

LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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REPORT SOURCE

60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

POCKET NUMBER

EVENT DATE

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On September 25, 1979 at 0316 hours while performing ST 5071.04, "Auxiliary Feedwater
0 3 | System Channel Functional Test", the Auxiliary Feed Pump Turbine steam inlet valve MS106
0 4 | on system 1 lost its indication. The system was declared inoperable placing the unit
0 5 | in the Action Statement of Technical Specification 3.7.1.2. On September 26, 1979 at
0 6 | 2030 hours while troubleshooting MS106, MS106A (cross-connect from system 1 to 2) was
0 7 | found not operating. The unit remained in the action statement. There was no danger
0 8 | to the public or to station personnel. The redundant system was operable (NP-33-79-111)

SYSTEM CODE C H 11		CAUSE CODE X 12		CAUSE SUBCODE Z 13		COMPONENT CODE X X X X X X 14				COMP. SUBCODE X 15		VALVE SUBCODE Z 16					
EVENT YEAR 7 9 21 22		SEQUENTIAL REPORT NO. 0 9 5 24 25 26		OCCURRENCE CODE 0 3 28 29		REPORT TYPE L 30		REVISION NO. 0 32									
ACTION TAKEN B 18		FUTURE ACTION B 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 9 0 22		ATTACHMENT SUBMITTED Y 23		NPRD-4 FORM SUB. Y 24		PRIME COMP. SUPPLIER Z 25		COMPONENT MANUFACTURER Z 9 9 9 26	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

Under Maintenance Work Order (MWO) 79-3033, the loss of indication of MS106 was determined to have been caused by a loose lamp retainer ring which grounded and blew the control power fuse. The ring was tightened and fuse replaced. Under MWO 79-3126, the faulty R2 relay (Deutsch) for MS106A was replaced. Auxiliary Feedwater System 1 was declared operable by the successful performance of ST 5071.04 at 1810 hours on 9/27/79.

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

FACILITY STATUS (28) E % POWER (29) 1 0 0 OTHER STATUS (30) NA METHOD OF DISCOVERY (31) B DISCOVERY DESCRIPTION (32) Operator observation

ACTIVITY CONTENT RELEASED OF RELEASE (33) Z (34) Z NA AMOUNT OF ACTIVITY (35) NA LOCATION OF RELEASE (36) NA

PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION (39)	
1	7	0	0	0	(37)	Z	(38) NA

PERSONNEL INJURIES	
NUMBER	DESCRIPTION
1	1
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1	8	0	0	0	(40)	NA											80
7	8	9	11	12													
LOSS OF OR DAMAGE TO FACILITY (43)															1245 348		
TYPE DESCRIPTION																	

TYPE		DESCRIPTION	
1	9	Z	(42) NA

7 8 9 10

PUBLICITY

1245 540

7010010369

NRC USE ONLY

ISSUED DESCRIPTION (45) 7910310387 NRC USE ONLY

2	0	N	(44)	NA
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DVR 79-141, 142 NAME OF PREPARER Thomas P. Beeler

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-111

DATE OF EVENT: September 25, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Lost indication on MS106 and failure of MS106A relay R2

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2770, and Load (Gross MWE) = 918.

Description of Occurrence: On September 25, 1979 at 0316 hours while performing Surveillance Test ST 5071.04, "Auxiliary Feedwater System Channel Functional Test", valve MS106, Auxiliary Feedwater Pump Turbine Steam Inlet Valve 1-1 from Steam Generator 1-1 lost its indication. Auxiliary Feedwater System 1-1 was declared inoperable placing the unit in the Action Statement of Technical Specification 3.7.1.2. This requires two independent auxiliary feedwater systems available while in Modes 1, 2, and 3. With one system inoperable, the inoperable system shall be restored to operable status within 72 hours or be in hot shutdown within the next 12 hours.

On September 26, 1979 at 2030 hours while troubleshooting MS106, it was discovered that MS106A was not operating because its closing relay R2 contacts were not closing. A new relay was installed. While attempting to complete ST 5071.04 on September 27, 1979, at 1500 hours, MS106A was not operating because its closing relay R2 contacts were not closing. A second new relay was installed. These relay failures are being reported to document a component failure.

Designation of Apparent Cause of Occurrence: MS106 was not operating properly because of a grounded control circuit which blew the control power fuse and caused its loss of all indication and control. MS106A was not operating because closing relay R2 contacts were not closing. The problem was determined to be internal to the relay. The relay coil would pickup properly but its contacts would not close. The second failure on September 27, 1979 was corrected by installing a new relay. The new relay had to have its pins spread to make proper contact in the socket base.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. Auxiliary Feedwater System Train 2 was operable had it been required.

Corrective Action: Under Maintenance Work Order (MWO) 79-3033, the first occurrence was investigated. It was found that the control circuit was grounded at the local open indicating light circuit. The lamp retaining ring was tightened, wire re-terminated and control power fuse replaced. As a followup, MWO 79-3132 was issued

LER #79-095

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to inspect additional local indicating lights for excessive loose retaining rings, sockets, etc. There were no significant additional findings. The second occurrence was investigated under MWO 79-3126. The defective R2 relay was replaced. The pins on the second relay were spread to assure proper contact. Facility Change Request 79-361 was written to evaluate the use of Deutsch relays in the Auxiliary Feedwater System. Auxiliary Feedwater System 1 was declared operable by the successful performance of ST 5071.04 at 1810 hours on September 26, 1979.

Failure Data: Previous failures of auxiliary feedwater system relays have been reported in Licensee Event Report NP-33-79-94.

LER #79-095

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