

# LICENSEE EVENT REPORT

CONTROL BLOCK: 

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[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME F L C R P 3										LICENSE NUMBER 0 0 - 0 0 0 0 0 - 0 0										LICENSE TYPE 4 1 1 1 1					EVENT TYPE 0 3	
7	8	9	14	15	25	26	27	28	29	30	31	32														
CATEGORY 01 CONT			REPORT TYPE L		REPORT SOURCE L		DOCKET NUMBER 0 5 0 - 0 3 0 2					EVENT DATE 0 7 1 2 7 7					REPORT DATE 0 8 0 5 7 7									
7	8	57	58	59	60	61	68	69	74	75	80															

## EVENT DESCRIPTION

02	In the process of reviewing completed surveillance procedures, it was discovered that the																																																																															
03	specified time limit for the Radiation Monitoring Instrumentation Functional Test SP-335																																																																															
04	had been exceeded by 5 days, contrary to Tech Spec 4.0.2.A. Redundancy NA. First time																																																																															
05	occurrence of this event. SP-335 was completed as scheduled by new surveillance schedule																																																																															
06	amended to meet ASME Section XI. (LER 77-82)																																																																															
7	8																																																																															80

SYSTEM CODE B A		CAUSE CODE D		COMPONENT CODE Z Z Z Z Z Z				PRIME COMPONENT SUPPLIER Z		COMPONENT MANUFACTURER Z 9 9 9			VIOLATION N			
7	8	9	10	11	12	13	14	15	16	17	43	44	45	46	47	48

## CAUSE DESCRIPTION

08	The schedule of surveillance procedures was changed to comply with the new ASME SECTION XI																																																																															
09	requirements causing a shift in scheduling dates. This should preclude recurrence of																																																																															
10	this event.																																																																															
7	8																																																																															80

FACILITY STATUS E		% POWER 1 0 0		OTHER STATUS NA				METHOD OF DISCOVERY C		DISCOVERY DESCRIPTION Reviewing completed surv. procedures						
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
FORM OF ACTIVITY RELEASED Z		CONTENT OF RELEASE Z		AMOUNT OF ACTIVITY NA				LOCATION OF RELEASE NA								
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23

## PERSONNEL EXPOSURES

NUMBER 0 0 0		TYPE Z		DESCRIPTION NA					
7	8	9	11	12	13				

## PERSONNEL INJURIES

NUMBER 0 0 0		DESCRIPTION NA						
7	8	9	11	12				

## OFFSITE CONSEQUENCES

TYPE Z		DESCRIPTION NA					
7	8	9	10				

## LOSS OR DAMAGE TO FACILITY

TYPE Z		DESCRIPTION NA					
7	8	9	10				

## PUBLICITY

TYPE Z		DESCRIPTION NA					
7	8	9	10				

## ADDITIONAL FACTORS

11	See attached Supplementary Information																																																																															
7	8																																																																															80

8002 280 804

10																																																																																
7	8																																																																															80

NAME: W. P. Stewart PHONE: (813) 866-4159

SUPPLEMENTARY INFORMATION

1. Report No.: 50-302/77-82
2. Facility: Crystal River Unit #3
3. Report Date: 5 August 1977
4. Occurrence Date: 12 July 1977
5. Identification of Occurrence:

The Failure to perform the Radiation Monitoring Instrumentation Functional Test SP-335 within the time interval as required by Technical Specification 4.0.2.A.

6. Conditions Prior to Occurrence:

Mode 1 operation

7. Description of Occurrence:

At 1030, in the process of reviewing completed surveillance procedures, it was discovered that the time interval of the Radiation Monitoring Instrumentation Functional Test SP-335 had been exceeded. A change to the surveillance schedule had been effected in order to comply with the ASME Section XI and SP-335 was scheduled and completed on 15 July 1977. The new surveillance schedule will insure the Tech Specs frequency requirements are met.

8. Designation of Apparent Cause:

The scheduling of surveillance procedures has changed to comply with the new ASME, Section XI requirements, causing a shift in scheduling dates.

9. Analysis of Occurrence:

There were no safety implications as the Radiation Monitoring System was operable and in service during this period.

10. Corrective Action:

The new surveillance schedule will preclude recurrence of this event.

11. Failure Data:

This was the first time this SP's time interval had been exceeded.