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)

01 | FLCRP3 (2) | 00-00000-00 (3) | 4 | 1111 (4) | | (5)
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

CON'T
01 | REPORT SOURCE L (6) | 05000-0302 (7) | 10291 82 (8) | 11 2682 (9)
7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | On October 29, 1982, at 0200, during daily surveillance, it was discovered
03 | that Feedwater Ultrasonic Flow Indicator FW-312-FI was inoperable. This
04 | event causes Train A of Emergency Feedwater to be considered inoperable,
05 | (T.S.3.7.1.2.). Maintenance was initiated, and operability restored
06 | at 0215, on October 29, 1982. Emergency Feedwater operability indication
07 | was available through the Steam Generator Level Indicators. There was
08 | no effect upon public health or safety. This was the second event for
7 8 9 this instrument and the seventeenth report under specification 3.7.1.2. 80

09 | SYSTEM CODE CH (11) | CAUSE CODE E (12) | CAUSE SUBCODE B (13) | COMPONENT CODE INSTRU (14) | COMP. SUBCODE T (15) | VALVE SUBCODE Z (16)
7 8 9 10 11 12 13 18 19 20

(17) LER/RO REPORT NUMBER: EVENT YEAR 82 | — | SEQUENTIAL REPORT NO. 0068 | / | OCCURRENCE CODE 03 | REPORT TYPE L | — | REVISION NO. 0
21 22 23 24 26 27 28 29 30 31 32

ACTION TAKEN A (18) | FUTURE ACTION F (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS (22) 0000 | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER A (25) | COMPONENT MANUFACTURER C626 (26)
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | This instrument failure was caused by insufficient clearance for the
11 | Coaxial Cable in the Transmitter Cabinet. The cable was replaced, and the
12 | Flow Indicator was functionally checked satisfactorily. Long term
13 | corrective action will be replacement with conventional Flow Transmitters.
14 |
7 8 9 80

15 | FACILITY STATUS C (28) | % POWER 000 (29) | OTHER STATUS (30) N/A | METHOD OF DISCOVERY B (31) | DISCOVERY DESCRIPTION (32) Operator observation
7 8 9 10 12 13 44 45 46 80

16 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) N/A | LOCATION OF RELEASE (36) N/A
7 8 9 10 11 44 45 80

17 | PERSONNEL EXPOSURES NUMBER 000 (37) | TYPE Z (38) | DESCRIPTION (39) N/A
7 8 9 11 12 13 80

18 | PERSONNEL INJURIES NUMBER 000 (40) | DESCRIPTION (41) N/A
7 8 9 11 12 80

19 | LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) | DESCRIPTION (43) N/A
7 8 9 10 80

20 | PUBLICITY ISSUED N (44) | DESCRIPTION (45) N/A | NRC USE ONLY
7 8 9 10 68 69 80

NAME OF PREPARER C. G. Brown PHONE: (904) 795-6486

SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-068/03L-0

FACILITY: Crystal River Unit #3

REPORT DATE: November 24, 1982

OCCURRENCE DATE: October 29, 1982

IDENTIFICATION OF OCCURRENCE:

On October 29, 1982, Train A of the Emergency Feedwater System was declared inoperable due to an inoperable Ultrasonic Flow Indicator, FW-312-FI. Operability of this sytem is required by Technical Specification 3.7.1.2.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 3 (HOT STANDBY)

DESCRIPTION OF OCCURRENCE:

At 0200 on October 29, 1982, during daily surveillance, the Feedwater Ultrasonic Flow Indicator, FW-312-FI was declared inoperable. This event causes Train A of the Emergency Feedwater System to be considered inoperable. Maintenance was performed, and operability was restored by 0215, on October 29, 1982.

DESIGNATION OF APPARENT CAUSE:

This event was caused by insufficient clearance for the coaxial cable in the flow transmitter cabinet. Repeated flexing of the cable when the cabinet was opened caused the cable connector to fail.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety. Emergency Feedwater operability indication was available through the Steam Generator Level Indicators.

CORRECTIVE ACTION:

The cable was replaced. The coaxial cable connectors on both Flow Indicators were replaced with 90° connectors to prevent excessive strain on the cable connectors. Long term corrective action will be to replace the transmitters with conventional Flow transmitters as part of the Emergency Feedwater Initiation and Control (EFIC) upgrade.

FAILURE DATA:

This was the second failure of FW-312-FI and the seventeenth report under Technical Specification 3.7.1.2.