UPDATE REPORT - PREVIOUS REPORT DATED MAY 6, 1983

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	LICENSEE CODE	F L C R P 3 (2)
	LICENSE NUMBER	0 0 - 0 0 0 0 0 - 0 0 (3)
	LICENSE TYPE	4 1 1 1 1 (4)
	CAT	(5)

CON'T

0 1	REPORT SOURCE	L (6)
	DOCKET NUMBER	0 5 0 - 0 3 0 2 (7)
	EVENT DATE	0 4 0 6 8 3 (8)
	REPORT DATE	0 7 2 6 8 3 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 1330 on April 6, 1983, a breaker in Engineered Safeguards Motor Control

0 3 Center 3B1 shorted out. Loss of the breaker caused various pieces of equip-

0 4 ment on ES train "B" to be inoperable. (See "Supplementary Information"

0 5 attached.) The breaker was returned to operability at 2100.

0 6

0 7

0 8

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	E D (11)	A (12)	C (13)	C K T B R K (14)	A (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 1 9	/	0 3	L	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
B (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	N (23)	N (24)	A (25)	A 1 6 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 This event was caused by personnel error. The breaker connectors were not

1 1 properly aligned, causing the breaker to short out. The breaker was

1 2 removed, cleaned, and reinstalled.

1 3

1 4

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	H (28)	0 0 0 (29)	N/A	A (31)	Operator Observation

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

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	N/A

PUBLICITY

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

NAME OF PREPARER P. G. Hughes PHONE: (904) 795-3802

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PDR ADOCK 05000302
S PDR

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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 operations 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 operations involving CORE ALTERATIONS or positive reactivity changes were performed.	The temperature of the Boric Acid solution remained at no less than 105°F.
Smoke detectors in: 1) Plant Battery Room 3B 2) Control Rod Drive Equipment Room 3) 4160 Volt Switchgear Bus Rooms 3A & 3B 4) Inverter Rooms 3A & 3B 5) Cable Spreading Room 3A and 3B	3.3.3.7	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.

Florida Power
CORPORATION

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,

G R Westafer

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

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