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0 2	At 1530, in Mode 1, it was determined that on 8 July 1979, the volume of the
	, NaOH tank (BST-2) exceeded the volume requirements of Technical Specification
9131	3.6.2.2 and that event is reportable under Section 6.9.1.8.b. Redundancy NA.
0 4	No effect upon the plant or general public. This is the first occurrence of
0 5	this type reported.
0 15	this type reported.
317	
7 3	9 SYSTEM CAUSE CAUSE . COMP VALVE
019	STATEM CAUSE SUSCOSE S
	TO ALER NO EVENT YEAR OF THE PROPERTY OF THE P
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110	The cause of this event is attributed to inadequate design. The existing design!
_	did not provide adequate indication of useable tank volume. Daily operating
	Surveillance Procedure ST-300 has been revised to include an operating band
	, requirement within the Technical Specification limit.
1131	
, II	STATUS 1 1 0 0 0 NA NA DISCOVERY CESCOVERY CES
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1	NAC USE CALY
	J. Cooper, Jr
	(MEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

SUPPLEMENTARY INFORMATION

Report No.:

50-302/79-096/01T-0

Facility:

Crystal River Unit #3

Report Date:

26 October 1979

Identification of Occurrence:

Sodium hydroxide tank BST-2 inoperable contrary to Technical Specification 3.6.2.2 and reportable under Section 6.9.1.8.b.

Conditions Prior to Occurrence:

Mode 1 power operation (100%)

Description of Occurrence:

It was determined at 1530 following a discussion with the onsite NRC inspector that a previous event, discovered on 8 July 1979 and evaluated not reportable, anculd have been reported contrary to Technical Specification 3.6.2.2 and reported under Section 6.9.1.8.b.

On 8 July 1979, in Mode 5, it was discovered that the level of the NaOH tank (BST-2) was being maintained at a volume greater than Technical Specification limit. Further investigation revealed that level transmitter BST-2-LT was calibrated with a zero reference point two (2) feet above the tank discharge. The usable volume provided by the additional two feet resulted in the level exceeding the limit. This event was not reported initially due to a misinterpretation of reporting requirements involving limiting conditions for operation and their applicable Mode requirements. The event involving BST-2 was discovered and corrected before entering into the applicable Mode.

Designation of Apparent Cause:

The cause of this event is attributed to inadequate design. The existing design did not provide adequate indication of useable tank volume.

Analysis of Occurrence:

No effect upon the plant or general public. The level of BST-2 was brought to within specification limits prior to entering into Mode 4.

Corrective Action:

1202 287

Daily operating Surveillance Procedure, SP-300, was revised to include an operating band requirement that will maintain the NaOH tank volume within the Technical Specification limits. In addition, responsible personnel have been instructed in regard to the reporting requirements for events of this type. Future events will be evaluated in this regard and reported appropriately.

Supplementary Information 50-302/79-096/01T-0 Page 2

Failure Data:

This is the first occurrence of this type reported.

/rc

1202 288