Florida Power
CORPORATION

November 10, 1982
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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 St. 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. 82-063

Dear Mr. O'Reilly:

Enclosed please find Licensee Event Report No. 82-063 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9.b.

Should there be any questions, please contact this office.

Very truly yours,

Patsy Y. Baynard

P. Y. Baynard
Assistant to Vice President
Nuclear Operations

PGH/mlg

Enclosure

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

SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-063/03L-0

FACILITY: Crystal River Unit #3

REPORT DATE: November 10, 1982

OCCURRENCE DATE: October 11, 1982

IDENTIFICATION OF OCCURRENCE:

The reactor building average air temperature exceeded the 130°F limit of Technical Specification 3.6.1.5.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 1 (97% FULL POWER).

DESCRIPTION OF OCCURRENCE:

At 0345, on October 11, 1982, the reactor building average air temperature reached 131.4°F. Air handling coolers were started and the reactor building temperature was decreased to within limit by 0530.

An investigation revealed a ruptured instrument air line on the Industrial Cooling Tower damper control. Loss of instrument air to the damper controllers caused the dampers to fail closed. This increased the temperature of the water supplied to the reactor building coolers. This subsequently led to the high reactor building temperature. The dampers were temporarily modified to maintain the open position until replacement of the ruptured instrument air line was complete.

DESIGNATION OF APPARENT CAUSE:

This event was caused by a component failure. The short instrument air lines were not installed in a configuration to withstand normal strains over a long period of time. Strain on the line to the damper controller caused the line to rupture.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety. Nuclear closed cycle cooling was available to provide emergency cooling if required.

CORRECTIVE ACTION:

The instrument air lines were replaced with longer lines on October 10, 1982.

FAILURE DATA:

This was the ninth time the reactor building temperature exceeded the 130°F limit.