

LICENSEE EVENT REPORT

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | G | A | E | I | H | 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
01 | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 2 | 1 | 7 | 0 | 5 | 1 | 2 | 8 | 2 | 8 | 0 | 5 | 2 | 7 | 8 | 2 | 9
7 8 REPORT SOURCE 80 81 DOCKET NUMBER 88 89 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
02 | While Unit I was in refuel, it was discovered that no SRO was on the refueling floor |
03 | during LPRM change out. Tech Spec section 6.2.2.e requires that all core alterations |
04 | shall be directly supervised by an SRO who has no other concurrent responsibilities |
05 | during this operation. Plant operation was not affected as a result of this event. |
06 | The health and safety of the public was not affected. This is a non-repetitive event. |
07 | _____ |
08 | _____ |

09 | Z | Z | 11 | A | 12 | A | 13 | Z | Z | Z | Z | Z | Z | 14 | Z | 15 | Z | 16 |
7 8 SYSTEM CODE 9 10 CAUSE CODE 11 12 CAUSE SUBCODE 13 COMPONENT CODE 14 COMP. SUBCODE 15 VALVE SUBCODE 16
17 | 8 | 2 | 21 | _____ | 22 | 0 | 4 | 8 | 23 | _____ | 24 | 0 | 3 | 25 | L | 26 | _____ | 27 | 0 | 28 | _____ | 29 | L | 30 | _____ | 31 | 0 | 32 |
18 | H | 18 | Z | 19 | Z | 20 | Z | 21 | 0 | 0 | 0 | 0 | 22 | Y | 23 | N | 24 | Z | 25 | Z | 9 | 9 | 9 | 26 |
33 34 35 36 37 40 41 42 43 44 47
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
10 | The cause of the event has been attributed to personnel error. Personnel failed |
11 | to realize that changing out an LPRM string was a core alteration. When this event |
12 | was discovered, LPRM change out was discontinued and was not resumed until an SRO |
13 | was on the refueling floor. |
14 | _____ |

15 | H | 28 | 0 | 0 | 0 | 29 | NA | 30 | A | 31 | Operator observation | 32
7 8 9 FACILITY STATUS 10 % POWER 12 OTHER STATUS 13 METHOD OF DISCOVERY 14 DISCOVERY DESCRIPTION 15
16 | Z | 33 | Z | 34 | NA | 35 | NA | 36
7 8 9 ACTIVITY CONTENT 10 RELEASED OF RELEASE 11 AMOUNT OF ACTIVITY 12 LOCATION OF RELEASE 13
17 | 0 | 0 | 0 | 37 | Z | 38 | NA | 39
7 8 9 PERSONNEL EXPOSURES 10 NUMBER 11 TYPE 12 DESCRIPTION 13
18 | 0 | 0 | 0 | 40 | _____ | 41 | NA | 42
7 8 9 PERSONNEL INJURIES 10 NUMBER 11 TYPE 12 DESCRIPTION 13
19 | Z | 43 | _____ | 44 | NA | 45
7 8 9 LOSS OF OR DAMAGE TO FACILITY 10 TYPE 11 DESCRIPTION 12

20 | N | 44 | _____ | 45 | 8206110208 820527 PDR ADOCK 05000366 S PDR | NRC USE ONLY
7 8 9 ISSUED DESCRIPTION 10 68 69 80

NAME OF PREPARER S.X. Baxley, Supt. of Operations PHONE: 912-367-7851

LER #: 50-321/1982-048
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-321

Narrative Report
for LER 50-321/1982-048

Tech. Specs. section 6.2.2.e. requires that all core alterations be directly supervised by a SRO who has no other concurrent responsibilities during this operation. A SRO was on the refueling floor to supervise fuel movement. Fuel was being removed from the Rx vessel to facilitate LPRM change out. At 1427 on 5-10-82, fuel movement was completed and LPRM change out began. Personnel did not realize that changing out LPRM strings was a core alteration and therefore the SRO left the floor. At 1830 on 5-12-82, Management determined that a SRO was required on the refueling floor for LPRM change out. LPRM change out was stopped until a SRO could return to the floor.

Personnel have been reinstructed on Tech. Specs. concerning refueling operations. Neither plant operation nor the health and safety of the public was affected by this event. This is a non-repetitive event.