NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

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 4 2 5 7 8 (8) | 0 5 1 5 7 8 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 1115 during the investigation of inverter 3A tripping, it was discovered
0 3 that 5 circuits of Vital Bus 3A were improperly fused. No hazard to the
0 4 health and safety of the general public as there are circuit breakers
0 5 wired in series with the fuses.
0 6
0 7
0 8

0 9

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP SUBCODE	VALVE SUBCODE
E B (11)	B (12)	C (13)	E L E C O N (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
7 8	—	0 2 8	/	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)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	1 2 0 2 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event was due to the installation of incorrect fuses in
1 1 Vital Bus 3A. An investigation of the maintenance records revealed that
1 2 the fuses were not installed during the operational phase of the plant. The
1 3 remaining three (3) 120 Volt busses were checked to ensure that proper
1 4 fuses were installed as indicated on applicable engineering drawings.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	H (28)	0 0 0 (29)	Defueled	C (31)	Technician 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 for J. Cooper PHONE (904) 795-6486

(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

8003040 953

SUPPLEMENTARY INFORMATION

1. Report No.: 50-302/78-028/03L-0

2. Facility: Crystal River Unit #3

3. Report Date: 15 May 1978

4. Occurrence Date: 25 April 1978

5. Identification of Occurrence:

   Improper fuses installed in Vital Bus 3A.

6. Conditions Prior to Occurrence:

   Mode 6 refueling.

7. Description of Occurrence:

   At 1115 during the investigation of inverter 3A tripping, it was discovered that five (5) circuits of Vital Bus 3A were improperly fused. Discrepancy Report DR-533 was initiated to install proper fuses in Vital Bus 3A as indicated on 120 Volt AC Vital Bus 3A drawing #201-063, rev. 7. DR-533 also initiated an investigation into the three (3) remaining 120 Volt Vital Busses to ensure that proper fuses have been installed as indicated on the applicable drawings.

8. Designation of Apparent Cause:

   The cause of this event was due to the installation of incorrect fuses in Vital Bus 3A circuits during the construction and testing phase.

9. Analysis of Occurrence:

   No hazard to the health and safety of the general public as Vital Bus 3A circuits were still protected because there are circuit breakers wired in series with the fuses.

10. Corrective Action:

    Plant operating records were thoroughly searched in an effort to determine when the incorrect fuses were initially installed. The results of this investigation revealed that the fuses were not installed during the operational phase of the plant. An investigation was also made into the three (3) remaining 120 Volt Vital Busses to ensure that proper fuses have been installed as indicated on applicable engineering drawings.

11. Failure Data:

    First occurrence of an event of this type.