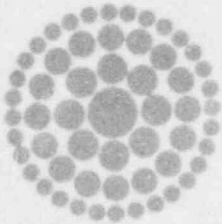


LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK:										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)									
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**Florida
Power**
CORPORATION

December 29, 1983
3F1283-38

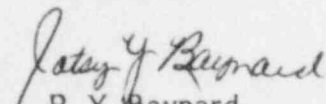
Mr. James P. O'Reilly
Regional Administrator, Region II
Office of Inspection & Enforcement
U.S. Nuclear Regulatory Commission
101 Marietta Street N.W., Suite 2900
Atlanta, GA 30303

Subject: Crystal River Unit 3
Docket No. 50-302
Operating License No. DPR-72
Licensee Event Report No. 83-060

Dear Mr. O'Reilly:

Enclosed is Licensee Event Report No. 83-060 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9(b).

Sincerely,


P. Y. Baynard

Assistant to Vice President
Nuclear Operations

AEF/feb

Enclosure

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

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SUPPLEMENTARY INFORMATION

REPORT NO.: 50-302/83-060/03L-0

FACILITY: Crystal River Unit 3

REPORT DATE: December 29, 1983

DATE OF OCCURRENCE: November 29, 1983

IDENTIFICATION OF OCCURRENCE:

Decay Heat Temperature Indicator (DH-2-TI2) was inoperable. This malfunction caused "B" Decay Heat Cooler to be considered inoperable contrary to the requirements of Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 (100% Full Power).

DESCRIPTION OF OCCURRENCE:

At 1525 on November 29, 1983, it was discovered that the "B" Decay Heat Cooler discharge temperature indicator, DH-2-TI2, was indicating mid-scale, 150° F, and not the actual temperature of 71° F indicated by the plant computer. The meter was removed, checked, cleaned, and returned to service at 1800 on November 29, 1983.

DESIGNATION OF APPARENT CAUSE:

The cause of this event is undetermined at this time.

ANALYSIS OF OCCURRENCE:

Only the temperature indication was lost. Correct temperature was available via the computer point. The redundant cooler was available maintaining the ability to meet the system's safety function. Furthermore, the cooler was functional. The loss of temperature indication would have presented conflicting information to the operator with regard to how well it was functioning.

CORRECTIVE ACTION:

The meter was checked, cleaned and returned to service. FPC will continue to monitor this component to determine if further corrective action is warranted.

FAILURE DATA:

This is the second event of this type and the twenty-fifth report under Technical Specification 3.5.2.