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)

0 1 | F L C R P 3 (2) | 0 0 - 0 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 (4) | (5)

LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 - 0 3 0 2 (7) | 0 9 1 5 8 2 (8) | 0 6 0 1 8 4 (9)

DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 0540, on September 15, 1982, while performing surveillance on decay heat
0 3 line "B", a valve (DHV-111) failed to control flow as intended. This is con-
0 4 trary to the requirements of T.S. 3.5.2. Operability was restored at 1500 on
0 5 September 16, 1982. Decay heat line "A" was available to provide emergency
0 6 core cooling. There was no effect on public health or safety. This is the
0 7 fifth occurrence for DHV-111 and the twenty-first report under this Specifi-
0 8 cation.

0 9 SYSTEM CODE	C F (11)
CAUSE CODE	E (12)
CAUSE SUBCODE	E (13)
COMPONENT CODE	I N S T R U (14)
COMP. SUBCODE	S (15)
VALVE SUBCODE	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 2	—	0 5 9	/	0 3	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
A (18)	X (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	B 0 8 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 This event was caused by an inoperable flow switch. The switch was replaced
1 1 and calibrated, and DHV-111 was functionally tested with satisfactory re-
1 2 sults. An engineering evaluation has determined the following additional corrective action to be implemented: (1) replace existing flow switch with
1 3 electronic controls; (2) change out helical gears in valve actuator.
1 4

1 5 FACILITY STATUS	F (28)
% POWER	0 9 7 (29)
OTHER STATUS (30)	N/A
METHOD OF DISCOVERY	B (31)
DISCOVERY DESCRIPTION (32)	Routine Inspection

1 6 ACTIVITY RELEASED	Z (33)
CONTENT OF RELEASE	Z (34)
AMOUNT OF ACTIVITY (35)	N/A
LOCATION OF RELEASE (36)	N/A

PERSONNEL EXPOSURES

1 7 NUMBER	0 0 0 (37)
TYPE	Z (38)
DESCRIPTION (39)	N/A

PERSONNEL INJURIES

1 8 NUMBER	0 0 0 (40)
DESCRIPTION (41)	N/A

8406050394 840601
PDR ADOCK 05000302
S PDR

LOSS OF OR DAMAGE TO FACILITY (43)

1 9 TYPE	Z (42)
DESCRIPTION	N/A

PUBLICITY

2 0 ISSUED	N (44)
DESCRIPTION (45)	N/A

NRC USE ONLY

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SUPPLEMENTARY INFORMATION

REPORT NO. : 50-302/82-059/03X-1

FACILITY : Crystal River Unit 3

REPORT DATE : June 1, 1984

OCCURRENCE DATE: September 15, 1982

IDENTIFICATION OF OCCURRENCE:

The flow path of decay heat line "B" was found to be inoperable when a valve failed to control the flow as intended. This is contrary to Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1, Power Operation (97%)

DESCRIPTION OF OCCURRENCE:

At 0540, on September 15, 1982, while performing surveillance on decay heat line "B", a valve (DHV-111) failed to control flow as intended. After performing maintenance, the valve was functionally tested and declared operable at 1500 on September 16, 1982. Decay heat line "A" was available to provide emergency core cooling.

DESIGNATION OF APPARENT CAUSE:

This event was caused by a stuck signal switch.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety.

CORRECTIVE ACTION:

The signal switch was replaced and calibrated, and the valve was functionally tested satisfactorily. An engineering evaluation 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 was the fifth occurrence for DHV-111 and the twenty-first report under this Specification.