



**Florida  
Power**  
CORPORATION

September 16, 1981

3-0-3-a-1

CS-81-207

#3-091-11

Mr. J. P. O'Reilly, Director  
U.S. Nuclear Regulatory Commission  
Office of Inspection & Enforcement  
101 Marietta St., Suite 3100  
Atlanta, GA 30303

Docket No. 50-302  
Licensee No. DPR-72  
LER No. 81-056/01T-0  
Crystal River Unit #3  
Occurrence Date:  
August 15, 1981

Dear Mr. O'Reilly:

Enclosed please find Licensee Event Report 81-056/01T-0 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.8.b.

Should there be any questions, please contact us.

Very truly yours,

FLORIDA POWER CORPORATION

*J. P. O'Reilly*  
for Nuclear Plant Manager

*Patsy V. Baynard*  
Patsy V. Baynard, Manager  
Nuclear Support Services

JC/rc

Attachments (2)

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SUPPLEMENTARY INFORMATION

Report No.: 50-302/81-056/01T-0

Facility: Crystal River Unit 3

Report Date: September 16, 1981

Occurrence Date: August 15, 1981

Identification of Occurrence:

Failure of RM-A5 created an event contrary to Technical Specification 3.7.7.1 and Technical Specification 3.0.3.

Conditions Prior to Occurrence:

Mode 1 power operation (100%).

Description of Occurrence:

At 1000, a high flow alarm was observed on Atmospheric Radiation Monitor RM-A5. At 1045 it was determined that the sample vacuum pump for RM-A5 had failed. Maintenance was initiated, and operability was restored at 1340. At 1615 on September 3, 1981, it was determined that Technical Specification 3.0.3 was applicable to the occurrence. A recirculation lineup had not been initiated within one (1) hour, as required.

Designation of Apparent Cause:

The cause of this event is attributed to a failed sample vacuum pump.

Analysis of Occurrence:

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

Corrective Action:

The pump failed due to broken carbon vanes. Grab samples were initiated, and a portable continuous air monitor was started. The pump was replaced and functionally tested. REI 79-10-9 is undergoing engineering evaluation of the failure of Radiation Monitor sample vacuum pumps. Modification MAR 80-2-7 will initiate an emergency recirculation lineup for the Control Room upon receiving a flow alarm for RM-A5.

Failure Data:

This was the sixth occurrence for RM-A5, and this is the eighth event reported under this Specification.