

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONT

0	1
7	8

REPORT SOURCE

L	6	0	5	0	0	0	3	4	6	7	0	4	2	3	8	1	8	0	5	2	2	8	1	9
60	61	DOCKET NUMBER						68	69	EVENT DATE						74	75	REPORT DATE						80

## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (4)

02 | (NP-33-81-27) During a review of the Safety Tagging Log prior to entering Mode 3, a

03 | Shift Supervisor discovered that Makeup (MU) Pump 2 was still tagged out from 4/11/81.

04 | Therefore, the unit had entered Mode 4 without the required two MU pumps operable.

05 | There was no danger to the public or station personnel. The action statement for TS

06 | 3.1.2.4 requires a shutdown to Hot Standby within 72 hours if less than two MU pumps

07 | are operable when in Modes 1-4. The second MU pump was restored within 9 hours of its

08 | required operability, and the unit was in Hot Shutdown.

7 8 9		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE					
0	9	P	C	11	A	12	A	13	P	U	M	P	X	X	14	B	15	Z	16
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
LER/RG REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.		ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD	
17	8	1	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.	
N	24	N	25	B	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

## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

1	0	A thorough review of the Safety Tagging Log and an absolute verification of TS require-
1	1	ments were not done prior to changing modes. Upon discovery, immediate action was
1	2	taken, and the second MU pump was restored by 0445 hours on 4/23/81. The incident was
1	3	reviewed with the personnel directly involved. A memorandum was written to all opera-
1	4	tions personnel to reinforce the necessity for proper procedural verifications.

8 9  
FACILITY STATUS (30) % POWER OTHER STATUS (30) METHOD OF DISCOVERY (32) DISCOVERY DESCRIPTION (32)  
1 5 C (28) 0 0 0 (29) NA A (31) operator observation  
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  
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)  
1 6 Z (33) 7 (34) NA NA  
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  
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)  
1 7 0 0 0 (37) Z (38) NA  
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  
PERSONNEL INJURIES NUMBER DESCRIPTION (41)  
1 8 0 0 0 (40) NA  
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  
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION (43)  
1 9 Z (42) NA  
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  
PUBLICITY ISSUED DESCRIPTION (45)  
2 0 N (44) NA 8105270372  
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  
NRC USE ONLY  
68 69

TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-27

DATE OF EVENT: April 23, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Changed modes without the required number of makeup pumps being operable

Conditions Prior to Occurrence: The unit was in Mode 4 with Power (MWT) = 0 and Load (Gross MWE) = 0.

Description of Occurrence: As a precaution for the OTSG tube plugging outage, both makeup pump breakers were racked out and remained racked out until startup procedures required the Makeup and Purification System be put in service to provide seal injection to the reactor coolant pumps. The end of the shift was near and since only one makeup pump was required for this operation, the Makeup and Purification System was made operable with one makeup pump and the reactor coolant pumps were started. Appropriate log entries were made and startup sequences continued as depicted by the Startup Mode Checklist and the Startup Procedure.

When Mode 4 was approached, the Assistant Shift Supervisor reviewed the Safety Tagging Log for "outstanding items required for entering Mode 4". He did not notice a tag for the racked out breaker of the second makeup was outstanding and signed off the requirement. The following shift, a second Assistant Shift Supervisor, realizing that the Makeup and Purification System was in service since the reactor coolant pumps had been running and the Safety Tagging Log had been reviewed, ascertained that Technical Specification requirements for makeup pumps for Mode 4 had been met and signed off that requirement on the Startup Checklist. With the Startup Checklist then complete, Mode 4 was attained at 2200 hours on April 22, 1981.

The completion of the Startup Checklist for Mode 3 continued which included additional review of the Safety Tagging Log. The Shift Supervisor making this review noticed the outstanding tag, immediately took the necessary action, and restored the second makeup pump by 0445 hours on April 23, 1981, approximately nine hours after entering Mode 4.

Designation of Apparent Cause of Occurrence: Events which resulted in this occurrence included errors on the part of two Assistant Shift Supervisors. A thorough review of the Safety Tagging Log and an absolute verification of Technical Specification requirements were not done prior to changing modes. Either check would have prevented the occurrence.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The action statement for Technical Specification 3.1.2.4 requires a shutdown to Hot Standby within 72 hours if less than two makeup pumps are operable when in Modes 1-4. The second makeup pump was restored within 9 hours of its required operability, and the unit was in Hot Shutdown.

Corrective Action: The second makeup pump was restored as required by 0445 hours on April 23, 1981. The incident was reviewed with the personnel directly involved. A memorandum was written to all operations personnel to reinforce the necessity for proper procedural verifications. In addition, as secondary corrective action, two procedural modifications were prepared to further emphasize the requirement of having both makeup pumps operable as specified in the Technical Specifications. These procedural hi-lites will further assist in preventing recurrence in the future.

Failure Data: One similar occurrence was reported in Licensee Event Report NP-32-78-13 (78-123).

LER #81-025