

LICENSEE EVENT REPORT

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

01	F	L	C	R	P	3	0	0	-	0	0	0	0	0	0	-	0	0	4	1	1	1	1	4	5	
8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34
LICENSEE CODE						LICENSE NUMBER						LICENSE TYPE						CAT 58								

01	L	0	5	0	-	0	3	0	2	0	7	0	9	8	1	0	7	2	9	8	1	9	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
REPORT SOURCE		DOCKET NUMBER						EVENT DATE						REPORT DATE									

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | At 0045 during cold shutdown operation, the 175' wind direction instrument was dis-

03 | covered to be out of calibration. This created an event contrary to T.S. 3.3.3.4.

04 | Maintenance was initiated and operability was restored on 7/15/81. There was no

05 | effect upon the health or safety of the general public. Redundancy is not applicable.

06 | This is the fourteenth event reported under this Specification.

09	I	E	A	C	I	N	S	T	R	U	X	Z					
7	8	9	10	11	12	13	14	15	16	17	18	19	20				
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE					COMP. SUBCODE		VALVE SUBCODE				
17	8	1	—	4	3	0	3	L	—	0							
7	8	9	10	11	12	13	14	15	16	17							
LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION							
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
E		A		Z		Z		0000		Y		N		A		E070	
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47			

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The cause of this event is attributed to personnel error in that the instrument

11 | technician used the wrong reference slot for mounting the optical orientation

12 | device on date of last calibration, resulting in improper calibration. A new

13 | base plate for the mounting of the optical orientation device will be obtained to

14 | prevent recurrence of this event.

15	G	0	0	0	NA	A	Operator observation
7	8	9	10	11	12	13	14
FACILITY STATUS		% POWER			OTHER STATUS		METHOD OF DISCOVERY
ACTIVITY CONTENT		RELEASED OF RELEASE			AMOUNT OF ACTIVITY		LOCATION OF RELEASE
Z		Z			NA		NA
7	8	9	10	11	12	13	14
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION	
000		Z		NA			
PERSONNEL INJURIES		NUMBER		DESCRIPTION			
000		NA					
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION			
Z		NA					
PUBLICITY		ISSUED		DESCRIPTION			
N		NA					

SUPPLEMENTARY INFORMATION

Report No.: 50-302/81-043/03L-0

Facility: Crystal River Unit 3

Report Date: July 29, 1981

Occurrence Date: July 9, 1981

Identification of Occurrence:

175' wind direction instrument was inoperable contrary to Technical Specification 3.3.3.4.

Conditions Prior to Occurrence:

Mode 5 cold shutdown (0%)

Description of Occurrence:

At 0045 during cold shutdown operation, the 175' wind direction instrument was discovered to be out of calibration. Maintenance was initiated and operability was restored on July 15, 1981.

Designation of Apparent Cause:

The cause of this event is attributed to personnel error. The instrument technician used the wrong reference slot for the mounting of the optical orientation device.

Analysis of Occurrence:

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

Corrective Action:

Calibration of 175' wind direction instrument using proper slot for mounting of the optical orientation device and a new base plate for mounting of the optical orientation device will be obtained.

Failure Data:

This is the fourteenth event reported under Technical Specification 3.3.3.4.

/rc