

NRC FORM 388
(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	3	4	1	1	1	1	4	5
LICENSEE CODE						LICENSE NUMBER						LICENSE TYPE						CAT								

CONT

01	L	8	0	5	0	-	0	3	0	2	7	0	9	1	5	8	2	8	0	6	0	1	8	4	9
REPORT SOURCE						DOCKET NUMBER						EVENT DATE						REPORT DATE							

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

At 0540, on September 15, 1982, while performing surveillance on decay heat line "B", a valve (DHV-111) failed to control flow as intended. This is contrary to the requirements of T.S. 3.5.2. Operability was restored at 1500 on September 16, 1982. Decay heat line "A" was available to provide emergency core cooling. There was no effect on public health or safety. This is the fifth occurrence for DHV-111 and the twenty-first report under this Specification.

09	C	F	11	E	12	E	13	I	N	S	T	R	U	14	S	15	Z	16				
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE										
17	8	2	0	5	9	0	3	X	1													
LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE COO		REPORT TYPE		REVISION NO.												
18	X	19	Z	20	Z	21	0	0	0	0	22	Y	23	N	24	A	25	B	0	8	0	26
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER						

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

This event was caused by an inoperable flow switch. The switch was replaced and calibrated, and DHV-111 was functionally tested with satisfactory results. An engineering evaluation has 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.

15	F	28	0	9	7	29	N/A	30	B	31	Routine Inspection	32
FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION				
16	Z	33	Z	34	N/A	35	N/A	36	N/A			
ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE						
17	0	0	0	37	Z	38	N/A	39				
PERSONNEL EXPOSURES NUMBER		TYPE		DESCRIPTION								
18	0	0	0	40		41		42				
PERSONNEL INJURIES NUMBER		DESCRIPTION										
19	Z	42		43		44		45				
LOSS OF OR DAMAGE TO FACILITY TYPE		DESCRIPTION		PUBLICITY		ISSUED		DESCRIPTION				
20	N	44		45	N/A	46		47				
PUBLICITY		ISSUED		DESCRIPTION		NRC USE ONLY						

NAME OF PREPARER R. H. Thompson

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SUPPLEMENTARY INFORMATION

REPORT NO. : 50-302/82-059/03X-1

FACILITY : Crystal River Unit 3

REPORT DATE : June 1, 1984

OCCURRENCE DATE: September 15, 1982

IDENTIFICATION OF OCCURRENCE:

The flow path of decay heat line "B" was found to be inoperable when a valve failed to control the flow as intended. This is contrary to Technical Specification 3.5.2.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1, Power Operation (97%)

DESCRIPTION OF OCCURRENCE:

At 0540, on September 15, 1982, while performing surveillance on decay heat line "B", a valve (DHV-111) failed to control flow as intended. After performing maintenance, the valve was functionally tested and declared operable at 1500 on September 16, 1982. Decay heat line "A" was available to provide emergency core cooling.

DESIGNATION OF APPARENT CAUSE:

This event was caused by a stuck signal switch.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety.

CORRECTIVE ACTION:

The signal switch was replaced and calibrated, and the valve was 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 was the fifth occurrence for DHV-111 and the twenty-first report under this Specification.