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) | 00-000-00 (3) | 4 (4) | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T
01 | REPORT SOURCE | L (6) | 05000302 (7) | 11 14 82 (8) | 12 07 82 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | At 1300, during normal operation, Radiation Monitoring Instrument RM-A5,
03 | Control Room Iodine Channel, was inoperable contrary to T.S. 3.3.3.1.
04 | Control Room Ventilation was placed in recirculation and maintenance
05 | was initiated. Operability was restored on 11-14-82. There was no
06 | effect upon the public health or safety. This is the second event
07 | for this radiation monitor and the eight report under Technical
08 | Specification 3.3.3.1.

09 | SYSTEM CODE: BA (11) | CAUSE CODE: E (12) | CAUSE SUBCODE: F (13) | COMPONENT CODE: INSTRU (14) | COMP. SUBCODE: S (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR 82 | — | SEQUENTIAL REPORT NO. 071 | / | OCCURRENCE CODE 03 | REPORT TYPE L | — | REVISION NO. 0

ACTION TAKEN: A (18) | FUTURE ACTION: Z (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: 1300 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The cause of this event is attributed to a failed rotary selector switch.
11 | The rotary selector switch was replaced and the radiation monitor
12 | functionally checked satisfactorily.
13 |
14 |

15 | FACILITY STATUS: E (28) | % POWER: 097 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Operator Observation

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

PERSONNEL EXPOSURES
17 | NUMBER: 000 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES
18 | NUMBER: 000 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)
19 | TYPE: Z (42) | DESCRIPTION: NA

PUBLICITY
20 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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

SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-071/03L-0

FACILITY: Crystal River Unit #3

REPORT DATE: December 7, 1982

OCCURRENCE DATE: November 14, 1982

IDENTIFICATION OF OCCURRENCE:

Control Room Iodine Activity Monitor, RM-A5, was inoperable. Technical Specification 3.3.3.1. requires that this Radiation Monitoring Instrument be operable in all modes.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 1 (97% Full Power).

DESCRIPTION OF OCCURRENCE:

At 1300, on November 14, 1982, RM-A5 was determined to be inoperable. The Control Room ventilation system was placed in the recirculation mode, and maintenance was initiated. Operability was restored on November 14, 1982.

DESIGNATION OF APPARENT CAUSE:

This failure was caused by a faulty rotary selector switch on the control panel of RM-A5.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety.

CORRECTIVE ACTION:

The switch was replaced, and the radiation monitor was functionally checked satisfactorily.

FAILURE DATA:

This is the second time RM-A5 failed and the eighth report under Technical Specification 3.3.3.1.