UPDATE REPORT - PREVIOUS REPORT DATED MAY 6, 1983

1.

NRC FORM 396 (7-77)	LICENSEE EVENT REPORT	U.S. NUCLEAR REGULATORY COMMISSION
CONTROL BLOCK:	1.10	EXHIBIT A
CONT		<u>3</u> <u>8</u> <u>0</u> <u>17</u> <u>2</u> <u>6</u> <u>8</u> <u>3</u> <u>9</u>
EVENT DESCRIPTION AND PROBABLE CO	<u> </u>	74 75 REPORT DATE 80
		Safeguards Motor Control
		ed various pieces of equip-
	be inoperable. (See "Supp	
	was returned to operabilit	ty at 2100.
0 8 9 SYSTEM CAUSE	CAUSE	COMP. VALVE 80
17 REPORT LE AL	REPORT NO. CODE	
ACTION AUTURE EFFECT SHUTDO		30 31 32 NPRD-4 PRIME COMP. COMPONENT ORM SUB. SUPPLIER MANUFACTURER
CAUSE DESCRIPTION AND CORRECTIVE		
	y personnel error. The bre	eaker connectors were not
[1]] properly aligned, causi	ng the breaker to short out	. The breaker was
[1]2 [removed, cleaned, and r	einstalled.	
IS HOLOLOGO N	A STATLE 30 METHOD OF DISCOVERY	DISCOVERY DESCRIPTION 3
7 8 ACTIVITY CONTENT 12 13 RELEASED OF RELEASE AMOUNT OF A 1 6 Z 33 Z 34 N/A	ACTIVITY 35	LOCATION OF RELEASE 36
7 8 9 10 11 PERSONNEL EXPOSURES		N/A
NUMBER         TYPE         DESCRIPTION         3           1         7         9         0         0         37         Z         38           7         8         9         11         12         13         13           9         PERSONNEL INJURIES         13         13         13         13	N/A	80
	N/A	<b></b>
LOSS OF OR DAMAGE TO FACILITY (3)	N/A	
PUBLICITY ISSUED DESCRIPTION (45)	N/A	
7 8 9 10	and the second	68 69 80 (904) 795-3802
	P. G. Hughes	PHONE
8308030387 830726 PDR ADOCK 05000302 S PDR		JE22

## SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/83-019/03L-1

FACILITY: Crystal River Unit #3

REPORT DATE: July 26, 1983

OCCURRENCE DATE: April 6, 1983

**IDENTIFICATION OF OCCURRENCE:** 

Engineered Safeguards Motor Control Center (3B1), which had been damaged during routine maintenance, short circuited.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 6 (REFUELING)

**DESCRIPTION OF OCCURRENCE:** 

On April 6, 1983, an Engineered Safeguards Motor Control Center breaker (8BR on ES MCC 3B1) short circuited causing various pieces of required equipment on ES Train B to be inoperable.

At the time that this event occurred, Emergency Diesel Generator A (EDG-A) had been removed from service to perform maintenance. Thus, the redundant systems (ES Train A) powered by Emergency Bus A were unable to be powered from an operable Emergency diesel generator.

Attached is a list of the equipment affected, applicable Technical Specifications, apparent causes, corrective actions and the significance of the loss of this equipment.

DESIGNATION OF APPARENT CAUSE:

This event was caused by personnel error. The breaker connectors were not properly aligned, causing the breaker to short circuit.

ANALYSIS OF OCCURRENCE:

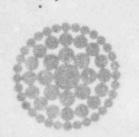
See the attached list.

CORRECTIVE ACTION:

The immediate corrective actions are described on the attached list. The faulty breaker was removed, cleaned, and reinstalled. The breaker was returned to operability at 2100 on April 6, 1983.

Technical Specification Equipment Affected	Applicable Tech. Specification	Apparent Cause	Corrective Action	Analysis of Occurrence
One of two 120 Volt A.C. Vital Busses	3.8.2.2	A large power spike, following ES MCC 3B1 failure, caused a fuse to blow in the Vital Bus inverter/ transformer.	Containment integrity was established and the fuse was replaced.	Although ES Train A was unable to be powered from its emergency power source it was capable of performing its normal functions due to the availability of its normal power source. Thus, redundant systems were available.
Boron injection flow path	3.1.2.1	DHV-6, DHV-35 and DHV-111, on decay heat train B, are powered by ES MCC 3B1.	Verified that no opera- tions involving CORE ALTERATIONS or positive reactivity changes were performed.	Same as above.
Boric Acid Storage System	3.1.2.8	Heat tracing on the Boric Acid Storage system is powered by ES MCC 3B1.	Verified that no opera- tions involving CORE ALTERATIONS or positive reactivity changes were performed.	The temperature of the Boric Acid solution remained at no less than 105°F.
<ul> <li>Smoke detectors in:</li> <li>1) Plant Battery Room 3E</li> <li>2) Control Rod Drive Equipment Room</li> <li>3) 4160 Volt Switchgear Bus Rooms 3A &amp; 3B</li> <li>4) Inverter Rooms 3A &amp; 3</li> </ul>		The distribution panel that supplies power for these detectors is powered by ES MCC 3B1.	A Fire Watch Patrol was established to inspect the affected areas.	The Fire Watch Patrol was available to detect and mitigate any fires that may have started in the affected areas.

4) Inverter Rooms 3A & 3B
5) Cable Spreading Room 3A and 3B



USNRO RE ATLANTA. 6

83 JUL 29 A



July 26, 1983 3F-0783-24

Mr. James P. O'Reilly Regional Administrator, Region II Office of Inspection & Enforcement U.S. Nuclear Regulatory Commission 101 Marietta Street N.W., Suite 2900 Atlanta, GA 30303

Subject: Crystal River Unit 3 Docket No. 50-302 Operating License No. DPR-72 Licensee Event Report No. 83-019

Dear Mr. O'Reilly:

Enclosed is Licensee Event Report No. 83-019 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9.b. This report supplies supplementary information to our initial report dated May 6, 1983.

Should there be any questions, please contact this office.

Sincerely,

Kute

G. R. Westafer Manager Nuclear Licensing and Fuel Management

AEF:mm

Enclosure

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

OFFICIAL COPY IEZZ

General Office 3201 Thirty-fourth Street South • P.O. Box 14042, St. Petersburg, Florida 33733 • 813-866-5151