

### LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	F	L	C	R	P	3	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5	
2	8	9	LICENSEE CODE					14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	57	CAT	58

N'T

0 1 7 8 REPORT SOURCE L 6 0 5 0 - 0 3 0 2 7 0 7 1 4 8 1 8 0 8 1 2 8 1 9 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | At 0954 during normal operation 120 A.C. Vital Bus #3A was de-energized when power was  
0 3 | interrupted at the "A" inverter. This created an event contrary to T.S.3.8.2.1. As  
0 4 | a result of this event, a Reactor/Turbine trip occurred. Power was restored to the  
0 5 | Vital Bus within ten minutes. There was no effect upon the health or safety of the  
0 6 | general public. This was the first event of this type, and this is the fifth event  
0 7 | reported under this specification.

0	8																	89				
7	8	9	SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE						COMP. SUBCODE		VALVE SUBCODE					
0	9		E	C	11	A	12	C	13	B	A	T	T	R	Y	14	Z	15	Z	16		
7	8		9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25			
(17) LER/RQ REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.												
8 1		0 4 6		0 3		L		0														
21 22		23 24 25 26 27		28 29		30 31		32														
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER						
X	18	X	19	A	20	C	21	0	0	1	3	Y	23	N	24	A	25	C	1	7	3	26
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event is attributed to inadvertent shorting of the "A" Station  
1 1 Battery during maintenance resulting in failure of the "A" Inverter which was supplying  
1 2 power to the Vital Bus. The inverter was repaired. Maintenance in the battery room  
1 3 will utilize tools with insulated handles, and of a length designed to prevent shorting  
1 4 and caution signs will be posted at the entrance.

FACILITY STATUS				% POWER				OTHER STATUS				METHOD OF DISCOVERY				DISCOVERY DESCRIPTION			
1	5	E	28	0	8	0	29	NA				A	31	Operator Observation					
ACTIVITY CONTENT				AMOUNT OF ACTIVITY				LOCATION OF RELEASE											
1	6	Z	33	Z	14	NA													
PERSONNEL EXPOSURES				PERSONNEL INJURIES				LOSS OF OR DAMAGE TO FACILITY				PUBLICITY							
1	7	0	0	0	0	0	37	0	0	0	40	0	0	0	42	N	44		
NUMBER TYPE DESCRIPTION				NUMBER DESCRIPTION				TYPE DESCRIPTION				ISSUED DESCRIPTION							
NA				NA				NA				NA							
NRC USE ONLY																			

NRC USE ONLY V

8108200174 810812  
PDR ADOCK 05000302  
S PDR

(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

PHONE

904/795-6486

# SUPPLEMENTARY INFORMATION

Report #50-302/81-046/03L-0

Facility: Crystal River Unit 3

Report Date: August 12, 1981

Occurrence Date: July 14, 1981

Identification of Occurrence:

120 Volt A.C. Vital Bus #3A was inoperable contrary to Technical Specification 3.8.2.1.

Conditions Prior to Occurrence:

Mode 1 - Power Operation (80%)

Description of Occurrence:

At 0954 during normal operation, 120 volt A.C. Vital Bus #3A was de-energized. The "A" station battery was shorted during maintenance which blew the output fuse of the "A" inverter which supplied the bus. As a result of the lost bus the interface valve for the turbine generator control fluid opened causing a loss of control fluid resulting in a Turbine/Reactor trip. Power was restored to the Vital Bus within ten (10) minutes.

Designation of Apparent Cause:

The cause of this event is attributed to a personnel error resulting in the short to the battery.

Analysis of Occurrence:

There was no effect upon the health or safety of the general public.

Corrective Action:

The "A" Inverter was repaired. Tools with insulated handles and of a length designed to prevent shorting will be obtained for exclusive use in the Battery Room. Additionally, a sign will be installed on the door to the Battery Room to provide sensitive equipment caution to persons entering.

Failure Data:

This was the first event of this type, and this is the fifth event reported under this specification.