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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 At 1551 on November 3, 1983 while performing maintenance on the 120 VAC
0 3 Vital Bus Transfer Switch (VBXS-1A), a fuse was blown rendering Inverter
0 4 3A inoperable. The Vital Bus then switched to the backup power supply
0 5 as designed. The Inverter was repaired, tested, and returned to service
0 6 at 1115 on November 10, 1983. The alternate power source to "A" Vital
0 7 Bus was available and Buses B,C and D were operating from normal power
0 8 supplies. This is the 3rd failure of Inverter 3A and the 6th report under T.S.3.8.2.1.

SYSTEM CODE	E B ⑪
CAUSE CODE	A ⑫
CAUSE SUBCODE	C ⑬
COMPONENT CODE	G E N E R A ⑭
COMP. SUBCODE	F ⑮
VALVE SUBCODE	E ⑯
LER/RO REPORT NUMBER ⑰ — EVENT YEAR	8 3
SEQUENTIAL REPORT NO.	0 5 8
OCCURRENCE CODE	0 3
REPORT TYPE	L
REVISION NO.	0
ACTION TAKEN	A ⑱
FUTURE ACTION	H ⑲
EFFECT ON PLANT	Z ⑳
SHUTDOWN METHOD	Z ㉑
HOURS ㉒	0 0 0 0
ATTACHMENT SUBMITTED	Y ㉓
NPRD-4 FORM SUB.	N ㉔
PRIME COMP. SUPPLIER	A ㉕
COMPONENT MANUFACTURER	S 2 5 0 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

1 0 The failure of Inverter "A" was due to a blown fuse caused by maintenance
1 1 personnel inadvertently shorting out a lamp base. The Inverter was re-
1 2 paired, tested, and returned to service. The responsible personnel will
1 3 be reinstructed on proper operation and maintenance of the Vital Bus
1 4 Transfer Switches.

1 5 FACILITY STATUS	E ㉘
% POWER	0 9 7 ㉙
OTHER STATUS ㉚	N/A
METHOD OF DISCOVERY	A ㉛
DISCOVERY DESCRIPTION ㉜	Operator Observation
1 6 ACTIVITY RELEASED	Z ㉝
CONTENT OF RELEASE	Z ㉞
AMOUNT OF ACTIVITY ㉟	N/A
LOCATION OF RELEASE ㊱	N/A
1 7 PERSONNEL EXPOSURES NUMBER	0 0 0 ㊲
TYPE	Z ㊳
DESCRIPTION ㊴	N/A
1 8 PERSONNEL INJURIES NUMBER	0 0 0 ㊵
DESCRIPTION ㊶	N/A
1 9 LOSS OF OR DAMAGE TO FACILITY TYPE	Z ㊷
DESCRIPTION ㊸	N/A
2 0 PUBLICITY ISSUED	N ㊹
DESCRIPTION ㊺	N/A
NRC USE ONLY	

NAME OF PREPARER R. E. Carbiener PHONE: 795-3802

IE22S

8401040314 831222
PDR ADOCK 05000302
S PDR

SUPPLEMENTARY INFORMATION

REPORT NO.: 50-302/83-058/03L-0

FACILITY: Crystal River Unit 3

REPORT DATE: December 22, 1983

DATE OF OCCURRENCE: November 3, 1983

IDENTIFICATION OF OCCURRENCE:

The 120 VAC Vital Bus #3A was operable. However, it was not energized from normal sources of power as required by Technical Specification 3.8.2.1.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 (97.7% Full Power).

DESCRIPTION OF OCCURRENCE:

At 1551 on November 3, 1983 while performing maintenance on the 120 VAC Vital Bus Transfer Switch (VBXS-1A), a fuse was blown rendering Inverter "3A" inoperable. The Vital Bus then switched to the backup power supply as designed. The Inverter was repaired, tested, and returned to service at 1115 on November 10, 1983.

DESIGNATION OF APPARENT CAUSE:

Maintenance personnel inadvertently short circuited a lamp base in Inverter "A" causing a fuse to blow.

ANALYSIS OF OCCURRENCE:

The alternate power source to "A" Vital Bus was available and Buses B, C, and D were operating from normal power supplies.

CORRECTIVE ACTION:

The Inverter was repaired, tested, and returned to service. Responsible personnel will be reinstructed on proper operation and maintenance of the Vital Bus Transfer Switches.

FAILURE DATA:

This is the third failure of Inverter "3A" and the sixth report under Technical Specification 3.8.2.1.

Florida Power
CORPORATION

83 DEC 29 A8:59

December 22, 1983
3F1283-35

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. 83-058

Dear Mr. O'Reilly:

Enclosed is Licensee Event Report No. 83-058 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.9(c). This report has been delayed beyond the required 30 day interval from date of occurrence because of a misinterpretation of the reportability on this item. The nature of the inverter failure caused the vital bus to automatically switch to its alternate AC power supply. This power source was presumed at the time to be a normal power source. On November 25, 1983, the reportability of this incident was re-assessed and determined to be reportable because the alternate AC power supply did not meet the requirement of being the normal power source.

Sincerely,

Patsy Y. Baynard

P. Y. Baynard
Assistant to Vice President
Nuclear Operations

WEK/feb

Enclosure

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

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