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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (1) At 1615 in Mode 1, it was reported that the plant ascended into	an opera-
tional mode while in action statements involving Technical Spec	ifications ,
O 3	
3.6.4.1 and 3.7.8.1. This created an event contrary to Tech. S	pec.
3.0.4. Redundancy NA. No effect upon the plant or general	public.
This is the first occurrence of this type reported.	
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7 8 9 SYSTEM CAUSE CAUSE DAUGE CAUSE NAME OF THE STATE STATES STA	80
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CAUSE DESCRIPTION AND CORRECTIVE STIDNS (1)	44 67
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error. A shift turnover checklist is being developed for implement	
AI-500, Conduct of Operations. This list will identify and acknow	all and the second
transfer of information regarding system alignment, component avai	ilability
and critical plant parameters at the time of shift change.	80
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SUPPLEMENTARY INFORMATION

Report No:

50-302/79-072/01T-0

Facility:

Crystal River Unit #3

Report Date:

22 August 1979

Occurrence Date:

16 August 1979

Identification of Occurrence:

Ascended into an operational Mode while in two (2) action statements contrary to Technical Specification 3.0.4.

Conditions Prior to Occurrence:

Mode 1 power operation (14%)

Description of Occurrence:

At 1615 is was reported that the plant ascended into an operational mode while in two (2) action statements. Operational status shows that the plant entered Mode 3 as a result of a Reactor trip at 1155 on 16 August and returned to Mode 2 at 1308 on 16 August 1979. Further investigation revealed that the plant had previously entered Mode 3 again as a result of a Reactor trip at 0255 on 16 August and had returned to Mode 2 at 0547 on 16 August 1979. In both cases, the ascension into Mode 2 and subsequent power operation occurred while the gas chromatograph (Tech. Spec. 3.6.4.1) and air handling fans AHF-14B and 14D (Tech. Spec. 3.7.8.1) were declared inoperable. The plant was returned to Mode 3 at 1738 on 16 August until repairs were made to inoperable equipment. The respective action statements were exited at 0350 on 17 August 1979.

Designation of Apparent Cause:

The inadvertent ascension into Mode 2 from Mode 3 is attributed to personnel error.

Analysis of Occurrence:

No effect upon the plant or general public as a result of this event.

Corrective Action:

A shift turnover checklist is being developed for implementation into AI-500, Conduct of Operations. This list will identify and acknowledge a transfer of information regarding system alignment, component availability and critical plant parameters at the time of shift change.

Failure Data:

This is the first occurrence of this type reported.