

LICENSEE EVENT REPORT

EXHIBIT A

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

01 | F | L | C | R | P | 3 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 8

01 | L | 6 | 0 | 5 | 0 | - | 0 | 3 | 0 | 2 | 7 | 0 | 7 | 2 | 8 | 8 | 2 | 6 | 0 | 6 | 0 | 1 | 8 | 4 | 8

02 | At 0600, while recirculating the BWST with DHP-1A per SP-320, DHV-110 was
03 | determined inoperable. This is contrary to T.S. 3.5.2. Maintenance was ini-
04 | tiated and operability restored at 1500. Redundancy was provided by "B" LFI
05 | train. There was no effect upon the health and safety of the general public.
06 | This is the tenth occurrence for DHV-110 and the twentieth report under this
07 | Specification.

09 | C | F | X | Z | I | N | S | T | R | U | E | Z | 8 | 2 | 0 | 5 | 1 | 0 | 3 | X | 1 | 1 | X | X | Z | Z | 0 | 0 | 0 | 0 | Y | N | A | B | 0 | 8 | 0

10 | The cause of this event is attributed to air in the DH-43-FIS sensing lines.
11 | The lines were vented and DHV-110 was functionally tested with satisfactory
12 | results. An engineering evaluation has determined the following additional
13 | corrective action to be implemented: (1) replace existing flow switch with
14 | electronic controls; (2) change out helical gears in valve actuator.

15 | E | 0 | 9 | 3 | N/A | B | Operator Observation
16 | Z | Z | N/A
17 | 0 | 0 | 0 | Z | N/A
18 | 0 | 0 | 0 | S | PDR | ADOCK | 05060302 | S | PDR
19 | Z | N/A
20 | N | N/A

SUPPLEMENTARY INFORMATION

REPORT NO. : 50-302/82-051/03X-1

FACILITY : Crystal River Unit 3

REPORT DATE : June 1, 1984

OCCURRENCE DATE: July 28, 1982

IDENTIFICATION OF OCCURRENCE:

DHV-110 was determined inoperable contrary to Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1, POWER OPERATION (93%)

DESCRIPTION OF OCCURRENCE:

At 0600 hours while recirculating the "A" decay heat pump (DHP), DHV-110 was determined inoperable. The decay heat flow indication on the Main Control Board was steady. However, the indication on the Flow Indicating Switch (DH-43-FIS) that regulates DHV-110 was oscillating sufficiently to operate the switches controlling the position of the valve. The control switches for DHV-110 were placed in "Manual" and maintenance was initiated. Operability was restored at 1500 hours on July 28, 1982.

DESIGNATION OF APPARENT CAUSE:

The cause of this event is attributable to air in the sensing lines.

ANALYSIS OF OCCURRENCE:

Backup was provided by the "B" low pressure injection train, therefore, there was no effect on the health or safety of the public.

CORRECTIVE ACTION:

The sensing lines were vented and DHV-110 was functionally tested with satisfactory results. An engineering evaluation of this problem determined the following additional corrective action to be implemented:

1. Replace existing flow switch with electronic controls.
2. Change out helical gears in valve actuator.

FAILURE DATA:

This is the tenth occurrence for DHV-110 and the twentieth report under this Specification.