

UPDATE REPORT - LAST REPORT DATED 7/9/82

NRC FORM 386
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

EXHIBIT A

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

01 F L C R P 3 2 0 0 - 0 0 0 0 0 0 - 0 0 3 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
 LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT

CONT
 01 L 6 0 5 0 - 0 3 0 2 7 0 6 0 8 8 2 8 0 6 0 1 8 4 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
 REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
 02 At 2100, while verifying operability of boron injection sources and pumps
 03 (SP-320), DHV-111 failed to control flow, contrary to T.S. 3.5.2. This same
 04 event occurred on June 22, 1982. Redundancy was provided by the "A" decay
 05 heat train in both cases. Maintenance was initiated and operability restored
 06 on June 8, 1982 and June 23, 1982, respectively. There was no effect upon
 07 the health of the general public. This was the third and fourth occurrences
 08 for DHV-111 and the nineteenth report under this Specification.
 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

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
 C F 11 X 12 Z 13 I N S I T R U 14 C 15 Z 16
 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

17 LER/RO REPORT NUMBER EVENT YEAR
 8 2
 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

18 ACTION TAKEN 19 FUTURE ACTION 20 EFFECT ON PLANT 21 SHUTDOWN METHOD 22 HOURS 23 ATTACHMENT SUBMITTED 24 NRC-4 FORM SUB. 25 PRIME COMP. SUPPLIER 26 COMPONENT MANUFACTURER
 E X Z Z 0 0 0 0 Y N A B 0 8 0
 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
 10 The cause of these events is attributed to a stuck high flow switch. The
 11 switch was exercised, calibrated, and functionally tested satisfactorily. An
 12 engineering evaluation has determined the following additional corrective
 13 action to be implemented: (1) replace existing flow switch with electronic
 14 controls; (2) change out helical gears in valve actuator.
 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

15 FACILITY STATUS 16 % POWER 17 OTHER STATUS 18 METHOD OF DISCOVERY 19 DISCOVERY DESCRIPTION 20
 E 28 0 9 0 29 N/A B 31 Operator Observation
 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

16 ACTIVITY RELEASED 17 CONTENT 18 AMOUNT OF ACTIVITY 19 LOCATION OF RELEASE 20
 Z 33 Z 34 N/A N/A
 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

17 PERSONNEL EXPOSURES 18 TYPE 19 DESCRIPTION 20
 0 0 0 37 Z 38 N/A
 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

18 PERSONNEL INJURIES 19 DESCRIPTION 20
 0 0 0 40
 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

19 LOSS OF OR DAMAGE TO FACILITY 20 TYPE 21 DESCRIPTION 22
 Z 42
 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

20 PUBLICITY 21 DESCRIPTION 22
 N 44 N/A
 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

NAME OF PREPARED R. H. Thompson PHONE: (904) 795-3802

SUPPLEMENTARY INFORMATION

REPORT NO. : 50-302/82-041/03X-1

FACILITY : Crystal River Unit 3

REPORT DATE : June 1, 1984

OCCURRENCE DATE: June 8, 1982

IDENTIFICATION OF OCCURRENCE:

On two occasions the decay heat pump discharge throttle valve would not control flow in automatic, contrary to Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1, POWER OPERATION (90%)

DESCRIPTION OF OCCURRENCE:

At 210C, while performing SP-320, Operability of Boron Injection Sources and Pumps, the decay heat pump discharge throttle valve, DHV-111, would not control flow in automatic. This same event occurred June 22, 1982. Maintenance was initiated and operability restored on June 8 and 23, 1982, respectively.

DESIGNATION OF APPARENT CAUSE:

The cause of these events is attributed to a stuck high flow control switch.

ANALYSIS OF OCCURRENCE:

Redundancy was provided by Engineered Safeguard Subsystem "A". There was no effect upon the health or safety of the general public.

CORRECTIVE ACTION:

The flow control switch was exercised, calibrated, and functionally tested satisfactorily. An engineering evaluation determined the following additional corrective action to be implemented:

1. Replace existing flow switch with electronic controls.
2. Change out helical gears in valve actuator.

FAILURE DATA:

This is the third and fourth occurrences for this valve and the nineteenth report under this Specification.