



#### Description of Event

On March 21, 1983, with Unit 1 at 100% power, an A/E site engineer discovered that a stiffener/support for the "1J" Bus Service Water Auxiliary Relay Panel was not installed as per Design Change 80-S45I. The stiffener for the "1H" Bus Service Water Auxiliary Relay Panel was installed as per the Design Change. The additional stiffener (consisting of unistrut and a thread rod attachment to the panel) was one of several modifications to be completed on both "H & J" Auxiliary Relay Panels.

#### Probable Consequences of Occurrence

The Auxiliary Service Water Relay Panel ("1J" Bus) is utilized primarily to provide the relay logic for the testing and operation of the 4160 Volt "1J" Emergency Bus Undervoltage Protection. Since a redundant fully operable relay panel was available to operate the "1H" 4160 Volt Emergency Bus Undervoltage Protection, and the "1J" Relay Panel was not subject to any seismic action since the panel was modified to require an additional stiffener, the public health and safety were not affected.

#### Cause of Event

The cause of this event was personnel error on the part of both Construction and Quality Control personnel. The reason for the work not being completed by the Construction personnel is not known since those involved are no longer on site. The Quality Control inspector involved failed to adequately review all of the supporting documentation prior to verification of the activity.

#### Immediate Corrective Action

After identifying that the stiffener/support was not installed on "1J" Bus Relay Panel the stiffener installed as per Design Change instructions and drawings.

#### Scheduled Corrective Action

None

#### Actions Taken to Prevent Recurrence

An investigation into the event was undertaken by both the construction and Quality Control organizations. The Construction investigation identified the individuals involved and the amount of work subject to question. Since the individuals involved are no longer on site no further action was taken. The Quality Control investigation attributed the event to human error and indicated that the error was an isolated event.

The Quality Control individual involved in this event was cautioned to review supporting documentation thoroughly prior to verification of an activity.

Generic Implications

There are no generic implications to this event.