



**Florida
Power**
CORPORATION
Crystal River Unit 3
Docket No. 50-302

January 23, 1991

3F0191-15

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D. C. 20555

Subject: Licensee Event Report (LER) 90-020

Dear Sir:

Enclosed is Licensee Event Report (LER) 90-020 which is submitted in accordance with 10 CFR 50.73.

Sincerely,

G. L. Boldt
Vice President
Nuclear Production

WLR:mag

Enclosure

xc: Regional Administrator, Region II
Project Manager, Region II
Senior Resident Inspector

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PDR ADOCK 05000302
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 600 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) **CRYSTAL RIVER UNIT 3** DOCKET NUMBER (2) **0 5 0 0 0 3 1 0 2** PAGE (3) **1 OF 0 1**

TITLE (4) **Loss of Auxiliary Building Ventilation Caused by Jarring of the Thermal Switch During Scaffold Erection Leads to Condition Prohibited by Technical Specification.**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)														
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)													
1	2	7	9	0	9	0	0	2	0	0	0	1	2	3	9	1	N/A	0	5	0	0	0	
									N/A	0			5	0	0	0							

OPERATING MODE (9) **1**

POWER LEVEL (10) **1 0 0**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.36(a)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.406(a)(1)(iii)	<input type="checkbox"/> 50.36(a)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 305A)
<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)	
<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **W. K. BANDHAUER, NUCLEAR SAFETY SUPERVISOR**

TELEPHONE NUMBER

AREA CODE **9 0 4** **7 9 5 - 6 4 8 6**

COMPLETE ONE LINE FOR EACH COMPONENT. FAILURE DESCRIBED IN TITLE REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single space typewritten lines) (16)

On December 27, 1990, Crystal River Unit 3 was in MODE 1 (POWER OPERATIONS) at 100% rated thermal power. At 1317 hours, all Auxiliary Building ventilation was lost when the operating exhaust fans tripped and the redundant fans would not start. The cause was determined to be the actuation of a temperature switch [VL,TS] in the exhaust duct. The switch is intended to detect a fire in the charcoal and high efficiency particulate (HEPA) filter [VL,FIL] units. If an elevated temperature is detected, the switch trips all of the Auxiliary Building fans [VL,FAN] in both trains. The switch was actuated by a mechanical shock, which occurred when it was inadvertently jarred during the erection of scaffolding. The scaffold was being erected to change light bulbs in the area. The scaffold erection crew was apprised of the sensitivity of the switch and told to reposition the scaffold. The switch was reset, the fans restarted, and the ventilation system restored to normal at 1344. There were no equipment failures during this event and all systems performed as they were designed. For this reason, the event had no safety consequences. There was no release in progress at the time of the event. This is an isolated event as there are no previous similar events and no other corrective action is planned or warranted. This item is reportable under 10 CFR 50.73(a)(2)(i)(B).