Attachment to AECM-82/393

Page 1 of 2
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 3 4 1 1 1 1 1 4 5 6 7 CAT 58
CON'T O 1
0 2 While under a Limiting Condition for Operation imposed by a violation of
0]3 T.S.3.7.7, daily fire door checks were not conducted on the days of June 17, 1982
and June 24, 1982 as required by T.S.4.7.7.2. This is reportable under
0 5 T.S.6.9.1.13.b.
06
0 7
08 1
SYSTEM CODE CODE SUBCODE SUBCO
TO LER/RO EVENT YEAR REPORT NO. CODE TYPE NO.
ACTION FUTURE EFFECT SHUTDOWN TAKEN ACTION ON PLANT METHOD HOURS (22) SUBMITTED FORM SUB. SUPPLIER MANUFACTURER
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) [1] Incomplete communication between operating shifts on these days was the probable
[1] cause. The immediate action was to increase personnel awareness of the performance
and documentation requirements of the surveillance. Long term action has been to
1 3 revise operating practices and surveillance procedures.
14
FACILITY STATUS % POWER OTHER STATUS 30 METHOD OF DISCOVERY DESCRIPTION 32 1 5 X 28 0 0 0 0 29 Pre-Core-Load B 31 Surveillance Review
7 8 9 10 12 13 44 45 46 80 ACTIVITY CONTENT RELEASE OF RELEASE AMOUNT OF ACTIVITY (35) NA LOCATION OF RELEASE (36)
7 8 9 10 11 44 45 80 PERSONNEL EXPOSURES
1 7 0 0 0 37 Z 38 NA NA NA 80
PERSONNEL INITIALIS
NUMBER DESCRIPTION (41) NA
NA NA NUMBER O TO FACILITY (43)
NUMBER DESCRIPTION (41) NA NA NA LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION NA NA
NUMBER DESCRIPTION (41) NA NA LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION NA 80

SUPPLEMENT TO LER NO. 82-046/03 L-0

Licensee: Mississippi Power & Light Company

Facility: Grand Gulf Nuclear Station

Docket No: 05-000416

Daily fire door checks required by Specification 4.7.7.2 were not conducted on (two days) 6-16-82 and 6-24-82. This is reportable under Specification 6.9.1.13.b.

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.

Surveillance procedures have been modified to ensure that personnel of a specified shift are designated to complete the surveillance and that the status of the surveillance is documented from one shift to another shift. The routing of completed data sheets has been modified to reduce the number of people who review and screen them.