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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 0540, on 9-15-82, while performing surveillance on the decay heat
0 3 line B, a valve (DHV-111) failed to control flow as intended. This is
0 4 contrary to the requirements of T.S.3.5.2. Operability was restored at
0 5 1500 on 9-16-82. Decay heat line A was available to provide emergency
0 6 core cooling. There was no effect on public health or safety. This is
0 7 the fifth occurrence for DHV-111 and the twenty-first report under this
0 8 specification.

0 9 | SYSTEM CODE: C F (11) | CAUSE CODE: E (12) | CAUSE SUBCODE: E (13) | COMPONENT CODE: I N S T R U (14) | COMP. SUBCODE: S (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 8 2 | — | SEQUENTIAL REPORT NO.: 0 5 9 | / | OCCURRENCE CODE: 0 3 | REPORT TYPE: L | — | REVISION NO.: 0

ACTION TAKEN: A (18) | FUTURE ACTION: X (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0 0 0 0 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: N (24) | PRIME COMP. SUPPLIER: A (25) | COMPONENT MANUFACTURER: B 0 8 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 This event was caused by an inoperable flow switch. The switch was re-
1 1 placed and calibrated and DHV-111 was functionally tested with satisfac-
1 2 tory results. An engineering evaluation has been initiated to determine
1 3 further corrective action.
1 4

1 5 | FACILITY STATUS: E (28) | % POWER: 0 9 7 (29) | OTHER STATUS (30): N/A | METHOD OF DISCOVERY: B (31) | DISCOVERY DESCRIPTION (32): Routine inspection

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

1 9 | TYPE: Z (42) | DESCRIPTION: N/A

PUBLICITY

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

NAME OF PREPARER P. G. Hughes PHONE (904) 795-6486

SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-059/03L-0

FACILITY: Crystal River Unit #3

REPORT DATE: October 15, 1982

OCCURRENCE DATE: September 15, 1982

IDENTIFICATION OF OCCURRENCE:

The flow path of Decay Heat Line B was found to be inoperable when a valve failed to control the flow as intended. This is contrary to Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode I, Power Operation, (97%).

DESCRIPTION OF OCCURRENCE:

At 0540, on September 15, 1982, while performing surveillance on Decay Heat Line B, a valve (DHV-111) failed to control flow as intended. After performing maintenance, the valve was functionally tested and declared operable at 1500 on September 16, 1982. Decay Heat Line A was available to provide emergency core cooling.

DESIGNATION OF APPARENT CAUSE:

This event was caused by a stuck signal switch.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety.

CORRECTIVE ACTION:

The signal switch was replaced and calibrated and the valve was functionally tested satisfactorily. An Engineering Evaluation has been initiated to determine further corrective action.

FAILURE DATA:

This was the fifth occurrence for DHV-111 and the twenty-first report under this Specification.