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 NUMBER — LICENSE TYPE

CONT

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0 2] At 1800, during performance of SP-112, RC flow, Channel "A" was found out-of-calibration.

[0 3] This created an event not attributed to a specific shutdown activity as required by Reg.

[0 4] Guide 1.16, and, therefore, contrary to T.S. 3.3.1.1. Maintenance was initiated and

[0 5] operability was restored on 2-26-82. There was no effect upon the health or safety of

[0 6] the general public. This is the second occurrence for RC flow, Channel "A", and the

[0 7] eleventh report under this Specification.

[0 8]

[0 9]

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
I A (11)	E (12)	E (13)	I N S T R U (14)	E (15)	Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR	SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.
8 2	0 1 1	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
A (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	B 0 4 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1 0] The cause of this event is attributed to the linear voltage differential transformer

[1 1] shorting out. The linear voltage differential transformer was replaced and the instru-

[1 2] ment was calibrated per SP-112. No further corrective actions are deemed necessary.

[1 3]

[1 4]

FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
G (28)	0 0 0 (29)	NA	B (31)	Technician observation

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

TYPE	DESCRIPTION
Z (42)	NA

PUBLICITY

ISSUED	DESCRIPTION (45)
8204080084 820317 PDR ADOCK 05000302 S PDR	NA

NRC USE ONLY

NAME OF PREPARER D. L. Tomasa PHONE: 904/795-6486

SUPPLEMENTARY INFORMATION

Report No.: 50-302/82-011/03L-0

Facility: Crystal River Unit 3

Report Date: March 17, 1982

Occurrence Date: February 24, 1982

Identification of Occurrence:

Failure of Channel "A", RC flow, to calibrate during Surveillance Procedure SP-112 performance. This created an event not attributed to a specific shutdown activity as required by Regulatory Guide 1.16, and, therefore, contrary to Technical Specification 3.3.1.1.

Conditions Prior to Occurrence:

Mode 5 cold shutdown (0%).

Description of Occurrence:

At 1800, during performance of Surveillance Procedure SP-112, RC flow, Channel "A" was found out of calibration. Maintenance was initiated and operability was restored on February 25, 1982.

Designation of Apparent Cause:

The cause of this event is attributed to the linear voltage differential transformer shorting out.

Analysis of Occurrence:

There was no effect upon the health or safety of the general public.

Corrective Action:

The linear voltage differential transmformer was replaced and the instrument was calibrated per Surveillance Procedure SP-112. No further corrective action is deemed necessary.

Failure Data:

This is the second occurrence for RC flow, Channel "A", and the eleventh report under this Specification.

/rc