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 2 2 3 7 9 (8) | 0 3 1 2 7 9 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 0100, while performing daily Operating Surveillance SP-300, it was dis-
0 3 covered that the heat trace recorder (HTRT-5), for the concentrated boric
0 4 acid flowpath, was malfunctioning and was rendered inoperable. This created
0 5 an event contrary to Technical Specification 3.1.2.2.a. Entered 72 hour
0 6 action statement "A". No hazard to the plant or general public as a flow-
0 7 path from the borated water storage tank was available and operable.
0 8 First occurrence of the heat trace system reported.

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

(17) LER RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO
	7 9	—	0 1 7	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB	PRIME COMP SUPPLIER	COMPONENT MANUFACTURER
A (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	L 1 3 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event is attributed to a failed recorder drive wheel. The
1 1 drive wheel was replaced and the heat trace recorder was returned to ser-
1 2 vice. Exited the action statement at 1500. No further corrective action
1 3 is required.
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 9 8 (29)	NA	B (31)	Operator observation

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

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

NAME OF PREPARER J. Cooper, Jr. PHONE (904) 795-6486

(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

7903230/51

SUPPLEMENTARY INFORMATION

Report No.: 50-302/79-017/03L-0

Facility: Crystal River Unit #3

Report Date: 12 March 1979

Occurrence Date: 23 February 1979

Identification of Occurrence:

One boron injection flowpath inoperable contrary to Technical Specification 3.1.2.2.a.

Conditions Prior to Occurrence:

Mode 1 power operation (98%)

Description of Occurrence:

At 0100, while performing daily Operating Surveillance SP-300, it was discovered that heat trace recorder 5 was malfunctioning. Heat trace recorder 5 monitors the concentrated boric acid flowpath. Further investigation revealed that the drive wheel had failed. Maintenance restored operability and the recorder was returned to service at 1500.

Designation of Apparent Cause:

The cause of this event is attributed to a failed recorder drive wheel.

Analysis of Occurrence:

No effect on the plant or general public as an alternate flowpath from borated water storage tank was available and operable.

Corrective Action:

The recorder drive wheel assembly was replaced. No further corrective action required.

Failure Data:

First occurrence of the heat trace system reported.

/rc