

## LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | 0 H D B S 1 | 2 | 0 0 - 0 0 N P F - 0 3 | 3 | 4 | 1 1 1 1 | 4 | | | 5  
 7 8 9 14 15 25 26 30 57 CAT 58  
 LICENSEE CODE LICENSE NUMBER LICENSE TYPE  
 CON'T  
 0 1 | REPORT SOURCE | L | 6 | 0 5 0 - 0 3 4 6 | 7 | 0 6 2 3 7 9 | 8 | 0 7 1 | 9 | 7 9 | 9  
 7 8 9 60 61 68 69 74 75 80  
 DOCKET NUMBER EVENT DATE REPORT

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On June 23, 1979, at 0355 hours during the performance of the Service Water (SW) System Monthly Test ST 5075.01, it was found that SW 1429, the Component Cooling Water (CCW) Heat Exchanger 1-3 SW Outlet Valve, failed to consistently go to the fully closed position. As the unit was in Mode 5 at the time of the occurrence, no action statement was applicable. This report is being submitted as documentation of a component failure. There was no danger to the health and safety of the public or station personnel. There were two loops of CCW available for operation at the time of occurrence.

SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE		(NP-33 -79-74)							
0	9	W	B	11	B	12	B	13	V	A	L	V	O	P	14	D	15	D	16		
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER					
F	18	Z	19	Z	20	Z	21	0	0	0	Y	23	Y	24	A	25	H	0	3	5	26
LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.											
17	7	9	21	22	0	6	8	24	26	0	3	28	29	L	30	0	32				

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | Slippage and misalignment of the valve linkage of SW 1429 was due to a vibrational

1 1 | loosening of a retaining nut. A visual inspection of the service water outlet valves

1 2 | on all three CCW heat exchangers was made and valve SW 1424 was realigned and recalibrated

1 3 | in addition to SW 1429 as a precautionary measure. Previously prepared Facility

1 4 | Change Request 79-151 was implemented on all three valves to prevent recurrence.

FACILITY STATUS			% POWER			OTHER STATUS			METHOD OF DISCOVERY			DISCOVERY DESCRIPTION			
1	5	G	28	0	0	29	0	0	30	NA	31	B	Surveillance Test ST 5075.01		
ACTIVITY CONTENT			RELEASED OF RELEASE			AMOUNT OF ACTIVITY			LOCATION OF RELEASE						
1	6	Z	33	Z	34	35	NA	36	NA						
PERSONNEL EXPOSURES			NUMBER			TYPE			DESCRIPTION						
1	7	0	37	Z	38	39	NA								
PERSONNEL INJURIES			NUMBER			DESCRIPTION									
1	8	0	40	NA	41										
LOSS OF OR DAMAGE TO FACILITY			TYPE			DESCRIPTION									
1	9	Z	42	NA	43										
PUBLICITY			ISSUED			DESCRIPTION									
2	0	N	44	NA	45										

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PHONE: 419-259-5000, Ext. 230

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TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-74

DATE OF EVENT: June 23, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Component Cooling Water Heat Exchanger 1-3 Service Water Outlet Valve SW 1429 operating improperly

Conditions Prior to Occurrence: The unit was in Mode 5, with power (MWT) = 0, and Load (Gross MWE) = 0.

Description of Occurrence: On June 23, 1979, at 0355 hours, during the performance of Service Water System Monthly Surveillance Test ST 5075.01, SW 1429, Component Cooling Water (CCW) Heat Exchanger 1-3 Service Water (SW) Outlet Valve failed to consistently provide a close indication. Visual inspection revealed the valve was not going to the fully closed position. The operator suspended the surveillance test, and submitted a work request. As the unit was in Mode 5 at the time of the occurrence, no action statement was applicable. This report is being submitted as documentation of a component failure.

Designation of Apparent Cause of Occurrence: The improper operation of valve SW 1429 was attributed to slippage and misalignment of the valve linkage. This was caused by a design deficiency which allowed vibrations to loosen the bolt that retains the two linkage arms together.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. There were two loops of component cooling water available for operation at the time of occurrence.

Corrective Action: The valve linkage was realigned and calibrated under Maintenance Work Order IC-309-79. As a precautionary measure, the linkage for SW 1424, CCW Heat Exchanger 1-1 SW Outlet Valve, was recalibrated under the same maintenance work order. A visual inspection of SW 1434, CCW Heat Exchanger 1-2 SW Outlet Valve, was performed and it was determined that recalibration would not be necessary due to a recent calibration performed on April 4, 1979 under Maintenance Work Order IC-223-79.

The applicable sections of ST 5075.01 were successfully performed to verify the operability of the valves. On July 3, 1979 implementation of previously prepared Facility Change Request (FCR) 79-151 was completed. This FCR modified the linkages to prevent vibrations from loosening the retaining bolt on all three valves.

Failure Data: There have been three previously reported occurrences of actuator inoperabilities of a service water valve. The inoperabilities reported in Licensee Event Report NP-33-78-120 were caused by a nut missing on the actuator. Licensee

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TOLEDO EDISON COMPANY  
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Event Report NP-33-78-11 was caused by a failure of a solenoid valve, and Licensee  
Event Report NP-33-78-147 was caused by vibrations loosening the bolt retaining the  
two linkage arms.

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