

# LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONT

REPORT SOURCE

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

DOCKET NUMBER

EVENT DATE

REPORT DATE

(NP 32-81-02) On June 24, 1981, a review of the analysis of the operation of the

04 | could not be closed from their present open limit of 65 degrees open during a design

06 i. There was no danger to the health and safety of the public or to station personnel.

total of 90 hours. The change of a design basis accident during this time would be remote.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 4 | a modification will limit the full open to 55 degrees during the next refueling outage

ISSUED		DESCRIPTION		45	
2	0	N	NA		

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TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-32-81-02

DATE OF EVENT: June 24, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Analysis of the containment purge and exhaust valves determined that these valves would not operate per design of the Final Safety Analysis Report (FSAR)

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2051 and Load (Gross MWE) = 680.

Description of Occurrence: On June 24, 1981, a review of the analysis of the operation of the containment purge and exhaust valves CV 5005, 5006, 5007, and 5008 during a design basis accident concluded that these four valves could not be closed from their present allowable open limit of 65 degrees (with 90 degrees being fully open). These containment isolation valves are Henry Pratt Company butterfly valves, Model No. T-520-SR-1, Serial Nos. 30566-1, 30566-2, 30566-3, and 30566-4. These valves are normally closed and are only opened to purge. When they are open, they create a direct path from containment to the environment. This condition was determined to be reportable under Technical Specification 6.9.1.8.i as the performance of a component that requires corrective action to prevent operation in a manner less conservative than assumed in the FSAR. Part 21 data has been included in order to satisfy the requirements of a 10 CFR 21 report, which is required for this design deficiency.

Designation of Apparent Cause of Occurrence: The cause of the finding is a design deficiency by the valve vendor, Henry Pratt Company. The opening of these valves is presently limited to 65 degrees open by Facility Change Request 79-434. This limit was the result of a preliminary analysis. A new analysis concludes that these valves could not be closed from 65 degrees open under design basis accident conditions. From greater than 55 degrees open position, the delta pressure across the valve would create forces in the valve that could prevent it from closing and could overstress the stub shaft should the valve have to close under these conditions. This analysis was conducted for valves with a pneumatic actuator as installed and would differ for the same valve with a motor actuator.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. These valves were normally in a closed position. They were opened to purge containment atmosphere, and this is normally done in Modes 5 and 6. Previously any purging done in Modes 1, 2, 3, or 4 is limited to a total of 90 hours or one percent of a years time. The chance of a design basis accident occurring during this limited time frame is remote.

Corrective Action: The initial action of the station was to ensure these valves were de-energized in their safety position, closed. From now on, these valves are tagged to prevent their use while in Modes 1, 2, 3, and 4 until Facility Change Request 79-434A has been completed to modify the valve actuator to limit the valve to 55 degrees fully open.

Failure Data: There have been no other reports of a design deficiency concerning these valves.

LER #81-035