

NRC FORM 365  
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

## LICENSEE EVENT REPORT

EXHIBIT A

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

01 F I L C R P 3 2 0 0 1 0 0 1 0 0 0 0 0 3 4 1 1 1 1 4 5

LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 31 CAT 34

CON'T

01 L 6 0 5 0 0 0 3 0 2 7 1 2 1 9 8 3 0 4 2 4 8 5 9

REPORT SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 During a routine walkdown of the Control Room at 2200 on December 19, 1983

03 the Reactor Building Radiation Monitor (RM-A6) was indicating a low flow

04 alarm. The alarm printed out at 1708; however, no audible annunciator was

05 received. The alarm was investigated and RM-A6 was returned to operation

06 at 2253, December 19, 1983. This is the third event of this type and the

07 thirteenth report under T. S. 3.4.6.1.

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SYSTEM CODE B A 11 CAUSE CODE E 12 CAUSE SUBCODE A 13 COMPONENT CODE I N S T R U 14 COMP. SUBCODE I 15 VALVE SUBCODE Z 16

LER/RO REPORT NUMBER 8 3 17 EVENT YEAR 8 3 SEQUENTIAL REPORT NO. 0 6 4 OCCURRENCE CODE 0 3 18 REPORT TYPE X 19 REVISION NO. 1 20

ACTION TAKEN A 18 FUTURE ACTION Z 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0 0 0 0 22 ATTACHMENT SUBMITTED Y 23 NRPD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER A 25 COMPONENT MANUFACTURER S 1 5 6 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 The cause of this event was a blown lamp in the local indicator for

11 a waste sampling valve, WSV-6. This caused a fuse in breaker 18 of DC

12 Distribution Panel (DPDP-5B) to blow. DPDP-5B supplies control power to

13 WSV-4 and WSV-6, which is the flow path for RM-A6. The fuse and lamp were

14 replaced and the system was returned to service.

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FACILITY STATUS E 28 % POWER 1 0 0 0 29 OTHER STATUS N/A 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Observation 32

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

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

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

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

PUBLICITY ISSUED N 44 DESCRIPTION N/A 45

NAME OF PREPARER D. G. Green PHONE (904) 795-3802

NRC USE ONLY

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PDR ADOCK 05000302  
S PDR

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## SUPPLEMENTARY INFORMATION

REPORT NO.: 50-302/83-064/03X- 1  
FACILITY: Crystal River Unit 3  
REPORT DATE: April 24, 1985  
DATE OF OCCURRENCE: December 19, 1983

### IDENTIFICATION OF OCCURRENCE:

Reactor Building Radiation Monitor (RM-A6) was discovered inoperable contrary to the requirements of Technical Specification 3.4.6.1.

### CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 (100% Full Power)

### DESCRIPTION OF OCCURRENCE:

During a routine walkdown of the Control Room at 2200 on December 19, 1983, the Reactor Building Radiation Monitor (RM-A6) was indicating a low flow alarm. The alarm printed out at 1708, however, no audible annunciator was received and/or acknowledged. The alarm was investigated and RM-A6 was returned to operation at 2253 December 19, 1983.

### DESIGNATION OF APPARENT CAUSE:

The root cause for this event was a blown lamp in the local indicator for waste sampling valve WSV-6. This caused a fuse in Breaker 18 of the DC Distribution Panel (DPDP-5B). These failures affected the control circuits for WSV-4 and WSV-6 (the isolation valves for RM-A6), resulting in reduced flow to RM-A6.

### ANALYSIS OF OCCURRENCE:

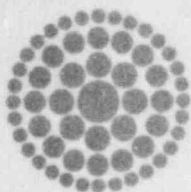
One of three of the Reactor Coolant System (RCS) Leakage Detection Systems (the containment sump level monitoring system), was operable and capable of indicating RCS leakage. A change in RCS leakage could also have been recognized by indications from the makeup tank and pressurizer level instruments.

### CORRECTIVE ACTION:

The fuse and lamp were replaced and the system was returned to service. An engineering investigation was conducted. It was determined, after a review of the control circuitry, that the proper sequence of events had occurred. A loss of power to the respective solenoid valves for WSV-4 and WSV-6 resulted in these valves to fail closed. This valve closure caused the low flow alarm indication. RM-A6 then shut as a result of WSV-4 and WSV-6 failing closed. Modifying the control circuitry to prevent RM-A6 from shutting off when WSV-4 and WSV-6 fail closed could result in damage to RM-A6. Therefore, it was concluded that no further actions should be taken.

### FAILURE DATA

This is the third event of this type and the thirteenth report under Technical Specification 3.4.6.1.



**Florida  
Power**  
CORPORATION

April 24, 1985  
3F0485-14

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

Subject: Crystal River Unit 3  
Docket No. 50-302  
Operating License No. DPR-72  
Licensee Event Report No. 83-064, Revision 1

Dear Sir:

Enclosed is Revision 1 to Licensee Event Report No. 83-064 and the attached supplementary information sheet.

Should there be any questions, please contact this office.

Sincerely,

G. R. Westafer  
Manager, Nuclear Operations  
Licensing and Fuel Management

DGG/feb

Enclosures

cc: Dr. J. Nelson Grace  
Regional Administrator, Region II  
Office of Inspection & Enforcement  
U.S. Nuclear Regulatory Commission  
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Atlanta, GA 30323

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