

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 M S G G S 1 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

CON'T

0 1 REPORT SOURCE L 6 0 5 0 0 0 4 1 6 7 0 8 1 0 8 2 8 0 4 1 2 8 3 9
7 8 60 61 DOCKET NUMBER 66 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On August 10, 1982, it was discovered that daily fire door checks were
0 3 not conducted while under an LCO on the days of June 17, 1982, and June
0 4 24, 1982, as required by T.S.4.7.7.2. The event had no effect on the
0 5 health and safety of the public and did not constitute a threat to plant
0 6 safety. The event is reported pursuant to T.S.6.9.1.13.b.
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SYSTEM CAUSE CAUSE COMPONENT COMP VALVE
CODE CODE SUBCODE CODE SUBCODE SUBCODE
0 9 A B 11 A 12 A 13 X X X X X X 14 Z 15 Z 16
7 8 9 10 11 12 13 16 19 20

17 LER NO. REPORT NUMBER 8 2 21 22
EVENT YEAR 8 2 21 22
SEQUENCE REPORT NO. 0 4 6 24 26
OCCURRENCE CODE 0 3 28 29
REPORT TYPE X 30 31
REVISION NO. 1 32 33
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NRPD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
G 18 Z 19 Z 20 Z 21 0 0 0 0 22 Y 23 N 24 A 25 Z 9 9 9 26
32 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Incomplete communication between operating shifts on these days was the
1 1 probable cause. The immediate action was to increase personnel awareness
1 2 of the performance and documentation requirements of the surveillance.
1 3 The midshift (2330-0730 hrs) was verbally designated the resp. shift
1 4 for completing the surveillance. This is submitted as a final report.
7 8 9

1 5 FACILITY STATUS X 28 0 0 0 29 Pre-Core-Load 30 METHOD OF DISCOVERY B 31 Surveillance Review 32 DISCOVERY DESCRIPTION
7 8 9 10 12 13 44 45 46 80

1 6 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35 LOCATION OF RELEASE 36
7 8 9 10 11 44 45 80

1 7 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 39
7 8 9 10 11 12 13 80

1 8 PERSONNEL INJURIES NUMBER DESCRIPTION 41
7 8 9 10 11 12 80

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION 43
7 8 9 10 11 12 80

2 0 PUBLICITY ISSUED DESCRIPTION 45
7 8 9 10 11 12 80

NAME OF PREPARER Ron Byrd

PHONE

NRC USE ONLY

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SUPPLEMENTARY INFORMATION TO
LER 83-046/03 X-1

Mississippi Power & Light Company
Grand Gulf Nuclear Station - Unit 1
Docket No. 50-416

Technical Specification Involved: T.S.4.7.7.2
Reported Under Technical Specification: T.S.6.9.1.13.b

Event Narrative:

This is an update to a previous report submitted on September 8, 1983. The following paragraphs describe the event reported.

Daily fire door checks required by Technical Specification 4.7.7.2 were not conducted on (two days) June 16, 1982 and June 24, 1982.

The checks were conducted on subsequent days up to and including the date of discovery. The probable cause was either inadequate turnover information about the status of the fire door checks between the operating shifts, or loss of the data sheets during routing and screening (prior to storage in the recovery vault).

Operating practices did not ensure adequate completion and retention of the surveillance data sheets.

In lieu of modifying the surveillance procedures, as stated in the previous report, the mid-shift (2330-0730 hours) was verbally designated the responsible shift for completing the surveillance.

The routing of completed data sheets has been modified to reduce the number of people who review and screen them.