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) | CAT (5)

LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 - 0 3 0 2 (7) | 0 9 2 7 8 2 (8) | 1 0 2 7 8 2 (9)

DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 In February 1982 monthly surveillance of the containment cooling system
0 3 was not performed as is required by T.S.4.6.2.3.a. This event was iden-
0 4 tified by a QA audit on 9-27-82. There was no effect on public health or
0 5 safety. This is the first time that monthly surveillance required by
0 6 T.S.4.6.2.3.a. was not performed as required.
0 7
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S B (11)	A (12)	A (13)	Z Z Z Z Z Z (14)	(15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	0 6 0	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 This event was caused by personnel error. Personnel were relying on an
1 1 uncontrolled document (control room status board) to determine the sur-
veillance requirements rather than the approved procedures. On 9-27-82
1 2
1 3 personnel were instructed on the importance of using controlled docu-
1 4 ments in daily operations.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	G (28)	0 0 0 (29)	N/A	B (31)	Quality Programs Audit

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	N/A

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	N/A	

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PDR ADOCK 05000302
S PDR

(SEE ATTACHED SUPPLEMENTARY INFORMATION SHEET)

SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-060/03L-0

FACILITY: Crystal River Unit #3

REPORT DATE: October 27, 1982

IDENTIFICATION DATE: September 27, 1982

OCCURRENCE DATE: February 1982

IDENTIFICATION OF OCCURRENCE:

On September 27, 1982, Florida Power Corporation Quality Programs Department reported that no objective evidence existed to show that the containment cooling system monthly surveillance had been completed for Feburary 1982.

CONDITIONS PRIOR TO OCCURRENCE:

Mode V (Cold Shutdown)

DESCRIPTION OF OCCURRENCE:

In February 1982, Technical Specification personnel were verbally informed that the containment cooling system surveillance frequency was being changed from monthly to quarterly. The control room surveillance status board was apparently changed to reflect the anticipated revision. The anticipated revision, however, was never approved or issued, thus the surveillance was not performed in February.

DESIGNATION OF APPARENT CAUSE:

This event was caused by personnel error, failure to follow approved procedures.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety. Containment cooling system surveillance performed in March showed that the system was operable.

CORRECTIVE ACTION:

On September 27, 1982, personnel were instructed on the importance of using approved procedures in daily operations.

FAILURE DATA:

This is the first time that monthly surveillance required by Technical Specification 4.6.2.3.a was not performed as required.