

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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7 8
9 14
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57 58

LICENSEE CODE
LICENSE NUMBER
LICENSE TYPE
CAT

CON'T

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 (NP-33-82-19) On 3/23/82, Operations personnel discovered that valve CS20, a locked
0 3 valve, was locked in the wrong position. PT 5186.01 was performed on 3/25/82 to ensure
0 4 that all other locked valves were in their proper position and locked valves FW786
0 5 and FW790 were also found out of their normal positions. These occurrences are being
0 6 reported per Technical Specification 6.9.1.9.c. There was no danger to the health
0 7 and safety of the public or station personnel. The affected systems were not required
0 8 for safe operation of the plant throughout these occurrences.

SYSTEM CODE S D		CAUSE CODE A		CAUSE SUBCODE A		COMPONENT CODE V A L V E X				COMP. SUBCODE E		VALVE SUBCODE D	
9 10		11 12		12 13		13 14 15 16 17 18				19 20		21 22	
(17) LER RO REPORT NUMBER		EVENT YEAR 8 2				SEQUENTIAL REPORT NO. 0 1 7		OCCURRENCE CODE 0 3		REPORT TYPE L		REVISION NO. 0	
21 22		23 24		24 25		26 27		28 29		30 31		32 33	
ACTION TAKEN H	FUTURE ACTION X	EFFECT ON PLANT Z	SHUTDOWN METHOD Z	HOURS 0 0 0	ATTACHMENT SUBMITTED Y	NPRD-4 FORM SUB. N	PRIME COMP. SUPPLIER Z	COMPONENT MANUFACTURER Z 9 9					
33 34	34 35	35 36	36 37	37 38 39 40	41 42	42 43	43 44	44 45 46 47					
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)													

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause was personnel error. An investigation revealed that CS20 had been placed in
1 1 an abnormal position during the performance of a containment penetration local leak
1 2 rate test. All shift operators were retrained on the safety significance and implica-
1 3 tions of having locked valve in abnormal positions and their responsibilities concern-
1 4 ing locked valves.

1		5		FACILITY STATUS		A		(28)		% POWER			0			0			0			(29)		OTHER STATUS			NA		(30)		METHOD OF DISCOVERY		A		(31)		DISCOVERY DESCRIPTION										(32)		Discovered by Operations Personnel		(80)	
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ACTIVITY CONTENT
RELEASED OF RELEASE

1 6 Z 33 10 Z 34 NA

AMOUNT OF ACTIVITY (35)

LOCATION OF RELEASE (36)

NA

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

PERSONNEL INJURIES	
NUMBER	DESCRIPTION
1 2	NA

7		8		9		11		12	
				LOSS OF OR DAMAGE TO FACILITY					
				TYPE		DESCRIPTION		(43)	
1	9	Z	(42)	NA					

7 8 9 10
PUBLICITY
ISSUED DESCRIPTION (45) 8204300204
2 0 N (44) NA
7 8 9 10 68 69 80
NRC USE ONLY

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-19

DATE OF EVENT: March 23, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Locked Valves Found in Wrong Position

Conditions Prior to Occurrence: The unit was in Mode 6 with Power (MWT) = 0 and Load (Gross MWE) = 0

Description of Occurrence: On March 23, 1982, Operations personnel discovered that Containment Spray Lower Spray Header Isolation Valve, CS20, a locked valve, was locked in the wrong position (closed). It was immediately restored to its proper position (open) and locked. As a precaution, PT 5186.01, "Locked Valve Verification Periodic Test" was performed on March 25, 1982, to ensure that all other locked valves were in their proper position. As a result of this test, two valves, Auxiliary Feedwater Pump 1-1 Suction Isolation Valve FW786 and Auxiliary Feedwater Pump 1-2 Suction Isolation Valve FW790, were found out of their normal positions and not logged in the Locked Valve Log. Both occurrences are in violation of Administrative Procedure AD 1839.02, "Operation and Control of Locked Valves" which states that all locked valves shall be locked in their designated positions or, when required to be abnormally positioned, be unlocked and logged in the Locked Valve Log as described in AD 1839.02.

This occurrence is being reported per Technical Specification 6.9.1.9.c which requires 30 day written notice of occurrences in which inadequacies in the implementation of administrative or procedural controls which threaten to cause reduction of the degree of redundancy provided in reactor protection systems or engineered safety features systems are observed.

Designation of Apparent Cause of Occurrence: This occurrence is attributed to personnel error. A thorough investigation indicates that CS20 had been placed in an abnormal position and subsequently restored and locked during the performance of a containment penetration local leak rate test on March 19, 1982. Plant operations during this time period did not require any repositioning of FW786 and FW790. Review of the control schemes for these valves indicated that the planned electrical bus outages occurring during this time period could not reposition FW786 and FW790. The investigation concluded that personnel error was the cause but it was undetermined from which person or persons these occurrences originated.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. Since the unit was in Mode 6 at the time of this occurrence, the affected systems, Containment Spray and Auxiliary Feedwater, were not required for the safe operation of the plant.

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Corrective Action: The Operations Engineer conducted intensive meetings and training sessions with all shift operators on this incident. These meetings consisted of a detailed discussion of the following topics:

- 1) The safety significance and implications of having locked valves in uncontrolled and incorrect positions,
- 2) Definition of a locked valve and the detailed procedure for placing a locked valve in an abnormal position and for restoring that valve to its normal locked position, and
- 3) The responsibilities that all operators have concerning locked valves

In order to further control the locked valve keys, all locked valves will be fitted with new locks and a separate key cabinet for locked valve keys will be installed in the Shift Supervisor's office. Until these new locks are installed, Operations will perform PT 5186.01 every four days on selected locked valves (see Modification T-6201 attached to PT 5186.01).

Failure Data: A similar occurrence has occurred, see Licensee Event Report NP-33-82-12 (82-010).

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