NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
01	LICENSEE CODE (2)	O H D B S 1
	LICENSE NUMBER (3)	Ø Ø - Ø Ø Ø Ø Ø - Ø Ø
	LICENSE TYPE (4)	4 1 1 1 1
	CAT (5)	
CON'T 01	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	Ø 5 Ø Ø Ø 3 4 6
	EVENT DATE (8)	Ø 9 Ø 4 8 2
	REPORT DATE (9)	1 Ø Ø 4 8 2

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 (NP-33-82-49) On 9/4/82 at 0945 hours, a Control Room operator observed Auxiliary
03 Feedwater (AFW) Pump 1-1, suction valve FW786 closed for no apparent reason without
04 an operator touching the close button. The station entered the action statement of
05 Technical Specification 3.7.1.2. There was no danger to the health and safety of the
06 public or station personnel. The valve was closed for less than a minute during
07 which the operator was aware of its position.
08

Line 09	Value
SYSTEM CODE (11)	C H
CAUSE CODE (12)	X
CAUSE SUBCODE (13)	X
COMPONENT CODE (14)	V A L V E X
COMP. SUBCODE (15)	X
VALVE SUBCODE (16)	G

(17) LER/RO REPORT NUMBER	Value
EVENT YEAR	8 2
	—
SEQUENTIAL REPORT NO.	Ø 4 5
	/
OCCURRENCE CODE	Ø 3
REPORT TYPE	L
	—
REVISION NO.	Ø

Field	Value
ACTION TAKEN (18)	X
FUTURE ACTION (19)	X
EFFECT ON PLANT (20)	Z
SHUTDOWN METHOD (21)	Z
HOURS (22)	Ø Ø Ø Ø
ATTACHMENT SUBMITTED (23)	Y
NPRD-4 FORM SUB. (24)	
PRIME COMP. SUPPLIER (25)	N
COMPONENT MANUFACTURER (26)	P 3 1 Ø

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause is unknown. Maintenance Work Order 82-2334 was performed on 9/28/82 to in-
11 vestigate the control circuit, however, no cause was found as to why the valve went
12 closed. FW786 was immediately reopened, and the applicable portion of ST 5071.04 was
13 performed to prove operability. Since 9/4/82, there have been no further random
14 closures of this valve.

Line	Field	Value
15	FACILITY STATUS (28)	E
	% POWER (29)	Ø 2 5
	OTHER STATUS (30)	NA
	METHOD OF DISCOVERY (31)	A
	DISCOVERY DESCRIPTION (32)	Operator Observation
16	ACTIVITY RELEASED (33)	Z
	CONTENT OF RELEASE (34)	Z
	AMOUNT OF ACTIVITY (35)	NA
	LOCATION OF RELEASE (36)	NA
17	PERSONNEL EXPOSURES NUMBER (37)	Ø Ø Ø
	TYPE (38)	Z
	DESCRIPTION (39)	NA
18	PERSONNEL INJURIES NUMBER (40)	Ø Ø Ø
	DESCRIPTION (41)	NA
19	LOSS OF OR DAMAGE TO FACILITY TYPE (42)	Z
	DESCRIPTION (43)	NA
20	PUBLICITY ISSUED (44)	N
	DESCRIPTION (45)	NA

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PDR ADOCK 05000346
S PDR

NRC USE ONLY

DVR 82-100 NAME OF PREPARER James W. Long PHONE: (419) 259-5000, Ext. 565

GPO 917-926

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-49

DATE OF EVENT: September 4, 1982

FACILITY: Davis-Besse Unit L

IDENTIFICATION OF OCCURRENCE: FW786 went closed for no apparent reason

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 693 and Load (Gross MWE) = 180

Description of Occurrence: On September 4, 1982 at 0945 hours, a Control Room operator observed Auxiliary Feedwater Pump (AFP) 1-1 suction valve FW786 go from open to close without an operator touching the close button. The station entered the action statement of Technical Specification 3.7.1.2. At 0945 hours, the valve was reopened by the Control Room operator, and the station was removed from the action statement.

Designation of Apparent Cause of Occurence: The cause for this spurious occurrence is unknown. Maintenance Work Order 82-2334 was performed on September 28, 1982 to thoroughly investigate the control circuit, however, no cause was found as to why the valve went closed. FW 786 is a locked valve; as such its local controller is locked and the manual valve handwheel on the limitorque operator was locked in the open position. This and the fact that the security computer did not show personnel in the room indicates that the valve was not intentionally closed.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. The valve was closed for less than a minute during which the operator was aware of its position. Auxiliary Feedwater Train 1 could have been manually restored from the Control Room if required. In addition, Auxiliary Feedwater Train 2 was operable during the time of the occurrence.

Corrective Action: The Control Room operator verified that SW 1382 did not open, and the auxiliary feedwater pump trouble alarm did not actuate which indicates it was not the low pressure switch interlock causing the closure. FW786 was reopened, and the applicable portion of Surveillance Test ST 5071.04 was performed to prove operability. Repeated attempts were made to duplicate the initial conditions of the event without success. Relay checks and electrical inspections under MWO 82-2334 did not reveal subsequent problems. Since September 4, 1982, there have been no further random closures of this valve.

Failure Data: A previous similar occurrence was reported in Licensee Event Report NP-33-80-33 (80-024) which described the Auxiliary Feed Pump Turbine 1-2 Main Steam Isolation Valve MS-107 randomly closing for no apparent reason.