

LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK: \_\_\_\_\_ (1)

0 | 0 | H | D | B | S | 1 | 2 | 0 | 0 | - | 0 | 0 | N | P | F | - | 0 | 3 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | \_\_\_\_\_ | 5

LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 37 CAT 58

CON'T

0 | 1 | REPORT SOURCE 60 L 61 0 | 5 | 0 | - | 0 | 3 | 4 | 6 | 7 | 0 | 8 | 0 | 1 | 7 | 8 | 8 | 0 | 8 | 2 | 8 | 7 | 8 | 9

DOCKET NUMBER 58 59 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On 8/1/78 at 0850 hours, station personnel discovered that the 4 hour surveillance re-

0 3 | quirements were not met as per T.S. 3/4.1.3.6a, when the regulating rod insertion

0 4 | alarm is inoperable. The 4 hour verification should have begun when the unit entered

0 5 | Mode 2 on 7/23/78. There was no danger to the health and safety of the public or to

0 6 | unit personnel. Verification of insertion limits was completed once per shift since

0 7 | startup as per Surveillance Test ST 5099.01. (NP-33-78-103)

0 9 | SYSTEM CODE 9 R B 10 11 CAUSE CODE 11 A 12 13 CAUSE SUBCODE 12 A 13 14 COMPONENT CODE 13 I N S T R U 14 15 COMP. SUBCODE 19 Z 16 VALVE SUBCODE 20 Z 16

17 LER/RO REPORT NUMBER 21 7 22 8 23 - 24 0 8 7 25 / 26 0 3 27 OCCURRENCE CODE 28 0 3 29 REPORT TYPE 30 L 31 REVISION NO. 32 0

33 ACTION TAKEN 34 H 35 FUTURE ACTION 36 Z 37 EFFECT ON PLANT 38 Z 39 SHUTDOWN METHOD 40 Z 41 HOURS 42 0 0 0 43 ATTACHMENT SUBMITTED 44 Y 45 NPRO-4 FORM SUB. 46 N 47 PRIME COMP. SUPPLIER 48 Z 49 COMPONENT MANUFACTURER 50 Z Z Z Z

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | Personnel error is attributed as the cause of this occurrence. The control room opera-

1 1 | tors did not perform the 4 hour verifications for the insertion limits. At 0900 hours

1 2 | on 8/1/78, the Control Room completed the required control rod position verification.

1 3 | This action removed the unit from violation of Surveillance Requirement 4.3.1.6a. This

1 4 | report will be distributed to responsible persons to prevent future recurrence.

1 5 | FACILITY STATUS 7 E 8 9 % POWER 10 0 3 8 11 12 OTHER STATUS 13 NA 14 15 METHOD OF DISCOVERY 16 C 17 18 19 NA 20 21 DISCOVERY DESCRIPTION 22 23 24 25 26 27 28 29 30 31 32

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

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

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

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

TOLEDO EDISON COMPANY  
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION  
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-103

DATE OF EVENT: August 1, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: The verification of the position of each regulating rod was not completed at the four (4) hour intervals.

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 1050, and Load (MWE) = 330

Description of Occurrence: On August 1, 1978, at 0850 hours, station personnel discovered that surveillance requirements were not met as per Technical Specification 3/4.1.3.6a. This Technical Specification requires that the position of each regulating group shall be determined to be within the insertion, sequence, and overlap limits at least once every twelve (12) hours except when the regulating rod insertion alarm is inoperable; then verify the groups to be within the insertion limits at least once per four (4) hours. The four hour verification should have begun when the unit entered Mode 2 on July 23, 1978.

Designation of Apparent Cause of Occurrence: Personnel error is attributed as the cause of this occurrence. The control room operators should have been aware of the four hour verifications for the insertion limits. On July 23, 1978, at 1916 hours, the reactor was critical. Since at this time the regulating rod insertion limit alarm was inoperable and the required four hour verification did not commence until August 1, 1978 at 0900 hours, the unit was in violation of Technical Specification 4.3.1.6a.

Analysis of Occurrence: There was no danger to the health and safety of the public or to unit personnel. Verification of insertion limits was completed once per shift since startup as per Surveillance Test ST 5099.01.

Corrective Action: At 0900 hours on August 1, 1978, the Control Room completed the required control rod position verification. This action removed the unit from violation of Surveillance Requirement 4.3.1.6a. Also, copies of this report will be distributed to responsible persons to prevent future recurrence.

Failure Data: This is not a repetitive occurrence.

LER #78-087