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 LICENSEE CODE: F L C R P 3 ② LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 ③ LICENSE TYPE: 4 1 1 1 1 ④ CAT: ⑤

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 At 2100 two individuals reported that the outer door of the reactor
0 3 building personnel hatch was inoperable. This is contrary to TS 3.6.1.3.
0 4 Containment closure was maintained by assuring that the inner door
0 5 functioned properly. There was no effect on public health or safety.
0 6 This is the first, occurrence for this door and the second report under
0 7 this specification.
0 8

0 9 SYSTEM CODE: S A ⑪ CAUSE CODE: B ⑫ CAUSE SUBCODE: A ⑬ COMPONENT CODE: P E N E T R ⑭ COMP SUBCODE: A ⑮ VALVE SUBCODE: Z ⑯

⑰ LER/RO REPORT NUMBER: EVENT YEAR: 8 2 — SEQUENTIAL REPORT NO.: 0 5 3 / OCCURRENCE CODE: 0 3 REPORT TYPE: L — REVISION NO.: 0

ACTION TAKEN: A ⑱ FUTURE ACTION: Z 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: C 3 1 0 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

1 0 The cause of this event is attributed to the failure of Cam Roller Bearings
1 1 in the mechanical interlock. The bearings were replaced, and the
1 2 door functionally tested satisfactorily. A modification was completed on
1 3 August 31 to eliminate the problem.
1 4

1 5 FACILITY STATUS: G ㉘ % POWER: 0 0 0 ㉙ OTHER STATUS ㉚: N/A METHOD OF DISCOVERY: A ㉛ DISCOVERY DESCRIPTION ㉜: Notification by personnel

1 6 ACTIVITY RELEASED: Z ㉝ CONTENT OF RELEASE: Z ㉞ AMOUNT OF ACTIVITY ㉟: N/A LOCATION OF RELEASE ㊱: N/A

PERSONNEL EXPOSURES

1 7 NUMBER: 0 0 0 ㊲ TYPE: Z ㊳ DESCRIPTION ㊴: N/A

PERSONNEL INJURIES

1 8 NUMBER: 0 0 0 ㊵ DESCRIPTION ㊶: N/A

LOSS OF OR DAMAGE TO FACILITY ㊸

1 9 TYPE: Z ㊷ DESCRIPTION: N/A

PUBLICITY

2 0 ISSUED: N ㊹ DESCRIPTION ㊺: N/A

NRC USE ONLY

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PDR ADOCK 05000302
PDR
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SUPPLEMENTARY INFORMATION

REPORT NO:	50-302/82-053/03L-0
FACILITY:	Crystal River Unit #3
REPORT DATE:	September 9, 1982
OCCURRENCE DATE:	August 8, 1982

IDENTIFICATION OF OCCURRENCE:

The outer door of the Reactor Building personnel hatch was inoperable, contrary to Technical Specification 3.6.1.3.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 3, (0%).

DESCRIPTION OF OCCURRENCE:

At 2100, it was identified by two individuals that the outer door of the personnel hatch was inoperable (i.e., full closure was not possible). Redundant levels of containment integrity were not achievable. Maintenance was initiated, and the door functionally tested satisfactorily at 0530 on August 9, 1982.

DESIGNATION OF APPARENT CAUSE:

The cause of this event is attributed to the cam roller bearing in the mechanical interlock failing. The failure is apparently due to an inadequate design of the mechanical interlock system.

ANALYSIS OF OCCURRENCE:

Containment closure was maintained by assuring that the inner door functioned properly. There was no effect upon the health and safety of the public.

CORRECTIVE ACTION:

The bearings were replaced to correct the outer door closure problem. A modification was completed on August 31, 1982, to eliminate this type of malfunction.

FAILURE DATA:

This is the first occurrence for the personnel hatch outer door and the second report under this specification.