IC FORM 365 77) LICENSEE EVENT REPORT (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) \square CONTROL BLOCK: 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 1 0 20 GAEIH LICENSEE CODE 101 REPORT L 6 0 5 0 0 0 3 6 6 0 0 1 2 9 8 0 0 0 3 1 1 8 0 0 SOURCE 60 0 61 DOCKET NUMBER 65 69 EVENT DATE 74 75 REPORT DATE 80 01 EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) While pulling rods in startup mode, operator discovered that rod 46-43] 0 2 had been bypassed full-out in RSCS but not pulled to its prescribed 0 3 target position. Further this was not reported to the commission. 0 4 These items are contrary to Tech. Specs. sections 3.1.3.7 and 6 9.1.9.C. 0 5 respectively. The RWM was operable during the incident. This is not al 0 6 repetitive occurrence and there were no effects on public health and 0 7 safety due to the event. 0 8 COMP. VALVE CODE CAUSE CAUSE COMPONENT CODE SUBCODE 0 9 REVISION OCCURRENCE SEQUENTIAL REFORT REPORT NO. CODE TYPE NO. EVENT YEAR LER/RO REPORT 21 13 NUMBER COMPONENT NPRD-4 PRIME COMP. SHUTDOWN SUBMITTED EFFECT ON PLANT ACTION HOURS (22) FORM SUB. SUPPLIER 10 18 10 Y 3 N (24) N (25) ____(26) 0 0 0 10 G H(18)L Z (20) CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) While investigating problem with RSCS. operator bypassed rod 46-43 but 1 0 inadvertently forgot to verify position as that prescribed in the 1 1 withdrawal sequence. Subsequently the rod was left at its full-in 1 2 position as rod withdrawal continued. Upon discovery of error, rod 1 3 was pulled to target position. 1 4 80 OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32) N POWER A (31) Operator Observation 0 5 N/A 1 01 80 4.4 CONTENT LOCATION OF RELEASE (16) AMOUNT OF ACTIVITY (35) OF RELEASE N/A N/A 80 44 EXPOSURES PERSONNEL DESCRIPTION (39) N/A 010 80 PERSONNEL INJURIES DISCRIPTION (41) N/A 0 1 8 OLS OF ON DAMAGE TO FACILITY (43) 8008210404 DESCRIPTION (42) N/A NRC USE ONL PUBLICITY OLSCRIPTION (45) N/A NAME OF PHEPAHER C. I. Coggin - Supt. Pit. Eng. Serv. PHONE 912-367-7781



LER 4: 50-265/1080-023 Licensee: Georgia Power Company Facility Name: Edwin I. Hatch Docket 4: 50-366

Narrative Report for LER 50-366/1980-023

At approximately 2000 CST on 1-29-80, during a normal startup, following a cold shutdown to perform PCIS modifications, rod withdrawal was being performed in the startup and hot standby mode to reach criticality. While in RSCS Group 2 the operator found that the system was blocking withdrawal of rod MA_M2. Rod 45-43 was the next to last rod in RSCS. Group 2 and was to be pulled from position 00 to position 48. While investigating the RSCS problem, the operator bypassed rod A6-43 full-out, but inadvertently left the rod at position 00. The normal withdrawal sequence was then followed until Group 3D when rod 10-117 was not pulled as prescribed from position 1? to position 48. Both errors were then indicated on the rod worth minimizer display as insert errors but not acknowledged. No rod block was applied, as two such errors are allower by the RUM. At 0745 CST on 1-20-80, the dayshift operator, while pulling rods in RSCS Group ND, recognized the errors. Rod withdrawal was stopped and the Shift Foreman and Reactor Engineer were notified. After consultation between these three parties it was decided to withdraw rod 10-17 to its targeted position. Upon successful completion of this, it was decided that rod 06-03 should be pulled to its targeted position. This involved bypassing the A34 rods full-in to be able to select the A12 rod. This having been done by two licensed RO's, the rod, 45-43, was withdrawn slowly by the operator under the observation of the Shift Foreman and Reactor Engineer. Finally the RSCS switches were returned to the normal configuration and after all rods were verified to be in their correct positions, normal startup continued. Deviation Report # 2-80-28 was written describing the incident.

On 2-12-90, the Deviation Report was reviewed by the PRB and based on the information in the report, the board concluded that the incident was not reportable. Their conclusion was based on the premise that the incident alone did not prevent the functional operation of the RSCS nor the RMM and that the fundamental error involved only failure to follow procedure HNP-2-0207, Rod Movement Sequence.

On R-6-RO, after the NRC Resident Inspector expressed concerns over the applicability of the incident to Technical Specification R.1.R.7.a.2, the PRB reviewed the deviation report again. After discussion, the PRB agreed that in its previous review the question of the operability of the RSCS had overshadoued the Technical Specification requirement that rods must be moved to the correct position in the proper sequence during periods of RSCS control. It was further agreed that progressing from one RSCS group to the next should not have been allowed unloss all rods were at their targeted positions. From this standooint it was concluded that indeed the incident was reportable as an observed inadequacy in the implementation of procedural controls which threatened to cause reduction of degree of redundancy provided in engineering safety system.