NRC FORM 306 U. S. MUCLEAR REGULATORY COMMISSION (7.77) LICENSEE EVENT REPORT **EXHIBIT A** CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) - 0 0 0 0 0 - 0 0 0 4 CONT LO050-101310120018101618100016101181410 0 1 EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) [6]2 At 0700, while performing SP-340, ECCS Pump Operability, DHV-110, "A" decay [6] heat pump discharge throttle valve, would not control flow in automatic. created an event contrary to T.S. 3.5.2. DHV-110 did respond in manual [control; decay heat loop "B" provided redundancy. There was no effect upon the general public health or safety. This was the sixth occurrence for DHV-110 and the thirteenth event reported under this Specification. 918 SI 0 9 0 0 0 0 N (24) C 6 8 0 3 Z (20) CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause is attributed to air in the controller sensing line. Operability [1] [was restored by venting the sensing line. The sensing lines for DHV-110 and DHV-111 will be vented monthly until permanent corrective action is implement-An engineering evaluation 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 actuator. OTHER STATUS (30) DISCOVERY DESCRIPTION (32) 0101012 B (31) Operator Observation LOCATION OF RELEASE (36) NT OF ACTIVITY (36 N/A now (41) N/A 8406050381 840604 PDR ADOCK 05000302 MAGE TO MAGUTY (4) 1 9 NAC USE ONLY DESCRIPTION (45) N/A (904) 795-3802 R. H. Thompson PHONE: NAME OF PREPARER ...

SUPPLEMENTARY INFORMATION

REPORT NO. : 50-302/80-058/03X-1

FACILITY : Crystal River Unit 3

REPORT DATE : June 1, 1984

OCCURRENCE DATE: August 6, 1980

IDENTIFICATION OF OCCURRENCE:

Failure of DHV-110 to control flow in automatic mode contrary to Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 3, HOT STANDBY (0%)

DESCRIPTION OF OCCURRENCE:

At 0700 during performance of SP-340, ECCS Pump Operability, it was discovered that DHV-110, "A" decay heat pump discharge throttle valve, would not control flow in automatic. DHV-110 did respond in manual control; maintenance actions were initiated.

DESIGNATION OF APPARENT CAUSE:

The cause is attributed to air in the sensing line of the controller.

ANALYSIS OF OCCURRENCE:

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

CORRECTIVE ACTION:

The sensing lines were vented and a functional check was completed. An engineering evaluation of the control system for DHV-110 and DHV-111 determined the following additional corrective action to be implemented:

- 1. Replace existing flow switches with electronic controls.
- 2. Change out helical gears in the valve actuators.

FAILURE DATA:

This was the sixth occurrence reported for DHV-110 and the thirteenth event reported under this Specification.