
2000-14	Quality of Completed Corrective Actions dated February 15, 2000
2000-16	Station Human Performance dated March 16, 2000
2000-22	Identifying and Processing Operability Concerns dated May 18, 2000
2000-41	Identification and Resolution of Problems dated September 22, 2000
2000-42	Health Physics Peer Assessment dated May 11, 2000
2000-43	Health Physics Peer Assessment dated June 8, 2000
2000-45	Corrective Action Self-Assessment dated July 5, 2000
2000-46	Timeliness of Audit Finding Closure dated August 8, 2000
2000-54	Equipment Performance Common Cause Analysis dated August 21, 2000

Audit	Title/Description
00-03	Plant Review Committee and Nuclear General Review Committee dated March 2, 2000
00-08	Fire Protection dated June 29, 2000
00-10	Radiation Protection dated August 24, 2000

Although, no formal QA audit of the CAP had been conducted in the last year, numerous Quality Spot Checks had been performed that included some aspects of the CAP. The inspectors reviewed the Quality Spot Check log for approximately 100 spot checks performed between May and October 2000 to verify that identified problems were entered into the CAP and reflected previous findings and conclusions.

b. Issues and Findings:

No findings of significance were identified. Licensee self-assessments and audits were thorough and effective in identifying deficiencies in the corrective action program, and other programmatic areas. These deficiencies were routinely entered into the CAP and

corrective actions were implemented. However, one negative observation was identified. The inspectors observed that the radiation protection group was formulating a Strategic Plan that would, when completed, contain specific and broad-based corrective actions and timetables to improve performance in numerous key areas. During the formulation of this plan, many of the recommendations for improvement made in the Health Physics (HP) peer assessments had been entered into the corrective action program as Level X precursor cards, which were then closed with no apparent corrective action or documented resolution. The inspectors also found that there was no documented link between the actions and timetables proposed for the Strategic Plan and the self-assessment PC's closed in the CAP. In response to this observation, the licensee initiated PC 00-2820 to address the high number of HP precursor cards closed with no specific corrective actions. No significant conditions adverse to quality were noted in these issues.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope:

The inspectors questioned licensee employees during interviews to determine whether any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors also reviewed the results of QA spot checks and licensee self-assessments that specifically interviewed plant personnel to assess the degree of trust they have in the CAP process. In addition, the inspectors reviewed numerous ECP issues. The ECP provides an alternate method to the corrective action program for employees to raise safety concerns and remain anonymous. Additionally, the inspectors evaluated the distribution of precursor cards initiated by plant organization group during the year 2000.

b. Issues and Findings:

No findings of significance were identified. The inspectors determined that the licensee has established and maintained a safety conscious work environment as evidenced by; the number and distribution of precursor cards by participating organizations, the results of applicable self-assessments, and by NRC independent interviews.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. J. Holden, Vice President and Director, Site Nuclear Operations, and other members of licensee management at the conclusion of the inspection on October 5, 2000. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any of the material examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

FPC
S. Johnson, Acting Director, Nuclear Quality Programs
J. Holden, Vice President and Director, Site Nuclear Operations
D. Roderick, Director, Nuclear Plant Operations
F. Dola, Manager of Corrective Actions and Self-Assessment
V. Hernandez, Manager of Employee Concerns Program
L. Clewett, Manager Nuclear Plant Operations
R. Prince, Manager of Radiation Protection
D. DeBoer, Manager of Nuclear Chemistry

NRC
L. Plisco, Director, Division of Reactor Projects, Region II

ITEMS OPENED, CLOSED AND DISCUSSED

None.

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety	Radiation Safety	Safeguards
● Initiating Events	● Occupational	● Physical Protection
● Mitigating Systems	● Public	
● Barrier Integrity		
● Emergency Preparedness		

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and

increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.

Attachment