

LICENSEE EVENT REPORT

EXHIBIT A

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

01 FILIC RIP3 00-000000-000 4111

CON'T REPORT SOURCE L050-0302 062481 111582

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

02 At 1245 on 6/24/81, FPC was notified by Henry Pratt Co. that containment
03 purge valves AHV-1A,1B,1C, and 1D were in a condition which could allow them
04 to fail during a LOCA. This is contrary to T.S. 3.6.1.1 and T.S.3.6.3.1.
05 Operability was restored at 1340 on 7/1/81. At 0930 on 11/1/82, Gilbert
06 Associates, Inc. informed FPC that containment purge valves, when in the
07 full open position could allow dose rates to exceed the 10CFR 100 limit during
08 a LOCA due to the longer closure time. There was no effect on public health.
09 This was the third event under T.S.3.6.1.1. and the thirty-sixth event under
10 T.S.3.6.3.1.

09 SYSTEM CODE SID CAUSE CODE B CAUSE SUBCODE A COMPONENT CODE VALV OCCURRENCE CODE 1 VALVE SUBCODE Z LER/RO REPORT NUMBER 81 EVENT YEAR 81 SEQUENTIAL REPORT NO. 0131 ATTACHMENT SUBMITTED Y NPRO-4 FORM SUB N PRIME COMP. SUPPLIER A COMPONENT MANUFACTURER L2P0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

10 The cause of this event is not known. On 7/1/81, the Pratt valves were modified
11 as recommended by H. Pratt Co to 50 for Bettis actuators and 35 for
12 Limitorque operators. The modifications also resolved the 10CFR 100 dose
13 rate excess identified by Gilbert Associates, Inc. on 11/1/82.

15 FACILITY STATUS F % POWER 100 OTHER STATUS N/A METHOD OF DISCOVERY D Vendor Notification

16 ACTIVITY CONTENT Z AMOUNT OF RELEASE N/A LOCATION OF RELEASE N/A

17 PERSONNEL EXPOSURES NUMBER 0 TYPE Z DESCRIPTION N/A

18 PERSONNEL INJURIES NUMBER 0 DESCRIPTION N/A

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z DESCRIPTION N/A

20 PUBLICITY ISSUED N DESCRIPTION N/A

NAME OF PREPARER P. G. Hughes P. G. Hughes PHONE (904) 795-3802

8211170270 821115 PDR ADOCK 05C00302 PDR

SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/81-031/01T-1
FACILITY: Crystal River Unit #3
REPORT DATE: July 8, 1981 (Rev. 0)/November 15, 1982 (Rev. 1)
OCCURRENCE DATE: June 24, 1981 (Rev. 0)/November 1, 1982 (Rev. 1)

IDENTIFICATION OF OCCURRENCE:

Containment Isolation Valves AHV-1A, 1B, 1C and 1D were operating in a condition less conservative than the vendors' reevaluations for safety-related application. This condition was contrary to Technical Specifications 3.6.1.1 and 3.6.3.1 and Final Safety Analysis Report, Section 14.2.2.7.2.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 1 (100% Full Power)

DESCRIPTION OF OCCURRENCE:

At 1245 on June 24, 1981, Henry Pratt Company informed Florida Power Corporation that the previously established operating limit of 60° on containment isolation valves AHV-1A, 1B, 1C and 1D was not adequate for LOCA conditions. The engineering evaluation to determine adequacy of the valves was initiated as a result of a 1979 commitment to the NRC. This evaluation determined that the valve structure and actuator were inadequate to withstand LOCA-reduced loads based on the torques calculated in the evaluation. The Pratt evaluation recommended partially closing the valves to 35° and 50° to relieve the over-torque expected to occur during a LOCA.

On June 24, 1981, the Reactor Building purge that was in progress was terminated at 1335, and the valves were deactivated pending implementation of an Engineering resolution to modify the valves as recommended.

At 0930 on November 1, 1982, Gilbert Associates, Inc., informed Florida Power Corporation that the original 90° operating limit on containment isolation valves AHV-1A, 1B, 1C and 1D would have allowed the post-LOCA dose rate to exceed 10 CFR 100 limits. Thus, prior to the initial modification to resolve the torquing concerns above, Crystal River Unit 3 was operating in a condition less conservative than assumed in the Safety Analysis, Section 14.2.2.7.2.

DESIGNATION OF APPARENT CAUSE:

These events were caused by apparent oversights in the design process.

ANALYSIS OF OCCURRENCE:

There was no effect on public health.

CORRECTIVE ACTION:

The valves were modified to comply with the recommended operating limits. Operability was restored at 1340 on July 1, 1981.

FAILURE DATA:

This is the thirty-sixth event reported under Technical Specification 3.6.3.1, and the third under Technical Specification 3.6.1.1.