

## (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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CON'T

|   |   |
|---|---|
| 0 | 1 |
| 7 | 8 |

REPORT SOURCE

|    |    |   |   |   |   |   |   |   |    |    |   |   |   |   |   |    |    |   |   |   |   |   |   |    |
|----|----|---|---|---|---|---|---|---|----|----|---|---|---|---|---|----|----|---|---|---|---|---|---|----|
| L  | 6  | 0 | 5 | 0 | - | 0 | 3 | 4 | 5  | 7  | 0 | 1 | 0 | 5 | 7 | 9  | 8  | 0 | 1 | 3 | 1 | 7 | 9 | 9  |
| 60 | 61 |   |   |   |   |   |   |   | 68 | 69 |   |   |   |   |   | 74 | 75 |   |   |   |   |   |   | 80 |

DOCKET NUMBER

EVENT DATE

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

|                         |    |               |    |                 |    |                       |  |                      |    |                  |    |                      |    |                        |   |               |  |
|-------------------------|----|---------------|----|-----------------|----|-----------------------|--|----------------------|----|------------------|----|----------------------|----|------------------------|---|---------------|--|
| 0 9                     |    | SYSTEM CODE   |    | CAUSE CODE      |    | CAUSE SUBCODE         |  | COMPONENT CODE       |    |                  |    |                      |    | COMP. SUBCODE          |   | VALVE SUBCODE |  |
| 7                       | 8  | Z             | Z  | A               |    | X                     |  | Z                    | Z  | Z                | Z  | Z                    | Z  | Z                      |   | Z             |  |
|                         |    | 9             | 10 | 11              | 12 | 13                    |  | 13                   |    |                  |    |                      | 18 | 19                     |   | 20            |  |
| 17 LER/RO REPORT NUMBER |    | EVENT YEAR    |    | SHUTDOWN METHOD |    | SEQUENTIAL REPORT NO. |  | OCCURRENCE CODE      |    | REPORT TYPE      |    | REVISION             |    |                        |   |               |  |
|                         |    | 7             | 9  | Z               |    |                       |  | 0                    | 0  | 4                | /  | 0                    | 3  | L                      |   | NO            |  |
|                         |    | 21            | 22 | 23              |    |                       |  | 24                   |    | 26               | 27 | 28                   | 29 | 30                     |   | 32            |  |
| ACTION TAKEN            |    | FUTURE ACTION |    | EFFECT ON PLANT |    | HOURS                 |  | ATTACHMENT SUBMITTED |    | NPRD-4 FORM SUB. |    | PRIME COMP. SUPPLIER |    | COMPONENT MANUFACTURER |   |               |  |
| G                       | Z  | Z             |    | Z               |    |                       |  |                      | Y  |                  | N  |                      | Z  | Z                      | Z | Z             |  |
| 18                      | 19 | 20            |    | 21              |    |                       |  | 22                   | 23 |                  | 24 |                      | 25 |                        |   | 26            |  |
| 32                      | 34 | 35            |    | 36              |    |                       |  | 37                   |    | 40               | 41 | 42                   | 43 | 44                     |   | 47            |  |

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

7 8 9  
FACILITY STATUS  
1 5 E (28)  
% POWER  
1 0 0 (29) NA  
OTHER STATUS (30)  
METHOD OF DISCOVERY  
A (31) NA  
DISCOVERY DESCRIPTION (32)

| PERSONNEL EXPOSURES |   |   |      |             |    |    |    |    |  |  |
|---------------------|---|---|------|-------------|----|----|----|----|--|--|
| NUMBER              |   |   | TYPE | DESCRIPTION |    |    |    |    |  |  |
| 1                   | 7 | 0 | 0    | 0           | 37 | Z  | 38 | NA |  |  |
| 7                   | 8 | 9 | 11   | 12          | 13 | 80 |    |    |  |  |

| TYPE |   | DESCRIPTION |    |
|------|---|-------------|----|
| 1    | 9 | Z           | NA |

7 8 9 10

PUBLICITY

2902060328

NRC USE ONLY

ISSUED DESCRIPTION  
2 0 N 44 NA  
7 8 9 10  
DVR 79-005 NAME OF DEBATED William H. Green  
PHONE 419-259-5000, Ext. 221

7902060328

NRC USE ONLY

419-259-5000, Ext. 221

DVR 79-005

NAME OF PREPARER

William H. Green

PHON

TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-05

DATE OF EVENT: January 5, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure to post guards at the entrance to containment during periods of free access

Conditions Prior to Occurrence: The unit was in Mode 1. Net Power (MWT) = 2772, and Load (Gross MWE) = 910.

Description of Occurrence: On January 5, 1979 at 1030 hours during a review of 10CFR73.55, it was noted that the unit had not posted a guard at the entrance to containment when there was free access to containment when the unit was shutdown, and was therefore in violation of 10CFR73.55(d)(8). The containment personnel hatches are locked above 5% full reactor power and access is controlled by the Shift Foreman. This regulation was required to be implemented by May, 1978. Subsequent review of the incident and the Technical Specifications revealed a breakdown of administrative controls. The incident is being reported in accordance with Technical Specification 6.9.1.9.c.

Designation of Apparent Cause of Occurrence: The cause of this occurrence is personnel error. The requirement for posting a guard during periods of free access to containment was overlooked in the station's review of 10CFR73.55.

Analysis of Occurrence: There was no danger to the health and safety of the public or to unit personnel. In order to access containment, personnel had to pass through other entrances which require the same security clearance as containment. Usual practice has been to post guards at the entrance to containment.

There were no other units or systems affected by the occurrence. There were no offsite consequences.

Corrective Action: No immediate corrective action was required. The station was not in violation of Technical Specifications because containment integrity was established and there was no "free" access to containment when the deficiency was discovered.

To prevent recurrence, Special Order 84 was revised to require the posting of guards when there is free access to containment.

Failure Data: There have been no previous similar occurrences.