

CONTROL BLOCK: 

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 ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'TEVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)SYSTEM

## CAUSE

### CAUSE

COMPONENT CODECOMP.VALVE

R	B
9	10

E (12)

12

I	N	S	T	R	U	14
13						18

19

Z (16)  
20

17 LER RO  
REPORT  
NUMBER

EVENT YEAR

7	9
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U

SEQUENTIAL REPORT NO.		
0	8	7

A small line graph with a vertical y-axis and a horizontal x-axis. A straight line starts at a point on the y-axis and extends upwards and to the right, indicating a positive linear relationship.

OCCURRENCE  
CODE  
0 3

REPORT  
TYPE  
[L]  
20

21

REVISION  
NO.  
32

ACTION TAKEN	FUTURE ACTION
A	Z
11	14

EFFECT  
ON PLANT

19 Z 20

35

SHUTDOWN  
METHOD  
Z (2)

HOURS

37

ATTACHMENT  
SUBMITTED  
Y 23  
41

NPRD-4  
FORM SUB.  
LY (2)  
42

PRIME COM  
SUPPLIER  
N

COMPONENT MANUFACTURER			
D	1	5	0

44

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

FACILITY STATUS		POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
7	8	9	10	11	12	13	14	15	16

8	9	10	11	12	13	14	15	16	17
<u>ACTIVITY RELEASED</u>		<u>CONTENT OF RELEASE</u>		<u>AMOUNT OF ACTIVITY</u> (35)			<u>LOCATION OF RELEASE</u> (36)		

PERSONNEL EXPOSURES									
NUMBER			TYPE		DESCRIPTION		(39)		
0	0	0	(23)	2	(20)	NA			

NUMBER		DESCRIPTION	(41)
1	0 0 0 (40)	NA	

TYPE		DESCRIPTION
1	9	Z (42) NA

NRC USE ONLY

ISSUED 20 44 NA 68 69 80

TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-101

DATE OF EVENT: July 31, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Loss of Group 6 out limit

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2680 and Load (Gross MWE) = 880

Description of Occurrence: On July 31, 1979 at 0110 hours and at 0140 hours while performing PT 5193.01, "Main Turbine Steam Valve Tests", operations personnel received a Control Rod Drive Sequence Fault. In both instances, they noticed that Group 6 had moved off of its out limit to approximately 95%. This placed the unit in the Action Statement (a) of Technical Specification 3.1.3.6. This Technical Specification requires Group 6 to be within the insertion limits during Modes 1 and 2. Action Statement (a) instructs the unit to restore the rod(s) to within the insertion limit within two hours.

In each case, operators immediately pulled Group 6 back to its out limit which removed the unit from the Action Statement (a) of Technical Specification 3.1.3.6. PT 5193.01 was suspended until the problem could be resolved.

Designation of Apparent Cause of Occurrence: The cause of this occurrence is attributed to a faulty integrated circuit (IC 2) on a logic gate module in the auxiliary power supply of the command logic string.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The Group 6 rod motion was minimal and no noticeable reactivity or core power distribution effects occurred.

Corrective Action: Instrument and Control personnel were called in and the IC was replaced and proper operation verified under work request IC-055-014-79. PT 5193.01 was successfully completed on July 31, 1979. The unit had been removed from the Action Statement of Technical Specification 3.1.3.6 immediately after the occurrence when operations personnel pulled Group 6 back to its out limit.

Failure Data: There have been no previously reported similar events.