LICENSEE EVENT REPORT

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

Field	Value
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 58	(5)
CON'T 0 1 Report Source	L (6)
Docket Number	0 5 0 - 0 3 0 2 (7)
Event Date	0 3 0 4 8 2 (8)
Report Date	0 4 0 8 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 Failure to properly complete a 10 CFR 50.59 review on a planned modification which resulted
0 3 in the approval of a modification to a system that could have allowed operation with
0 4 response time greater than T.S. 3.3.1.1. limit. This is contrary to T.S. 6.9.1.9.c. The
0 5 system to which the modification had been accomplished was declared inoperable. Power
0 6 operation was delayed until relief was granted by the NRC. There was no effect upon the
0 7 health or safety of the general public. This is the second occurrence of improper 10 CFR-
0 8 50.59 review and this is the twelfth report under this Specification.

0 9	System Code	Cause Code	Cause Subcode	Component Code	Comp. Subcode	Valve Subcode
	I A (11)	A (12)	X (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO Report Number	Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
	8 2	—	0 1 6	/	0 3	L	—	0

Action Taken	Future Action	Effect on Plant	Shutdown Method	Hours (22)	Attachment Submitted	NPRD-4 Form Sub.	Prime Comp. Supplier	Component Manufacturer
X (18)	Z (19)	C (20)	Z (21)	0 0 2 4	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event is attributed to human error; personnel not realizing that an
1 1 amendment to T.S. 3.3.1.1 had changed the required response time. That system was de-
1 2 clared inoperable and power operation was not allowed until approval was granted by the
1 3 NRC. A change to T.S. 3.3.1.1 will prevent a recurrence of this event.
1 4

1 5	Facility Status	% Power	Other Status (30)	Method of Discovery	Discovery Description (32)
	G (28)	0 0 0 (29)	NA	A (31)	Engineer observation

1 6	Activity Released	Content of Release	Amount of Activity (35)	Location of Release (36)
	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

1 7	Number	Type	Description (39)
	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

1 8	Number	Description (41)
	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	Type	Description
	Z (42)	NA

PUBLICITY

2 0	Issued	Description (45)	NRC USE ONLY
	N (44)	NA	

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NAME OF PREPARER Charles G. Brown PHONE: 904/795-6486

SUPPLEMENTARY INFORMATION

Report No.: 50-302/82-016/03L-0

Facility: Crystal River Unit 3

Report Date: April 8, 1982

Occurrence Date: March 4, 1982

Identification of Occurrence:

Modification could have allowed power operation with a response time greater than Technical Specification 3.3.1.1 limit, contrary to Technical Specification 6.9.1.9.c.

Conditions Prior to Occurrence:

Mode 3 Hot Standby (0%)

Description of Occurrence:

On March 4, 1982, it was discovered that an improper 10 CFR 50.59 review had allowed a system modification to be completed that exceeded the response time limits set forth by Technical Specification 3.3.1.1.

Designation of Apparent Cause:

The cause of this event is attributed to personnel error.

Analysis of Occurrence:

The plant was in a shutdown condition when the error was identified. Power operation was not allowed until the problem was investigated and relief was granted by the Nuclear Regulatory Commission. There was no effect upon the health or safety of the general public.

Corrective Action:

Plant mode change nor power operation was allowed until a safety analysis was conducted and approval was granted by the Nuclear Regulatory Commission.

Failure Data: This is the second occurrence of improper 10 CFR 50.59 review and this is the twelfth report under this specification.