Florida Power
CORPORATION

December 7, 1982
#3F-1282-03
File: 3-0-3-a-1

Mr. James P. O'Reilly
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
Office of Inspection & Enforcement
101 Marietta Street N.W., Suite 3100
Atlanta, Ga. 30303

Subject: Crystal River Unit 3
Docket No. 50-302
Operating License No. DPR-72
Licensee Event Report No. 82-070

Dear Mr. O'Reilly:

Enclosed please find Licensee Event Report No. 82-070 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9.b.

Very truly yours,

G. R. Westafer

G. R. Westafer
Manager
Nuclearing Licensing and Fuel Management

PGH/mlg

Enclosure

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

IE2.

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SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-070/03L-0

FACILITY: Crystal River Unit #3

REPORT DATE: December 7, 1982

OCCURRENCE DATE: November 7, 1982

IDENTIFICATION OF OCCURRENCE:

Channel "B" of the Nuclear Overpower Instrumentation, a Reactor Protection System, was inoperable. Technical Specification 3.3.1.1. requires initiation of Action Statement Two with one of the four Nuclear Overpower Channels inoperable.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 1 (69% Full Power).

DESCRIPTION OF OCCURRENCE:

At 0734 on November 7, 1982, Reactor Coolant Flow Transmitter (RC-14A-FT2) failed. Failure of the transmitter caused Channel "B" of the Nuclear Overpower Instrumentation to be inoperable. Channel "B" was verified in the tripped condition. The minimum channels operable requirement was met; Channels A, C, and D were available. The Quadrant Power Tilt was monitored every 8 hours. Both transmitters in Channel "B" were recalibrated. During calibration operations, the companion flow transmitter (RC-14B-FT2) sustained damage. Channel was restored to operability at 1500 on November 9, 1982.

DESIGNATION OF APPARENT CAUSE:

The failure of RC-14A-FT2 was caused by a shorted capacitor in the transmitter power supply. The failure of RC-14B-FT2 was caused by inoperable bellows. At this time, it is believed that the bellows failed due to improperly isolating the transmitter to perform a channel calibration.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety. Nuclear Overpower Channels A, C, and D were operable to provide the necessary trip function.

CORRECTIVE ACTION:

The capacitor and bellows were replaced, the channel was recalibrated and functionally tested satisfactorily.

FAILURE DATA:

This is the fourth failure for Channel "B" and the twentieth report under Technical Specification 3.3.1.1.