NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

EXHIBIT A

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (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)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 - 0 3 0 2 (7) | 0 1 1 1 7 8 (8) | 0 2 0 2 7 8 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During normal mode 1 operations, it was discovered that the breaker for HPI
0 3 isolation valve MUV-25 was inadvertently opened and "red tagged" out of
0 4 service. This caused a plant condition contrary to Tech Spec 3.6.3.1. No
0 5 safety hazard as redundant HPI subsystem was available and operable. Upon
0 6 discovery, the breaker was immediately closed restoring operability of MUV-25
0 7 First occurrence of this event.
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP SUBCODE	VALVE SUBCODE
0 9	I B (11)	A (12)	B (13)	V A L V E X (14)	D (15)	D (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 8	—	0 0 6	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	H (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	W 0 3 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 This occurrence was caused by the inadvertent opening of the breaker for
1 1 MUV-25. A clearance order for clearing DOP-2B had been issued. The breaker
1 2 cubicle for DOP-2B was adjacent to the breaker cubicle of MUV-25 and the
1 3 wrong breaker was cleared. The Clearance Procedure was reviewed with con-
1 4 cerned personnel. Plant personnel have been instructed as to the safety aspects of this event.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	1 0 0 (29)	NA	Z (31)	Control Operator observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

NAME OF PREPARER J. Cooper PHONE (904) 795-6486

(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

8002280873

SUPPLEMENTARY INFORMATION

1. Report No.: 50-302/78-006/03L-0

2. Facility: Crystal River Unit #3

3. Report Date: 2 February 1978

4. Occurrence Date: 11 January 1978

5. Identification of Occurrence:

High pressure injection isolation valve MUV-25 inoperable contrary to Technical Specification 3.6.3.1.

6. Conditions Prior to Occurrence:

Mode 1 operation.

7. Description of Occurrence:

At 2145, it was discovered that Control Center position indication for the HP injection isolation valve MUV-25 was inoperable. An immediate investigation revealed that the breaker for valve MUV-25 was open and the breaker was "red tagged". Further investigation revealed that a clearance had been issued for the domestic water pump, DOP-2B. The breaker cubicle for DOP-2B was adjacent to the breaker cubicle for MUV-25. It was confirmed that the breaker for MUV-25 was mistakenly opened and "red tagged" in lieu of the breaker for DOP-2B. Upon confirmation of the clearance error the breaker for MUV-25 was closed, restoring its operability.

8. Designation of Apparent Cause:

The cause of this event was personnel error, in that the wrong breaker was opened and "red tagged".

9. Analysis of Occurrence:

There were no safety implications as either HPI subsystem in conjunction with the core flooding system would maintain temperatures within prescribed limits in the event of accident conditions.

10. Corrective Action:

All shift supervisors have been instructed to inform and discuss the safety aspects of proper clearance and tagging with personnel on their shifts. A plant safety meeting was held and the Clearance Procedure was reviewed for all attendees.

11. Failure Data:

This is the first occurrence of an event due to improper clearance of equipment out of service.