

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Sequoyah, Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 2 7 1										PAGE (3) 1 OF 0 2																					
TITLE (4) Inoperability of Rod Position Indication (RPI) System																																									
EVENT DATE (5)						LER NUMBER (6)						REPORT DATE (7)						OTHER FACILITIES INVOLVED (8)																							
MONTH			DAY			YEAR			YEAR			SEQUENTIAL NUMBER			REVISION NUMBER			MONTH			DAY			YEAR			FACILITY NAMES						DOCKET NUMBER(S)								
0 1			2 8			8 5			8 5			0 0			9			0 0			0 2			2 6			8 5									0 5 0 0 0					
OPERATING MODE (9) 1						THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																																			
POWER LEVEL (10) 1 0 0						20.402(b)						20.405(c)						50.73(a)(2)(iv)						73.71(b)																	
						20.405(a)(1)(i)						50.36(c)(1)						50.73(a)(2)(v)						73.71(c)																	
						20.405(a)(1)(ii)						50.36(c)(2)						50.73(a)(2)(vii)						OTHER (Specify in Abstract below and in Text, NRC Form 366A)																	
						20.405(a)(1)(iii)						50.73(a)(2)(i)						50.73(a)(2)(viii)(A)																							
						20.405(a)(1)(iv)						50.73(a)(2)(ii)						50.73(a)(2)(viii)(B)																							
20.405(a)(1)(v)						50.73(a)(2)(iii)						50.73(a)(2)(ix)																													
LICENSEE CONTACT FOR THIS LER (12)																																									
NAME David P. Ormsby, Compliance Section Engineer																TELEPHONE NUMBER 6 1 1 5 8 7 1 0 - 1 6 1 1 4 6																									
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																									
CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NPDs		CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NPDs																							
SUPPLEMENTAL REPORT EXPECTED (14)																EXPECTED SUBMISSION DATE (15)		MONTH		DAY		YEAR																			
YES (If yes, complete EXPECTED SUBMISSION DATE) XX NO																																									

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

All rod position indication simultaneously lowered approximately twenty (20) steps resulting in misalignment from the step counter of greater than twelve (12) steps allowed by technical specifications. All power parameters remained unchanged indicating false rod position indication readings. All rod position indicators gradually returned to normal in nine (9) minutes.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Sequoyah, Unit 1	0 5 0 0 0 3 2 7 8 5	—	0 0 9	—	0 0	0 2	OF 0 2

TEXT (If more space is required, use additional NRC Form 366A's) (17)

On January 28, 1985, with both units in mode 1 at 100 percent reactor power, all unit 1 control room rod position indicators (RPI) simultaneously lowered approximately twenty (20) steps. This resulted in exceeding the technical specification allowed maximum twelve-step difference between the RPI and demand position indication systems. Since all power parameters remained unchanged, it was determined that the RPIs were reading falsely. All unit 1 RPIs were declared inoperable, and unit 1 entered limiting condition for operation (LCO) 3.0.3. (NUREG-1022 specifies reportability under 10 CFR 50.73(a)(2)(i) any time this LCO is entered.) The RPI slowly returned to normal within nine (9) minutes.

It was determined that the only failure which could cause all of the RPIs to fail would be an interruption or reduction in 120 VAC power. After it was determined that no breaker switching had occurred, a check was made of the Solatron line voltage regulator in the cable spreading room. This check revealed small (2-3 inch diameter) puddles of water beneath the Solatron. The most likely sequence of events was wetting of the Solatron induction circuitry resulting in voltage reduction. As the moisture dissipated due to the heat generated by the unit, the normal voltage was reestablished, and the RPIs gradually returned to normal. No damage to the Solatron was noted.

The actual means of water entering the Solatron could not be determined. An inspection of surrounding equipment and systems did not reveal any likely source of water. In the event that the water was a result of some inadvertent personnel error, supervisors have been instructed to caution their employees about activities in the vicinity of plant equipment/instrumentation. This event is considered an isolated occurrence, and no additional action is considered necessary.

There was no effect on public health or safety.

Previous occurrences - none.

SEQUOYAH NUCLEAR PLANT  
TENNESSEE VALLEY AUTHORITY

Post Office Box 2000  
Soddy Daisy, Tennessee 37379

February 26, 1985

U.S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, DC 20555

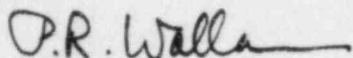
Gentlemen:

TENNESSEE VALLEY AUTHORITY - SEQUOYAH NUCLEAR PLANT UNIT 1 - DOCKET NO.  
50-327 - FACILITY OPERATING LICENSE DPR-77 - REPORTABLE OCCURRENCE REPORT  
SQRO-50-327/85009

The enclosed licensee event report provides details concerning the inoperability of the rod position indication system. This event is reported in accordance with 10 CFR 50.73, paragraph a.2.i.B.

Very truly yours,

TENNESSEE VALLEY AUTHORITY



P. R. Wallace  
Plant Manager

Enclosure  
cc (Enclosure):

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NRC Inspector, NUC PR, Sequoyah