NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: [| | | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	LICENSEE CODE	F L C R P 3 (2)
	LICENSE NUMBER	0 0 - 0 0 0 0 0 - 0 0 (3)
	LICENSE TYPE	4 1 1 1 1 (4)
	CAT	(5)
0 1 CON'T	REPORT SOURCE	L (6)
	DOCKET NUMBER	0 5 0 - 0 3 0 2 (7)
	EVENT DATE	0 8 2 0 8 0 (8)
	REPORT DATE	0 8 2 8 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During performance of SP-439, Maximum Circulating Water Discharge Temperature,
0 3 the temperature at the P.O.D. exceeded 103°F for more than 3 consecutive hours con-
0 4 trary to the specification of E.T.S. 2.1.2. Increased circulating water flow and
0 5 generation load reduction were utilized to reduce temperature to <103°F within 5
0 6 hours. There was no effect upon the general public health or safety. This is the
0 7 second occurrence reported under this specification.
0 8

0 9	
SYSTEM CODE	Z Z (11)
CAUSE CODE	A (12)
CAUSE SUBCODE	A (13)
COMPONENT CODE	Z Z Z Z Z Z (14)
COMP. SUBCODE	Z (15)
VALVE SUBCODE	Z (16)

(17) LER/RO REPORT NUMBER	
EVENT YEAR	8 0
	—
SEQUENTIAL REPORT NO.	0 3 4
	/
OCCURRENCE CODE	0 4
REPORT TYPE	T
	—
REVISION NO.	0

ACTION TAKEN	X (18)
FUTURE ACTION	H (19)
EFFECT ON PLANT	Z (20)
SHUTDOWN METHOD	Z (21)
HOURS (22)	0 0 0 0
ATTACHMENT SUBMITTED	Y (23)
NPRD-4 FORM SUB.	N (24)
PRIME COMP. SUPPLIER	Z (25)
COMPONENT MANUFACTURER	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Apparent cause was high temperature and high power levels; the duration is attrib-
1 1 uted to poor communication between the licensed operators on duty which retarded
1 2 corrective action. RWP-3A and 3B were started and Units 1 & 2 load was reduced
1 3 by 100 MWe. Licensed personnel have been instructed in proper control room com-
1 4 munication and timely implementation of Surveillance Procedure Action Requirements.

1 5	
FACILITY STATUS	E (28)
% POWER	0 9 2 (29)
OTHER STATUS (30)	NA
METHOD OF DISCOVERY	B (31)
DISCOVERY DESCRIPTION (32)	Operator Observation

1 6	
ACTIVITY RELEASED	Z (33)
CONTENT OF RELEASE	Z (34)
AMOUNT OF ACTIVITY (35)	NA
LOCATION OF RELEASE (36)	NA

PERSONNEL EXPOSURES

1 7	
NUMBER	0 0 0 (37)
TYPE	Z (38)
DESCRIPTION (39)	NA

PERSONNEL INJURIES

1 8	
NUMBER	0 0 0 (40)
DESCRIPTION (41)	NA

POOR ORIGINAL

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	
TYPE	Z (42)
DESCRIPTION	NA

PUBLICITY

2 0	
ISSUED	N (44)
DESCRIPTION (45)	NA
NRC USE ONLY	

NAME OF PREPARER: Victor A. Hernandez PHONE: (904) 795-6486

8009050268

(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

SUPPLEMENTARY INFORMATION

Report No.:	50-302/80-034/04T-0
Facility:	Crystal River Unit 3
Report Date:	28 August 1980
Occurrence Date:	20 August 1980
Identification of Occurrence:	The point of discharge temperature exceeded 103°F for a time greater than 3 hours, contrary to Environmental Technical Specification 2.1.2.
Conditions Prior to Occurrence:	Mode 1 Power Operation
Description of Occurrence:	At 1210 Crystal River Units 1 & 2 Control Center informed Crystal River Unit 3 that the temperature at the point of discharge exceeded 102°F per SP-439, Maximum Circulating Water Discharge Temperature. At 1730 Unit 3 was informed that temperature was greater than 103°F. The Unit 3 requirements of SP-439 were implemented after the second notification. Circulating water flow was increased by starting decay heat seawater pumps RWP-3A and 3B; Units 1 & 2 load was reduced by 100 MWe. Temperature remained greater than 103°F from 1600 until 2100 and reached a high of 103.4°F.
Designation of Apparent Cause:	High discharge temperature was caused by high intake temperature and the high power levels of Units 1 & 2 and 3. The duration of the event is attributed to poor communication between the licensed operators on duty which delayed implementation of immediate corrective action until the second notification from Units 1 & 2.
Analysis of Occurrence:	There was no effect upon the general public health or safety as a result of this event.
Corrective Action:	Licensed Personnel have been reinstructed on the importance of proper control room communication and timely implementation of surveillance procedure action requirements.
Failure Data:	This is the second occurrence reported under this specification.