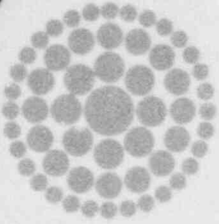

Florida Power
CORPORATION

September 16, 1981
3-0-3-a-1
CS-81-207
#3-091-11

Mr. J. P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Office of Inspection & Enforcement
101 Marietta St., Suite 3100
Atlanta, GA 30303

Docket No. 50-302
Licensee No. DPR-72
LER No. 81-056/01T-0
Crystal River Unit #3
Occurrence Date:
August 15, 1981

Dear Mr. O'Reilly:

Enclosed please find Licensee Event Report 81-056/01T-0 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.8.b.

Should there be any questions, please contact us.

Very truly yours,

FLORIDA POWER CORPORATION

For Nuclear Plant Manager

Patsy Y. Baynard, Manager
Nuclear Support Services

JC/rc

Attachments (2)

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PDR ADOCK 05000302
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General Office 3201 Thirty-fourth Street South • P.O. Box 14042, St. Petersburg, Florida 33733 • 813—866-5151

SUPPLEMENTARY INFORMATION

Report No.: 50-302/81-056/01T-0

Facility: Crystal River Unit 3

Report Date: September 16, 1981

Occurrence Date: August 15, 1981

Identification of Occurrence:

Failure of RM-A5 created an event contrary to Technical Specification 3.7.7.1 and Technical Specification 3.0.3.

Conditions Prior to Occurrence:

Mode 1 power operation (100%).

Description of Occurrence:

At 1000, a high flow alarm was observed on Atmospheric Radiation Monitor RM-A5. At 1045 it was determined that the sample vacuum pump for RM-A5 had failed. Maintenance was initiated, and operability was restored at 1340. At 1615 on September 3, 1981, it was determined that Technical Specification 3.0.3 was applicable to the occurrence. A recirculation lineup had not been initiated within one (1) hour, as required.

Designation of Apparent Cause:

The cause of this event is attributed to a failed sample vacuum pump.

Analysis of Occurrence:

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

Corrective Action:

The pump failed due to broken carbon vanes. Grab samples were initiated, and a portable continuous air monitor was started. The pump was replaced and functionally tested. REI 79-10-9 is undergoing engineering evaluation of the failure of Radiation Monitor sample vacuum pumps. Modification MAR 80-2-7 will initiate an emergency recirculation lineup for the Control Room upon receiving a flow alarm for RM-A5.

Failure Data:

This was the sixth occurrence for RM-A5, and this is the eighth event reported under this Specification.

/rc