(7-77)

LICENSEE EVENT REPORT

LER 78-9/3L

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

Line	Field	Value
01	LICENSEE CODE (2)	VTVYS1
01	LICENSE NUMBER (3)	00000000000
01	LICENSE TYPE (4)	41111
01	CAT (5)	
01 CON'T	REPORT SOURCE (6)	L
01	DOCKET NUMBER (7)	05000271
01	EVENT DATE (8)	031778
01	REPORT DATE (9)	042878

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02–08: See attached sheet

Line	Field	Value
09	SYSTEM CODE (11)	IB
09	CAUSE CODE (12)	X
09	CAUSE SUBCODE (13)	Z
09	COMPONENT CODE (14)	ZZZZZZ
09	COMP. SUBCODE (15)	Z
09	VALVE SUBCODE (16)	Z

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
78	—	009	/	03	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
H	G	Z	Z	0000	Y	N	Z	Z999

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10–14: See attached sheet

Line	Field	Value
15	FACILITY STATUS (28)	E
15	% POWER (29)	099
15	OTHER STATUS (30)	NA
15	METHOD OF DISCOVERY (31)	Z
15	DISCOVERY DESCRIPTION (32)	NA
16	ACTIVITY RELEASED (33)	Z
16	CONTENT OF RELEASE (34)	Z
16	AMOUNT OF ACTIVITY (35)	NA
16	LOCATION OF RELEASE (36)	NA
17	PERSONNEL EXPOSURES NUMBER (37)	000
17	TYPE (38)	Z
17	DESCRIPTION (39)	NA
18	PERSONNEL INJURIES NUMBER (40)	000
18	DESCRIPTION (41)	NA
19	LOSS OF OR DAMAGE TO FACILITY TYPE (42)	Z
19	DESCRIPTION (43)	NA
20	PUBLICITY ISSUED (44)	Z
20	DESCRIPTION (45)	NA

2237 237

NRC USE ONLY

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GPO 917-926

7906040258

Event Description and Probable Consequences

During weekly surveillance testing of the control rods, the "A" Rod Block Monitor was bypassed several times after various control rods were inserted one notch and were then prevented from returning to their previous position. Tech. Spec. Table 3.2.5 requires that both Rod Block Monitors be operable in the RUN mode. However, one monitor may be removed from service for up to 24 hours in order to perform maintenance and/or testing. There were no similar events previously reported to the commission.

Cause Description and Corrective Actions

The apparent cause of this event is attributed to a misunderstanding by the Shift Supervisor of an earlier instruction from the Operations Supervisor. The misunderstanding has been clarified and appropriate precautions have been added to the station operating procedures.