

EXHIBIT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTEVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE C I F (11)		CAUSE CODE E (12)		CAUSE SUBCODE E (13)		COMPONENT CODE I N S I T I R I U (14)		COMP SUBCODE C (15)		VALVE SUBCODE Z (16)	
LER NO REPORT NUMBER 18 1 0 (17)		EVENT YEAR 21 22		SEQUENTIAL REPORT NO. 0 1 3 1 6 (24 25)		OCCURRENCE CODE 0 1 3 (26 27)		REPORT TYPE L (28 29)		REVISION NO. 1 (30 31)	
ACTION TAKEN E (18)		FUTURE ACTION F (19)		EFFECT ON PLANT Z (20)		SHUTDOWN METHOD Z (21)		HOURS 0 0 1 0 1 0 (22 23)		ATTACHMENT SUBMITTED Y (24)	
APPROX FORMULS N (25)		PRICE CODE A (26)		COMPONENT MANUFACTURER C I 6 1 8 1 0 (27 28)							

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)	
110	The cause is attributed to air in the sensing line. Operability was restored by
111	venting the sensing line and performing a functional check. The sensing line was
112	vented prior to surveillance for three (3) months; it will be vented monthly until
113	permanent corrective action is implemented. An engineering evaluation of DHV-111
114	and DHV-110 control method is in progress. (Ref. REI 80-9-3) This revision corrects
	cause and corrective action.

cause and corrective action.

FACILITY STATUS		POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	5	E	33	01810	29	NA	B	21	Operator observation
7	8	9	10	11	12	13	14	15	16
ACTIVITY CONTENT					AMOUNT OF ACTIVITY				
RELEASED OR RELEASE					LOCATION OF RELEASE				
1	6	Z	33	Z	34	NA			
7	8	9	10	11	12	13	14	15	16

PERSONNEL EXPOSURES										
NUMBER		TYPE	DESCRIPTION							
1	7	01010	37	Z	23	NA				

PERSONNEL NUMBER		DESCRIPTION
1	2	NA

1 9 Z 42 NA

REF ID: A60789

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DESCRIPTION (45)

NA

NAC USE ONLY

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(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

8103170576

SUPPLEMENTARY INFORMATION

Report No.: 50-302/80-036/03L-1

Facility: Crystal River Unit 3

Report Date: March 10, 1981

Occurrence Date: 27 August 1980

Identification of Occurrence:

Failure to have two (2) independent ECCS subsystems operable contrary to Technical Specification 3.5.2.

Conditions Prior to Occurrence:

Mode 1 power operation (80%).

Description of Occurrence:

At 0300 during performance of SP-320, Operability of Boron Injection Sources and Pumps, it was discovered that DHV-111 "B" Decay Heat Pump Discharge Throttle Valve would not control flow in automatic. DHV-111 did respond in manual control; maintenance actions were initiated.

Designation of Apparent Cause:

The cause is attributed to air in the sensing lines.

Analysis of Occurrence:

There was no effect upon the general public health and safety. Redundancy was maintained by the "A" Decay Heat Loop.

Corrective Action:

The sensing lines were vented and a functional check was completed. The line was vented prior to surveillance checks for three months; it will be vented monthly until a permanent corrective action is implemented. An engineering evaluation of the control system for DHV-111 and DHV-110 is currently in progress. (Reference REI 80-9-3). This revision corrects cause and corrective action of Revision 0.

Failure Data:

This is the first occurrence for DHV-111, and the tenth report made under this Specification.

/rc