

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK:

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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 F I L C R I P 3 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 1 1 4 5 7 C A T 6 8 5

7 8 9 14 15 25 26 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 68

CON'T

REPORT SOURCE: 01
DOCKET NUMBER: 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80
0 1 0 5 0 1 - 0 3 0 0 2 7 1 1 2 5 8 3 8 1 2 2 7 8 3 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | During the period between November 25, 1983 and December 8, 1983, a multi-
03 | point recorder for the post-accident monitoring system was inoperable on
04 | four occasions. Attachment 1 represents the details of the occurrences.
05 | There were redundant indicators and/or recorders available during the
06 | time recorders were inoperable. This is the fourteenth report under
07 | Technical Specification 3.3.3.6.

08		9		80	
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE	
I E (11)		X (12)		Z (13)	
COMP. SUBCODE		VALVE SUBCODE		SEQUENTIAL REPORT NO.	
R (15)		Z (16)		0 1 5 1 9 (26)	
EVENT YEAR		SHUTDOWN METHOD		HOURS (22)	
1 8 1 3 (21 22)		Z (21)		0 0 0 0 (40)	
ACTION TAKEN		FUTURE ACTION		ATTACHMENT SUBMITTED	
D (16) G (19)		Z (19)		Y (23)	
EFFECT ON PLANT		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
Z (20)		A (25)		L 1 3 0 (26)	
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)					

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | A summary of the above events and their apparent causes are presented
1 1 | in Attachment 1. The immediate corrective action for each failure is
1 2 | included in Attachment 1. The long term corrective action is to place
1 3 | the instrumentation involved on a Preventive Maintenance Program to
1 4 | prevent recurrence.

FACILITY STATUS			POWER			OTHER STATUS			METHOD OF DISCOVERY			DISCOVERY DESCRIPTION			
1	5	E	28	1	0	0	29	N/A			1	31	Operator Observation		
7	8	9		10	11	12		13	14	15		16	17	18	
ACTIVITY CONTENT			AMOUNT OF ACTIVITY						LOCATION OF RELEASE						
RELEASED OF RELEASE															
1	6	Z	33	Z	34	N/A			N/A						
7	8	9		10	11	12		13	14	15		16	17	18	
PERSONNEL EXPOSURES			NUMBER			TYPE			DESCRIPTION						
1	7	0	37	0	38	N/A									
7	8	9		10	11	12		13	14	15		16	17	18	
PERSONNEL INJURIES			NUMBER			DESCRIPTION									
1	8	0	40	N/A											
7	8	9		10	11	12		13	14	15		16	17	18	
LOSS OF OR DAMAGE TO FACILITY			TYPE			DESCRIPTION									
1	9	Z	42	N/A											
7	8	9		10	11	12		13	14	15		16	17	18	
PUBLICITY			ISSUED			DESCRIPTION						NRC USE ONLY			
2	0	N	44	N/A											
7	8	9		10	11	12		13	14	15		16	17	18	

NRC USE ONLY

NAME OF PREPARER R. E. Carbeiner

PHONE: 795-3802

8401040143 831227
PDR ADOCK 05000302
S PDR

SUPPLEMENTARY INFORMATION

REPORT NO.: 50-302/83-059/03L-0

FACILITY: Crystal River Unit 3

REPORT DATE: December 27, 1983

DATE OF OCCURRENCE: November 25, 1983

IDENTIFICATION OF OCCURRENCE:

A multi-point recorder for Post-Accident Monitoring Instrumentation was not operable as required by Technical Specification 3.3.3.6.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 (100% Full Power).

DESCRIPTION OF OCCURRENCE:

During the period between November 25, 1983 and December 8, 1983, a multi-point recorder for the post-accident monitoring system was inoperable on four occasions. Attachment I presents the details of the occurrence.

DESIGNATION OF APPARENT CAUSE:

A summary of the above events and their apparent causes are presented in Attachment I. The root cause of most of the failures was an apparently inadequate preventive maintenance program for this recorder.

ANALYSIS OF OCCURRENCE:

There were redundant systems available with the appropriate indications during the time the recorder was inoperable. In addition, recorded values are available for certain of the parameters.

CORRECTIVE ACTION:

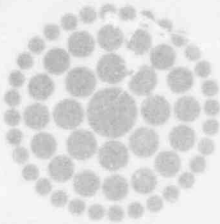
The immediate corrective action for each failure is included in Attachment I. The long term corrective action is to place the instrumentation involved on an upgraded preventive maintenance program to prevent recurrence.

FAILURE DATA:

This is the fourteenth report under Technical Specification 3.3.3.6.

ATTACHMENT 1
CRYSTAL RIVER UNIT 3
LER 83-059

Failure Number	Failure Action Entered Date/Approx. Time	Repaired Action Exited Date/Approx. Time	Apparent Cause	Corrective Action
1.	11/25/83 /2100	11/26/83 /0530	Inadequate Procedure. Poor state of repair.	Cleaned and Repaired Recorder. Unit placed on PM Pro- gram.
2.	11/27/83 /2000	11/28/83 /1500	Input wire shorted while performing maintenance.	Repaired shorted condition. Unit placed on PM Program.
3.	12/06/83 /1100	12/06/83 /2150	Inadequate Procedure. Worn slip clutch.	Repaired recorder. Unit placed on PM Program.
4.	12/08/83 /1730	12/08/83 /2240	Inadequate Procedure. Worn Bushing.	Repaired recorder. Unit placed on PM Program.



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**Florida
Power**
CORPORATION

December 27, 1983
3F1283-27

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. 83-059

Dear Mr. O'Reilly:

Enclosed is Licensee Event Report No. 83-059 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9(b).

Sincerely,

P. Y. Baynard
P. Y. Baynard
Assistant to Vice President
Nuclear Operations

RMB/feb

Enclosure

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

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