	CONTROL BLOCK:
	[0] Ell C PIP 3 C O O O O O O O O O
	CON'T O 1 REPORT L O O 5 O - O 3 O 2 O 1 O 1 7 8 2 O 1 1 1 6 8 2 O
	[0] 1 On October 17, 1982, at 1315, during an unrelated shutdown, con-
	[0]3] tainment isolation valve DHV-4 could not be operated from the
	[0]4] Control Room and was subsequently determined to be inoperable
	[0]5] [(T.S.3.6.1). Before continuing shutdown operations, DHV-3 and DHV-41 were cycled to assure that the effected penetration could be secured.
	[0]7] L_DHV-4 was returned to operability at 1430. There was no effect on
	public health or safety. This was the first time DHV-4 failed due to
	CODE SUBCODE S
	LERIND EVENT YEAR SEQUENTIAL REPORT NO. 17 REPORT NUMBER 21 22 23 24 26 56 27 27 28 29 30 31 32 24 27 28 29 30 31 32 24 24 27 28 29 30 31 32 24 27 29 28 29 30 31 32 24 27 28 29 29 29 29 29 29 29 29 29 29 29 29 29
	10 This event was caused by a stuck mechanical interlock on DHV-4.
	[1]] The interlock was cleaned and lubricated. DHV-4 was tested satis-
	[1]2] I factorily and returned to service.
	(1)
	1 4 1
	STATUS STATUS
	N/A LOCATION OF RELEASE N/A LOCATION OF RELEASE 3
	TO TO TO TO TO THE DESCRIPTION OF N/A
	1 8 10 0 0 0 0 CESCRIPTION (1) N/A
	TOTAL OF OR DAVAGE TO FACILITY (3) I [9] [7] (4) N/A N/A
	PUBLICITY ISSUED DESIGNATION (S) NAC USE CYLLY NAC USE CYLLY NAC USE CYLLY
	NAME OF PREPARER / Aug (904) 795-3802
PDR S	230449 821116 ADDCK 05000302 PDR

SUPPLEMENTARY INFORMATION

REPORT NO:

50-302/82-065/03L-0

FACILITY:

Crystal River Unit #3

REPORT DATE:

November 16, 1982

OCCURRENCE DATE:

October 17, 1982

IDENTIFICATION OF OCCURRENCE:

Containment isolation valve DHV-4 was inoperable contrary to Technical Specification 3.6.3.1.

CONDITIONS PRIOR TO OCCURRENCE:

MODE 4 (HOT SHUTDOWN)

DESCRIPTION OF OCCURRENCE:

On October 17, 1982, at 1315, during an unrelated shutdown, containment isolation valve DHV-4 could not be operated from the control room and was subsequently determined to be inoperable. DHV-3 and DHV-41 were cycled to assure that the affected penetration could be isolated. DHV-4 was returned to operability by 1430.

DESIGNATION OF APPARENT CAUSE:

This event was caused by a stuck mechanical interlock on DHV-4.

ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety because the penetration could be isolated using DHV-3 and DHV-41.

CORRECTIVE ACTION:

The interlock was cleaned and lubricated. DHV-4 was tested satisfactorily and returned to service.

FAILURE DATA:

This is the first time that DHV-4 failed due to an inoperable switch and is the forty-fourth report under Sepecification 3.6.3.1.