TOLEDO EDISON

March 16, 1979

L79-184
FILE: RR 2 (NP-32-79-02)

Docket No. 50-346
License No. NPF-3

Mr. James G. Keppler
Regional Director, Region III
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Dear Mr. Keppler:

Reportable Occurrence 79-029
Davis-Besse Nuclear Power Station Unit 1
Date of Occurrence: March 6, 1979

Enclosed are three copies of Licensee Event Report 79-029 with a supplemental information sheet which is being submitted in accordance with Technical Specification 6.9 to provide 14 day written notification of the subject occurrence.

Yours truly,

Terry D. Murray/jkk

Terry D. Murray
Station Superintendent
Davis-Besse Nuclear Power Station

TDM/SNB/ljk

Enclosure

cc: Dr. Ernst Volgenau, Director
Office of Inspection and Enforcement
Encl: 40 copies LER 79-029

Mr. William G. McDonald, Director
Office of Management Information
and Program Control
Encl: 3 copies LER 79-029
2 copies telecopy

Corrective Action: At 0415 hours, the Reactor Operator discovered that both DH7A and DH7B were closed and immediately opened them from the Control Room. Disciplinary action was taken against the Auxiliary Operator.

Failure Data: There have been no previous similar events. There have been similar personnel errors previously reported in Licensee Event Reports NP-33-77-111, NP-33-77-113, and NP-33-78-08.

LER #79-029

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-32-79-02

DATE OF EVENT: March 6, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Inadvertent closing of Borated Water Storage Tank (BWST) Isolation Valves DH7A and DH7B

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2384, and Load (Gross MWE) = 790.

Description of Occurrence: During the 0000 to 0800 hours shift on March 6, 1979, operations personnel were performing a valve lineup to drain down the Spent Fuel Pool per Clean Liquid Radwaste Operating Procedure, SP 1104.29, Modification T-3431. In accordance with this modification, the Control Room Reactor Operator instructed an Auxiliary Operator to close BWST to Borated Water Recirculation Pump 1-1 Valve, BW 7. At 04:08:25 hours, the Auxiliary Operator mistakenly closed BWST Isolation Valves DH7A and DH7B using their local switches.

At approximately 0415 hours, the Auxiliary Operator returned to the Control Room and informed the Reactor Operator that he had closed DH7A and DH7B. The Reactor Operator realizing that closing DH7A and DH7B placed the unit in violation of a Technical Specification, immediately opened DH7A and DH7B from the Control Room. The valves were both open at 04:15:17 hours on March 6, 1979.
Closing DH7A and DH7B placed the unit in the Action Statement of Technical Specification 3.5.2 which states that two independent Emergency Core Cooling System (ECCS) subsystems shall be operable with each subsystem comprised of one operable high pressure injection pump, one operable low pressure injection pump, one operable decay heat cooler, and one operable flowpath capable of taking suction from the BWST.

The unit was in this Action Statement for approximately 6 minutes, 52 seconds. This report is being submitted in accordance with Technical Specification

Designation of Apparent Cause of Occurrence: This incident was caused by personnel error. An operator mistakenly closed BWST outlet valves DH7A and DH7B instead of BWST to Borated Water Recirculation Pump 1-1 Valve BW 7.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. A signal from the Safety Features Actuation System would have opened DH7A and DH7B and fully restored the ECCS flowpath, but the 66 second opening time of the valves would have exceeded the 30 second valve safety position criteria of FSAR Section 6.3.4, "ECCS Test and Inspections". The consequences of this event are being analyzed at this time.

LER #79-029