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(TEMPORARY FORM)

CONTROL NO: **12632**
FILE: INCIDENT REPORT FILE

FROM: Metropolitan Edison Co Reading, Pa R C Arnold		DATE OF DOC 10-31-75	DATE REC'D 11-3-75	LT XXX	WX	RPT	OTHER
TO: ML		ORIG one signed	CC	OTHER	SENT AEC PDR <u>XX</u> SENT LOCAL PDR <u>XX</u>		
CLASS	UNCLASS XXXXXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-289		

DESCRIPTION:

Ltr reporting abnormal Occurrence #75-38 on 10-21-75 concerning inadequacy in the implementation of a Control Rod Program Verification...
.....(1 cy rec'd)

ENCLOSURES:

ACKNOWLEDGED

DO NOT REMOVE

PLANT NAME: Three Mile Island #1

FOR ACTION/INFORMATION 11-6-75 ehf

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FILE & REGION (2)	BENAROYA		V. WILSON (L)	*WIGGINTON
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METROPOLITAN EDISON COMPANY

POST OFFICE BOX 542 READING, PENNSYLVANIA 19603

TELEPHONE 215-929-3601

October 31, 1975
GQL 1662

Director of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sir:

Docket No. 50-289
Operating License No. DPR-50

In accordance with the Technical Specifications of our Three Mile Island Nuclear Station Unit 1 (TMI-1), we are reporting the following abnormal occurrence.

- (1) Report Number: AO 50-289/75-38
- (2a) Report Date: October 31, 1975
- (2b) Occurrence Date: October 21, 1975
- (3) Facility: Three Mile Island Nuclear Station Unit 1
- (4) Identification of Occurrence:

Title: Inadequacy in the implementation of a Control Rod Program Verification.

Type: An abnormal occurrence as defined by the Technical Specifications, paragraph 1.8g, in that the surveillance requirements of Technical Specification 4.7.2.1 were not satisfied during a Control Rod Program Verification.

- (5) Conditions Prior to Occurrence:

Power: Core: 89%
Elec.: 773 MWe

RC Flow: 138×10^6 lbs./hr.

RC Pressure: 2155 psig

RC Temp.: 579°F

PRZR Level: 237"

PRZR Temp.: 650°F



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(6) Description of Occurrence:

On October 21, 1975, during a Plant Operation Review Committee review of the results of the Control Rod Program Verification, it was found that the surveillance requirements of Technical Specification 4.7.2.1 were not satisfied. The surveillance was performed by moving a group of rods the required distance and verifying that the computer input for each rod responded. The procedure requires that each rod in the group should be moved separately.

The Plant Operation Review Committee concluded that the surveillance, as performed, verified that the rods were in the correct group. In addition, a visual inspection of each patch plug was performed and assured that each rod was properly connected within the group.

(7) Designation of Apparent Cause of Occurrence:

The cause of this occurrence has been determined to be personnel/procedure in that the personnel involved misinterpreted the Control Rod Program Verification procedure. Procedure inadequacy contributed to the occurrence since the surveillance procedures do not conclusively state that each rod must be moved individually to assure a satisfactory test.

(8) Analysis of Occurrence:

It has been determined that this occurrence did not constitute a threat to the health and safety of the public in that:

- a. The incorrect procedure used in the surveillance did not result in any improper connection of control rods and did not affect the normal operation of the equipment involved and
- b. if an incorrect rod assignment within a group would have occurred, flux distribution during normal operation would have not been affected since all rods within a group are moved together.

(9) Corrective Action:

In addition to immediate action described above, long term corrective actions are as follows:

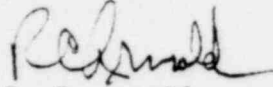
- a. The Surveillance Procedure will be revised to clearly state that individual rod movement is a requirement for the performance of the Control Rod Program Verification.
- b. Operations personnel will be cautioned that strict compliance with surveillance procedures is required.

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(10) Failure Data: Not Applicable

Similar Occurrences: None

Sincerely,



R. C. Arnold
Vice President

RCA:JMC:ilm

File: 20.1.1/7.7.3.5.1

cc: Office of Inspection and Enforcement, Region I

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