LICENSEE EVENT REPORT

EXHIBIT

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

Line	Field	Value
0 1	Licensee Code (2)	F L C R P 3
	License Number (3)	0 0 - 0 0 0 0 0 - 0 0
	License Type (4)	4 1 1 1 1
	CAT (5)	
CONT 0 1	Report Source (6)	L
	Docket Number (7)	0 5 0 - 0 3 0 2
	Event Date (8)	0 2 0 9 8 1
	Report Date (9)	0 3 1 0 8 1

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

At 2230 while performing SP-317, RCS System Water Inventory Balance, it was discovered that RC drain tank level indication was erratic and prevented determination of RCS leakrate within the required surveillance frequency. This created a condition contrary to T.S. 3.4.6.2. Maintenance was initiated and the leakrate was determined at 0400 on 2/10/81, 5.5 hours beyond the surveillance frequency window. There was no effect upon the health or safety of the general public. This was the first occurrence of overdue leakrate surveillance and this was the first report under this Specification.

System Code (11)	Cause Code (12)	Cause Subcode (13)	Component Code (14)	Comp. Subcode (15)	Valve Subcode (16)
C I	B	A	I N S T R U	I	Z

(17) LER RO Report Number

Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
8 1	—	0 0 9	/	0 3	L	—	0

Action Taken (18)	Future Action (19)	Effect on Plant (20)	Shutdown Method (21)	Hours (22)	Attachment Submitted (23)	NPRD-4 Form Sub. (24)	Prime Comp. Supplier (25)	Component Manufacturer (26)
X	F	Z	Z	0 0 0 0	Y	N	A	L 1 3 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

The cause of this event is attributed to vapor condensation in the instrument sensing lines. The lines were blown down and operability was restored. A modification has been installed to prevent recurrence. (MAR 80-9-8)

Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
E	1 0 0	NA	B	Operator observation

Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
Z	Z	NA	NA

PERSONNEL EXPOSURES

Number (37)	Type (38)	Description (39)
0 0 0	Z	NA

PERSONNEL INJURIES

Number (40)	Description (41)
0 0 0	NA

LOSS OF OR DAMAGE TO FACILITY (43)

Type (42)	Description
Z	NA

PUBLICITY

Issued (44)	Description (45)
N	NA

NRC USE ONLY

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(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

SUPPLEMENTARY INFORMATION

Report No.: 50-302/81-009/03L-0

Facility: Crystal River Unit 3

Report Date: March 10, 1981

Occurrence Date: February 9, 1981

Identification of Occurrence:

Failure to determine Reactor Coolant System leakage within the surveillance frequency required by Technical Specification 4.4.6.2d contrary to Technical Specification 3.4.6.2.

Conditions Prior to Occurrence:

Mode 1 power operation (100%)

Description of Occurrence:

At 2230 while performing SP-317, RC System Water Inventory Balance, it was discovered that Reactor Coolant Drain Tank indication was erratic. This prevented accurate determination of the magnitude of the Reactor Coolant System leakrate. Maintenance was initiated and the leakrate was determined at 0400 on February 10, 1981. This was 5.5 hours beyond the allowable surveillance frequency window.

Designation of Apparent Cause:

The cause of this event is attributed to vapor condensation in the instrument sensing lines.

Analysis of Occurrence:

There was no effect upon the health or safety of the general public.

Corrective Action:

The lines were blown down and operability was restored. A modification has been installed to prevent recurrence. (MAR 80-9-8).

Failure Data:

This was the first occurrence of overdue leakrate surveillance, and this is the first event reported under this Specification.

/rc