UPDATE REPORT - LAST REPORT DATED 9/19/80

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)

Line	Field	Entry
01	Licensee Code (2)	FLCRP3
01	License Number (3)	00-00000-00
01	License Type (4)	41111
01	Cat (5)	
CON'T 01	Report Source (6)	L
01	Docket Number (7)	050-0302
01	Event Date (8)	082780
01	Report Date (9)	060184

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While performing SP-320, Operability of Boron Injection Sources and Pumps,
03 DHV-111, "B" decay heat pump discharge throttle valve, would not control flow
04 in automatic. This created an event contrary to Technical Specification
05 3.5.2. DHV-111 did respond in manual control; decay heat loop "A" provided
06 redundancy. There was no effect upon the general public health or safety.
07 This is the second event of this type and the tenth report under this Speci-
08 fication.

Line	Field	Entry
09	System Code (11)	CF
09	Cause Code (12)	E
09	Cause Subcode (13)	E
09	Component Code (14)	INSTRU
09	Comp. Subcode (15)	C
09	Valve Subcode (16)	Z
(17) LER/RO Report Number	Event Year	80
	Sequential Report No.	036
	Occurrence Code	03
	Report Type	X
	Revision No.	1
	Action Taken (18)	E
	Future Action (19)	X
	Effect on Plant (20)	Z
	Shutdown Method (21)	Z
	Hours (22)	0000
	Attachment Submitted (23)	Y
	NPRD-4 Form Sub. (24)	N
	Prime Comp. Supplier (25)	A
	Component Manufacturer (26)	C680

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause is attributed to water in the sensing line. Operability was re-
11 stored by blowing down the sensing line and performing a functional check. An
12 engineering evaluation has determined the following additional corrective ac- tions to be implemented: (1) replace existing flow switches with electronic
13 controls; (2) change out helical gears in valve actuators.
14

Line	Field	Entry
15	Facility Status (28)	E
15	% Power (29)	080
15	Other Status (30)	N/A
15	Method of Discovery (31)	B
15	Discovery Description (32)	Operator Observation
16	Activity Released (33)	Z
16	Content of Release (34)	Z
16	Amount of Activity (35)	N/A
16	Location of Release (36)	N/A
17	Personnel Exposures Number (37)	000
17	Type (38)	Z
17	Description (39)	N/A
18	Personnel Injuries Number (40)	000
18	Description (41)	N/A
19	Loss of or Damage to Facility (43) Type (42)	Z
19	Description	N/A
20	Publicity Issued (44)	N
20	Description (45)	
	NRC USE ONLY	

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PDR ADOCK 05000302
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NAME OF PREPARER R. H. Thompson PHONE: (904) 795-3802

SUPPLEMENTARY INFORMATION

REPORT NO. : 50-302/80-036/03X-1

FACILITY : Crystal River Unit 3

REPORT DATE : June 1, 1984

OCCURRENCE DATE: August 27, 1980

IDENTIFICATION OF OCCURRENCE:

Failure to have two independent ECCS subsystems operable, contrary to Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1, POWER OPERATION (80%)

DESCRIPTION OF OCCURRENCE:

At 0300, during performance of SP-320, Operability of Boron Injection Sources and Pumps, it was discovered that DHV-111, "B" decay heat pump discharge throttle valve, would not control flow in automatic. DHV-111 did respond in manual control; maintenance actions were initiated.

DESIGNATION OF APPARENT CAUSE:

The cause is attributed to water in the sensing lines.

ANALYSIS OF OCCURRENCE:

There was no effect upon the general public health and safety. Redundancy was maintained by the "A" decay heat loop.

CORRECTIVE ACTION:

The sensing lines were blown down and a functional check was completed. (The lines will be blown down after surveillance checks for three months to determine the extent of a condensation problem.) An engineering evaluation of the control system for DHV-111 and DHV-110 has determined the following additional corrective actions to be implemented:

1. Replace existing flow switches with electronic controls.

2. Change out helical gears in valve actuators.

FAILURE DATA:

This is the second occurrence reported for DHV-111 and the tenth report made under this Specification.