

## EXHIBIT A

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## SUPPLEMENTARY INFORMATION

REPORT NO.: 50-302/83-036/01T-0

FACILITY: Crystal River Unit 3

REPORT DATE: October 5, 1983

OCCURRENCE DATE: September 21, 1983

### IDENTIFICATION OF OCCURRENCE:

Area surveys of the fuel storage pool area were not performed once every twenty-four hours from September 15 through September 21, 1983, as required by Technical Specification 3.3.3.1, Action 14.

### CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 (73% full power)

### DESCRIPTION OF OCCURRENCE:

On September 15, 1983, at 1900, the Spent Fuel Criticality Monitor (RM-G14) was taken out of service to perform maintenance. The operators recorded in the log book that RM-G14 was out-of-service and that the Chemistry and Radiation Protection Department had been informed that, per Specification 3.3.3.1, an area survey of the fuel storage pool area must be performed every 24 hours.

On September 21, 1983, Health Physics personnel discovered, during a review of the departmental log, that the required surveys had not been performed. An area survey was performed immediately with satisfactory results. Daily surveys of the fuel storage pool area were performed until the monitor was returned to service on September 26, 1983.

### DESIGNATION OF APPARENT CAUSE:

This event was caused by personnel error. After responsible personnel were informed of the survey requirement, an entry was made in the departmental log noting the requirement. Personnel failed to inform the oncoming shift, hence oncoming shifts were unaware of the requirement.

### ANALYSIS OF OCCURRENCE:

The primary function of RM-G14 is to provide indication of possible criticality in the fuel storage pool when reactivity changes are being made to the pool (i.e., moving fuel or changing the concentration or location of neutron absorbers in the pool). The secondary function of RM-G14 is to warn the Control Room of possible criticality due to an unanticipated event. The primary function of RM-G14 was not compromised because no changes were made within the pool. If an unanticipated event had occurred within the pool, another monitor (RM-G13) could have alerted the Control Room of inadvertent criticality.

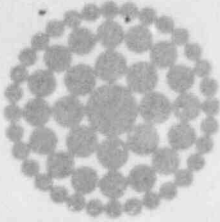
### CORRECTIVE ACTIONS:

On September 21, 1983, a management instruction was issued by the Chemistry and Radiation Protection Department stressing the importance of including information on applicable Technical Specification Action statements in effect during shift turnover.

The Master Surveillance Plan (SP-443) will be revised to ensure that responsible personnel are informed, at least daily, of Action statements in effect.

FAILURE DATA:

This was the first time that personnel failed to perform daily surveys when RM-G14 was out-of-service.



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**Florida  
Power**  
CORPORATION

October 5, 1983  
3F-1083-05

Mr. James P. O'Reilly  
Regional Administrator, Region II  
Office of Inspection & Enforcement  
U.S. Nuclear Regulatory Commission  
101 Marietta Street N.W., Suite 2900  
Atlanta, GA 30303

Subject: Crystal River Unit 3  
Docket No. 50-302  
Operating License No. DPR-72  
Licensee Event Report No. 83-036

Dear Mr. O'Reilly:

Enclosed is Licensee Event Report No. 83-036 and the attached supplementary information sheet, which are submitted in accordance with Technical Specification 6.9.1.8(b).

Should there be any questions, please contact this office.

Sincerely,

W.S. Wilgus  
Vice President  
Nuclear Operations

AEF:jcf

Enclosure

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

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