

UPDATED REPORT

PREVIOUS REPORT DATED 01/28/83

NRC FORM 368  
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: 1 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 F L C R P 3 00 0 0 - 0 0 0 0 0 0 - 0 0 03 4 1 1 1 1 04   05  

LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 31 CAT 58

CON'T

01 L 02 0 5 0 - 0 3 0 2 07 1 2 3 1 8 2 08 0 7 2 6 8 3 09  

REPORT SOURCE 80 81 DOCKET NUMBER 88 89 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 At 0030 on December 31, 1982, the circuit breaker for DHV-6 was found de-

03 energized. This caused loop "B" of the Low Pressure Injection System to be

04 inoperable (T.S. 3.5.2). Research has indicated that DHV-6 was verified as

05 operable just prior to changing from Mode 2 to 1 at 1700 on December 30,

06 1982. This is the first failure for DHV-6 and the twenty-second report

07 under T.S. 3.5.2.

08  

09  

SYSTEM CODE S F 11 CAUSE CODE A 12 CAUSE SUBCODE C 13 COMPONENT CODE C K T B R K 14 COMP. SUBCODE A 15 VALVE SUBCODE Z 16

17 LER/RO REPORT NUMBER 8 2 21 EVENT YEAR 8 2 22 SEQUENTIAL REPORT NO. 0 7 7 24 OCCURRENCE CODE 0 3 29 REPORT TYPE L 30 REVISION NO. 1 32

ACTION TAKEN E 18 FUTURE ACTION Z 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0 0 0 0 22 ATTACHMENT SUBMITTED Y 23 NPD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER A 25 COMPONENT MANUFACTURER A 1 6 0 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 This event was caused by personnel error. Maintenance Personnel working

11 near the breaker accidentally opened the breaker. The breaker was closed

12 immediately following discovery. Subsequent Engineering investigation re-

13 sulted in marking off the areas around Motor Control Centers to reduce re-

14 currence. This revision documents corrective action taken as a result of

15 Engineering investigation.

16  

FACILITY STATUS F 28 % POWER 0 0 6 29 OTHER STATUS N/A 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Observation 32

16 Z 33 ACTIVITY CONTENT Z 34 AMOUNT OF ACTIVITY N/A 35 LOCATION OF RELEASE N/A 36

17 0 0 0 37 PERSONNEL EXPOSURES NUMBER Z 38 DESCRIPTION N/A 39

18 0 0 0 40 PERSONNEL INJURIES NUMBER   41 DESCRIPTION N/A 42

19 Z 42 LOSS OF OR DAMAGE TO FACILITY TYPE   43 DESCRIPTION N/A 44

20 N 44 PUBLICITY ISSUED N 45 DESCRIPTION N/A 46

NAME OF PREPARER R. H. Thompson PHONE: (813) 866-5151

## SUPPLEMENTARY INFORMATION

REPORT NO.: 50-302/82-077/03L-1  
FACILITY: Crystal River Unit 3  
REPORT DATE: July 26, 1983  
EVENT DATE: December 31, 1982

### IDENTIFICATION OF OCCURRENCE:

At 0030 on December 31, 1982, loop "B" of the Low Pressure Injection (LPI) System was inoperable. Two LPI loops are required to be operable by Technical Specification 3.5.2.

### CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 (06% Full Power)

### DESCRIPTION OF OCCURRENCE:

At 0030 on December 31, 1982, the circuit breaker for DHV-6 was found de-energized. This caused loop "B" of the LPI system to be inoperable (T.S. 3.5.2). DHV-6 was returned to service immediately following discovery.

### DESIGNATION OF APPARENT CAUSE:

This event was caused by personnel error. Maintenance Personnel, working near the breaker, apparently accidentally opened the breaker.

### ANALYSIS OF OCCURRENCE:

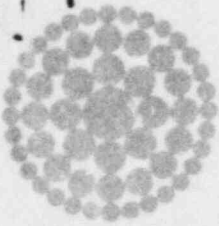
Loop "A" of the LPI system was available for emergency core cooling. Research has indicated that DHV-6 was verified as operable just prior to changing from Mode 2 to Mode 1 at 1700 on December 30, 1982. In addition, loop "B" had been removed from service for maintenance from 2235 on December 30, 1982 until 1805 on December 31, 1982. Thus, loop "B" of the LPI system was inoperable due to DHV-6 inoperability for no more than six hours. DHV-6 was capable of performing its intended function following Operator action to close the breaker. There was no effect on public health or safety.

### CORRECTIVE ACTION:

The breaker was closed immediately following discovery. An Engineering investigation was conducted and resulted in marking off the area around Motor Control Centers in order to prevent a recurrence.

### FAILURE DATA:

This is the first failure for DHV-6 and the twenty-second report under Technical Specification 3.5.2.



USNRC REGION II  
ATLANTA, GEORGIA

83 JUL 29 49:00

**Florida  
Power**  
CORPORATION

July 26, 1983  
3F-0783-23

Mr. James P. O'Reilly  
Regional Administrator, Region II  
Office of Inspection & Enforcement  
U.S. Nuclear Regulatory Commission  
101 Marietta Street N.W., Suite 2900  
Atlanta, GA 30303

Subject: Crystal River Unit 3  
Docket No. 50-302  
Operating License No. DPR-72  
Licensee Event Report No. 82-077

Dear Mr. O'Reilly:

Enclosed is Licensee Event Report No. 82-077 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9.b. This report supplies supplementary information to our initial report dated January 28, 1983.

Should there be any questions, please contact this office.

Sincerely,

G. R. Westafer  
Manager  
Nuclear Licensing and Fuel Management

AEF:mm

Enclosure

cc: Document Control Desk  
U. S. Nuclear Regulatory Commission  
Washington, D.C. 20555

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