

## EXHIBIT A

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE		COMP. SUBCODE		VALVE SUBCODE	
0	9	S	B	A	A	I	N	S	T	R	U
7	8	9	10	11	12	13	14	15	16	17	18
17		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.	
1		8		0		0		L		0	
21		22		23		24		25		26	
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED	
X	Z	Z		Z		0		0		Y	
33	34	35		36		37		38		39	
NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER		N		A		J	
42		43		44		45		46		47	

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

FACILITY STATUS (1) 5 (E) (28) % POWER (0) 9 (7) (29) n/a OTHER STATUS (30) METHOD OF DISCOVERY (B) (31) operator observation DISCOVERY DESCRIPTION (32)

ACTIVITY CONTENT (1) 6 (Z) (33) (Z) (34) n/a AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

PERSONNEL EXPOSURES									
NUMBER		TYPE		DESCRIPTION					
1	7	0	0	37	2	38	n/a	39	

PERSONNEL INJURIES									
NUMBER						DESCRIPTION			
1	3					(40)	n/a	(41)	

1		9		42		43	
TYPE				DESCRIPTION			
7	8	9	10	n/a			

[illegible]

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## SUPPLEMENTARY INFORMATION

REPORT NO: 50-302/82-061/03L-0

FACILITY: Crystal River Unit #3

REPORT DATE: October 29, 1982

OCCURRENCE DATE: September 29, 1982

### IDENTIFICATION OF OCCURRENCE:

Reactor Building average air temperature exceeded the 130°F limit of Technical Specification 3.6.1.5.

### CONDITIONS PRIOR TO OCCURRENCE:

MODE 1 (97% RATED THERMAL POWER).

### DESCRIPTION OF OCCURRENCE:

On September 29, 1982, water in the instrument air system caused a fan damper operator on the Industrial Cooler to fail. This failure caused a reduction in the amount of cooling air available for the Reactor Building, thus causing the Reactor Building temperature to exceed the 130°F limit. Additional cooling was initiated so that by 0051 the Reactor Building temperature was reduced below the 130°F limit.

### DESIGNATION OF APPARENT CAUSE:

This event was caused by personal error. On September 21, 1982, personnel were using an inappropriate document (flow diagram) to determine the correct position of FSV-250 rather than the approved procedure (OP-207). FSV-250 is the valve isolating Fire Service water from the Instrument Air System. Leaving FSV-250 open allowed water from Fire Service to back up into Instrument Air. Although water was drained from the Instrument Air System and the valve closed, enough water apparently remained in the Instrument Air System to cause the damper operator to fail.

### ANALYSIS OF OCCURRENCE:

There was no effect on public health or safety. Containment temperature was reduced to within the limit within the time frame required by the Action Statement of Specification 3.6.1.5.

### CORRECTIVE ACTION:

Personnel were instructed on the importance of using approved documents and procedures. The dampers were wired open until the system was returned to operability late September 29, 1982. An engineering evaluation has been initiated to determine if further corrective actions are required.

### FAILURE DATA:

This is the eighth time the Reactor Building temperature has exceeded the 130°F limit of Specification 3.6.1.5.