

LICENSEE EVENT REPORT

CONTROL BLOCK: \_\_\_\_\_ (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | F | L | S | L | S | 1 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 1 | 1 | 1 | 1 | 4 | \_\_\_\_\_ | 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

0 1 | R | S | 0 | 5 | 0 | 0 | 0 | 3 | 3 | 5 | 7 | 0 | 3 | 2 | 0 | 8 | 3 | 3 | 0 | 4 | 1 | 9 | 8 | 3 | 9  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

0 2 | On 3-20-83 and again on 3-22-83, while in Mode 6 refueling, during core  
0 3 | alterations the mechanical interlock on the personnel hatch to the contain-  
0 4 | ment building was defeated. Both the inner and outer doors were opened  
0 5 | and left open for approx. 2 hours and 10 minutes. This is not in accord-  
0 6 | ance with T.S.3.9.4.b. During both events normal refueling practices were  
0 7 | being observed. The health and safety of the public were not in jeopardy.  
0 8 | This is the first LER of this type.

0 9 | S | A | 11 | A | 12 | C | 13 | P | E | N | E | T | R | 14 | A | 15 | Z | 16  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

17 | LER NO. | 8 | 3 | SEQUENTIAL REPORTING | 0 | 1 | 7 | OCCURRENCE CODE | 0 | 3 | REPORT TYPE | L | REVISION NO. | 0  
21 22 23 24 25 26 27 28 29 30 31 32 33

ACTION TAKEN | H | Z | 19 | EFFECT ON PLANT | Z | 20 | SHUTDOWN METHOD | Z | 21 | HOURS | 0 | 0 | 0 | 0 | ATTACHMENT SUBMITTED | Y | 22 | NPROG FORMS/SUB. | N | 23 | PRIME COAP SUPPLIER | A | 24 | COMPONENT MANUFACTURER | C | 3 | 1 | 0 | 25  
27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47

1 0 | In both events personnel became trapped in the hatch and the interlocks  
1 1 | had to be defeated in order to release them. In both situations core  
1 2 | alterations were stopped immediately until the hatch was repaired and  
1 3 | closed. The personnel involved were counselled as to the seriousness of  
1 4 | their actions.

1 5 | H | 23 | 0 | 0 | 0 | 25 | OTHER STATUS | NA | 26 | METHOD OF DISCOVERY | A | 27 | DISCOVERY DESCRIPTION | Observation | 28  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

1 6 | Z | 33 | Z | 34 | AMOUNT OF ACTIVITY | NA | 35 | LOCATION OF RELEASE | NA | 36  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

1 7 | 0 | 0 | 0 | 37 | Z | 38 | PERSONNEL EXPOSURES | NA | 39  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

1 8 | 0 | 0 | 0 | 40 | PERSONNEL INJURIES | NA | 41  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

1 9 | Z | 42 | LOSS OF OR DAMAGE TO FACILITY | NA | 43  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

2 0 | N | 44 | RELEASED DESCRIPTION | NA | 45  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

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SUPPLEMENTAL INFORMATION  
ST. LUCIE UNIT #1  
DOCKET 05000335  
LER 83-17

AMPLIFICATION OF THE EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

In the first instance, during operation, the personnel hatch interlock linkage became jammed. The personnel inside were unable to free the mechanism and the Maintenance Department was contacted to release them. The maintenance personnel defeated the interlock and left both doors open without notifying the proper individuals.

In the second instance, the situation was the same except the personnel inside the hatch defeated the interlock and left both doors open without notifying the proper individuals.

AMPLIFICATION OF CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

Both situations were investigated thoroughly and all personnel involved have been informed of the importance of maintaining containment integrity during core alterations. In addition to the retraining, personnel have been stationed at the hatch to aid personnel in opening and closing the doors.