

APPROVED BY OMB  
3150-0011  
EXPIRES 4-30-82

CONTROL BLOCK:										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)									
<div style="display: flex; justify-content: space-between;"> <span>1</span><span>2</span><span>3</span><span>4</span><span>5</span><span>6</span><span>7</span><span>8</span><span>9</span><span>10</span> </div>																			
<div style="display: flex; justify-content: space-between;"> <span>1</span><span>2</span><span>3</span><span>4</span><span>5</span><span>6</span><span>7</span><span>8</span><span>9</span><span>10</span> </div>										<div style="display: flex; justify-content: space-between;"> <span>11</span><span>12</span><span>13</span><span>14</span><span>15</span><span>16</span><span>17</span><span>18</span><span>19</span><span>20</span> </div>									
CON'T																			
REPORT SOURCE										DOCKET NUMBER									
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES																			
On March 29, 1983 two fire doors were left open and unattended for over one																			
hour. The likelihood of a fire in that specific area in that short time inter-																			
val was low. The area around the doors is frequently traveled by personnel and																			
a fire/smoke there would have been highly visible. Also, the use of any heat																			
producing device/procedure would have required fire prevention measures. The																			
health and safety of the general public were not compromised by this incident.																			
SYSTEM CODE										CAUSE CODE									
A B										A C									
COMPONENT CODE										COMP. SUBCODE									
Z Z Z Z Z Z										Z									
VALVE SUBCODE										Z									
LER/RO REPORT NUMBER										EVENT YEAR									
8 3										—									
ACTION TAKEN										FUTURE ACTION									
X X										Z									
EFFECT ON PLANT										SHUTDOWN METHOD									
Z										Z									
HOURS										ATTACHMENT SUBMITTED									
0 0 0 0										N									
PRIME COMP. SUPPLIER										REVISION NO.									
Z										0									
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS																			
The cause of this occurrence was personnel error. The doors were shut and																			
the personnel involved received appropriate disciplinary actions. Work prac-																			
tices will be changed so that one person is assigned to make sure compliance																			
with station fire regulations is maintained. Certain specific station annual																			
training will later include fire protection.																			
FACILITY STATUS										% POWER									
E										1 0 0									
OTHER STATUS										METHOD OF DISCOVERY									
NA										A									
DISCOVERY DESCRIPTION																			
Operator observation																			
ACTIVITY CONTENT RELEASED OF RELEASE										AMOUNT OF ACTIVITY									
Z										NA									
LOCATION OF RELEASE																			
NA																			
PERSONNEL EXPOSURES NUMBER										TYPE									
0 0 0										Z									
DESCRIPTION																			
NA																			
PERSONNEL INJURIES NUMBER										DESCRIPTION									
0 0 0																			
LOSS OF OR DAMAGE TO FACILITY TYPE										DESCRIPTION									
Z																			
PUBLICITY ISSUED										DESCRIPTION									
N																			
NAME OF PREPARER										PHONE									
Jocelyn C. Petty										(704) 373-8270									

8304220487 830412  
PDR ADCK 05000270  
S PDR