

LICENSEE EVENT REPORT

EXHIBIT A

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

01 F L Q R P 3 0 0 - 0 0 0 0 0 - 0 0 4 1 1 1 1 4 - - 5
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CONT

01 REPORT SOURCE L G 0 5 0 - 0 3 0 2 0 8 1 4 7 9 5 0 9 0 4 7 9 9
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 At 1000 in Mode 1, it was determined that the Containment Gas Chromatograph
03 could not be calibrated. This created an event contrary to Tech. Spec. 3.6.4.1
04 and a thirty (30) day action statement was implemented. No effect upon the
05 plant or general public as a redundant containment hydrogen analyzer was avail-
06 able and operable. Fourth occurrence of this event as reported by LER's
07 77-72 and 79; and 78-47.
08
09

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE
P B E E I N S T R U E Z
10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 LER NO REPORT NUMBER 7 9 0 7 6 0 3 L 0
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATT. SUBMITTED NRC FORM 365 REVISED SUPPLIER COMPONENT MANUFACTURER
X A Z Z 0 0 0 0 Y N N F 1 4 1 1
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of this event was due to internal failure of the thermo-conductivity
11 detector. A spare analyzer was used to return the unit to operational status
12 at 0355, on 17 August 1979. The detector for the Fisher Hamilton model 29
13 gas chromatograph was renewed, satisfactorily tested and returned to
14 service on 28 August 1979.
15
16

15 FACILITY STATUS N POWER OTHER STATUS METHOD OF DISCOVERY
E 1 0 0 NA B Technician observation
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

16 ACTIVITY RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE
Z Z NA NA
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
0 0 Z NA
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

18 PERSONNEL INJURIES NUMBER TYPE DESCRIPTION
0 0 NA
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

19 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
Z NA
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 ISSUED DESCRIPTION NA
21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NAME OF PREPARER J. Cooper, Jr.

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(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

3323507909110430

Supplementary Information

Report No.: 50-302/79-076/03L-0

Facility: Crystal River Unit #3

Report Date: 4 September, 1979

Occurrence Date: 14 August 1979

Identification of Occurrence: Containment gas chromatograph inoperable contrary to Technical Specification 3.6.4.1.

Conditions Prior to Occurrence: Mode 1, power operation (100%)

Description of Occurrence: At 1000, it was determined by Chemistry/Radiation lab techs that the Containment gas chromatograph could not be calibrated in accordance with Chemistry Procedure Ch-120-L, Fisher Hamilton Model 29 gas partitioner. This created an event contrary to Technical Specification 3.6.4.1 and entry into a thirty (30) day action statement was implemented. Investigation revealed that the thermo-conductivity detector had failed. A spare analyzer was interconnected with the chromatograph and the unit was returned to operational status at 0355 on 17 August 1979.

Designation of Apparent Cause: The cause of this event can be attributed to internal failure of the thermo-conductivity detector.

Analysis of Occurrence: No effect upon the plant or general public as a containment hydrogen analyzer was available and operable.

Corrective Action: The thermo-conductivity detector for the Fisher Hamilton Model 29 gas chromatograph was renewed, satisfactorily tested and returned to service on 28 August 1979.

Failure Data: This is the fourth occurrence of this event as reported by LER's 77-72 and 79, and 78-47.