

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CON'T
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On 7/12/79 at 0415 hours while repositioning Group 8, the absolute position indica-
0 3 tion (API) for Rod 4 of Group 8 shifted from the 25% withdrawn position to the 0%
0 4 position. This placed the unit in the Action Statement of T.S. 3.1.3.3 which re-
0 5 quires all API channels to be operable in Modes 1 and 2. There was no danger to the
0 6 health and safety of the public or station personnel. The relative and the group
0 7 position indications were operable the entire time the API was inoperable.
0 8 (NP-33-79-100)

0 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The apparent cause is that of oxide film buildup on the reed switch contacts. As the
1 1 rod withdrawal continued past the faulty reed switch, the API indication returned to
1 2 normal, removing the unit from the Action Statement. Maintenance personnel in conjunc-
1 3 tion with the API vendor representative performed corrective maintenance using a reed
1 4 switch rejuvenator rendering the switch operable on July 1 1979.

1 5 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-100

DATE OF EVENT: July 12, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Faulty absolute position indication (API) reed switch for Rod 4 of Group 8

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 580, and Load (Gross MWE) = 200

Description of Occurrence: On July 12, 1979, at 0415 hours while repositioning Group 8, Rod 4 of Group 8 absolute position indication (API) shifted from the 26% withdrawn to 0% actuating the asymmetric rod alarm. This placed the unit in the Action Statement of Technical Specification 3.1.3.3. The Technical Specification requires all absolute position indication channels to be operable and capable of determining the rod group position within 6.5% when the unit is in Modes 1 and 2. As the rod withdrawal continued, the API indication returned to normal removing the unit from the Action Statement of Technical Specification 3.1.3.3.

Designation of Apparent Cause of Occurrence: The cause of this occurrence has been determined to be a component failure in the position indicator tube reed switch. An oxide film is believed to have built up on the reed switch contacts which interferes with the conduction across the switch contacts.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The relative position indication and the group position channels were operating and once the rod was withdrawn past the faulty reed switch, the API indication returned to operable status.

Corrective Action: Under Maintenance Work Order (MWO) 79-2499, maintenance personnel with Diamond Power (the position indicator manufacturer) performed corrective maintenance on the reed switch with a position indicator reed switch rejuvenator. This instrument places a higher than normal operation voltage across the reed switch while the rod is run past the switch causing the switch to actuate. The higher voltage removes the oxide film which returns the switch to operability. On July 13, 1979, the switch was retested and declared operable.

Failure Data: Although there have been numerous previously reported occurrences of API failures, only two have been identified as oxide buildup in reed switch contacts; see Licensee Event Reports NP-33-79-90 and NP-33-79-97.

LER #79-079