

U.S. NUCLEAR REGULATORY COMMISSION  
LICENSEE EVENT REPORT

CONTROL BLOCK:         ①

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | S | C | N | E | E | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 |  |  |  | 5

7 8 9 14 19 25 26 30 37 48

LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

CONT

0 1 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 0 | 2 | 6 | 9 | 7 | 1 | 0 | 1 | 8 | 8 | 2 | 8 | 1 | 1 | 0 | 1 | 8 | 2 | 9

7 8 60 61 68 69 74 75 80

DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 | On October 18, 1982, as a result of an internal QA audit, it was determined

0 3 | that Unit 1 E.S. Surveillance tests were not performed in January 1982 within

0 4 | the 45 day maximum allowable interval for monthly reports; thus the systems

0 5 | involved were declared technically inoperable. When the tests were performed

0 6 | February 4, 1982, this made the systems operable and proved the systems

0 7 | functional. Thus, the health and safety of the public were not jeopardized.

0 9 | SYSTEM CODE | I | B | 11 | CAUSE CODE | X | 12 | CAUSE SUBCODE | Z | 13 | COMPONENT CODE | Z | Z | Z | Z | Z | Z | 14 | COMP. SUBCODE | Z | 15 | VALV. SUBCODE | Z | 16

7 8 9 10 11 12 13 18 19 20

17 | LER/RO REPORT NUMBER | 8 | 2 | 21 | 22 | SEQUENTIAL REPORT NO. | 0 | 1 | 6 | 24 | 25 | OCCURRENCE CODE | / | 0 | 1 | 27 | 28 | 29 | REPORT TYPE | T | 30 | 31 | REVISION NO. | 0 | 32

18 | ACTION TAKEN | G | 18 | 33 | FUTURE ACTION | G | 19 | 34 | EFFECT ON PLANT | Z | 20 | 35 | SHUTDOWN METHOD | Z | 21 | 36 | HOURS | 0 | 0 | 0 | 0 | 22 | 37 | ATTACHMENT SUBMITTED | N | 23 | 40 | 41 | NPRD-4 FORM SUB. | N | 24 | 42 | PRIME COMP. SUPPLIER | Z | 25 | 43 | COMPONENT MANUFACTURER | Z | 9 | 9 | 9 | 26 | 44 | 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ⑳

1 0 | The cause was personnel error and administrative deficiency. The person

1 1 | involved failed to reschedule the E.S. tests, and the accepted methods used

1 2 | contributed to the missed surveillance being undetected. The methods involved

1 3 | will be modified, and a new system will be established to note overdue tests.

1 4 | The person involved was counseled.

1 5 | FACILITY STATUS | X | 28 | 7 | 8 | 9 | 10 | % POWER | 0 | 7 | 5 | 29 | 12 | 13 | OTHER STATUS | Varied | 30 | 44 | METHOD OF DISCOVERY | A | 31 | 45 | 46 | DISCOVERY DESCRIPTION | Internal QA Audit | 32 | 80

1 6 | ACTIVITY CONTENT RELEASED OF RELEASE | Z | 33 | 7 | 8 | 9 | 10 | 11 | Z | 34 | 12 | AMOUNT OF ACTIVITY | NA | 35 | 44 | LOCATION OF RELEASE | NA | 36 | 48 | 49 | 50

1 7 | PERSONNEL EXPOSURES NUMBER | 0 | 0 | 0 | 37 | 7 | 8 | 9 | 10 | TYPE | Z | 38 | 11 | DESCRIPTION | NA | 39 | 12 | 13 | 80

1 8 | PERSONNEL INJURIES NUMBER | 0 | 0 | 0 | 40 | 7 | 8 | 9 | 10 | DESCRIPTION | NA | 41 | 11 | 12 | 80

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE | Z | 42 | 7 | 8 | 9 | 10 | DESCRIPTION | NA | 43 | 11 | 12 | 80

2 0 | PUBLICITY ISSUED DESCRIPTION | N | 44 | 7 | 8 | 9 | 10 | 8211100310 821101  
PDR ADOCK 05000269  
S PDR

NRC USE ONLY

NAME OF PREPARER J. C. Petty

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