

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | F | I | L | I | C | R | P | | 3 | | 0 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | | 3 | | 4 | | 1 | | 1 | | 1 | | 1 | | 4 | | 5 |
7 8 9 14 15 25 26 30 57 CAT 58

CON'T
0 1 | L | 6 | 0 | 5 | 0 | - | 0 | 3 | 0 | 2 | | 7 | | 1 | 0 | 2 | 8 | 8 | 2 | | 8 | | 1 | | 1 | 2 | 6 | 1 | 2 | | 9 |
7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
0 2 | On October 28, 1982, at 2240, during daily surveillance, it was discovered
0 3 | that Feedwater Ultrasonic Flow Indicator, FW-313-FI, was inoperable.
0 4 | This event caused Train B of Emergency Feedwater to be considered
0 5 | inoperable (T.S.3.7.1.2.). Maintenance was initiated, and operability
0 6 | restored at 0030 on October 29, 1982. Emergency Feedwater operability
0 7 | indication was available through Steam Generator Level Indicators. There
0 8 | was no effect upon public health or safety. This was the seventh event
0 9 | for this instrument and the sixteenth report under specification, 3.7.1.2.
7 8 9

0 9 | SYSTEM CODE: C H (11); CAUSE CODE: E (12); CAUSE SUBCODE: G (13); COMPONENT CODE: I N S T R U (14); COMP. SUBCODE: T (15); VALVE SUBCODE: Z (16)
17 | LEF/RO REPORT NUMBER: 8 2 (21); SEQUENTIAL REPORT NO.: 0 6 7 (24); OCCURRENCE CODE: 0 3 (28); REPORT TYPE: L (30); REVISION NO.: 0 (32)
ACTION TAKEN: A (33); FUTURE ACTION: F (34); EFFECT ON PLANT: Z (35); SHUTDOWN METHOD: Z (36); HOURS: 0 0 0 0 (37); ATTACHMENT SUBMITTED: Y (40); NPRD-4 FORM SUB.: N (42); PRIME COMP. SUPPLIER: A (43); COMPONENT MANUFACTURER: C 6 2 6 (44)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
1 0 | This event was caused by a defective Scale Card. The Scale Card was
1 1 | replaced and a functional check was satisfactorily completed. Long
1 2 | term corrective action will be replacement with conventional Flow
1 3 | Transmitters.

1 4 | _____
1 5 | FACILITY STATUS: C (28); % POWER: 0 0 0 (29); OTHER STATUS: N/A (30); METHOD OF DISCOVERY: B (31); DISCOVERY DESCRIPTION: Operator observation (32)
1 6 | ACTIVITY CONTENT: Z (33); AMOUNT OF ACTIVITY: N/A (35); LOCATION OF RELEASE: N/A (36)
1 7 | PERSONNEL EXPOSURES: NUMBER: 0 0 0 (37); TYPE: Z (38); DESCRIPTION: N/A (39)
1 8 | PERSONNEL INJURIES: NUMBER: 0 0 0 (40); DESCRIPTION: N/A (41)
1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE: Z (42); DESCRIPTION: N/A (43)
2 0 | PUBLICITY ISSUED: N (44); DESCRIPTION: N/A (45)

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

SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-067/03L-0
FACILITY: Crystal River Unit #3
REPORT DATE: November 24, 1982
OCCURRENCE DATE: October 28, 1982

IDENTIFICATION OF OCCURRENCE:

On October 28, 1982, it was discovered that the Feedwater Ultrasonic Flow Indicator, FW-313-F1, was inoperable. This event causes Train B of the Emergency Feedwater System to be considered inoperable contrary to Technical Specification 3.3.3.4.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 3 (HOT STANDBY)

DESCRIPTION OF OCCURRENCE:

At 2240 on October 28, 1982, Train B of the Emergency Feedwater System was declared inoperable due to an inoperable Flow Indicator (FW-313-F1). Maintenance was performed, and operability was restored by 0030 on October 29, 1982.

DESIGNATION OF APPARENT CAUSE:

This event was caused by a defective scale card. The most probable cause at this time of the scale card failure is excessive heat in the transmitter cabinet.

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 scale card was replaced and functionally tested satisfactorily. The defective card has been returned to the manufacturer to determine the cause of the failure. Short term corrective action includes moving the transmitter cabinet to a cooler area. Long term corrective action will be replacement of the Ultrasonic indicators with conventional flow transmitters as part of the Emergency Feedwater Initiation and Control (EFIC) upgrade.

FAILURE DATA:

This is the seventh failure for this instrument and the sixteenth report under Technical Specification 3.7.1.2.